Queen Victoria Hospital
NHS Foundation Trust

Business Meeting of the Board of Directors

Thursday 6 July 2023

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

MEMBERSHIP
BOARD OF DIRECTORS
July 2023

Members (voting):

Trust Chair	-	Jackie Smith
Senior Independent Director	-	
Non-Executive Directors	-	Paul Dillon-Robinson
	-	Kevin Gould
	-	Karen Norman
	-	Peter O'Donnell
	-	Shaun O'Leary
	-	Russell Hobby
Director of Strategy and acting Chief Executive	-	Abigail Jago
Medical Director	-	Tania Cubison
Chief Nurse	-	Nicky Reeves
Chief Finance Officer	-	Maria Wheeler

In full attendance (non-voting):

Director of Operations	-	Shane Morrison-McCabe
Director of Communications and Corporate Affairs	-	Clare Pirie
Chief People Officer	-	
Deputy Company Secretary	-	Leonora May

Annual declarations by directors 2023/24

Declarations of interests

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

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

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

Register of declarations of interests

	Relevant and material interests							
	Directorships, including non-executive directorships, held in private companies or public limited companies (with the exception of dormant companies).	Ownership, part ownership or directorship of private companies, businesses or consultancies likely or possibly seeking to do business with the NHS or QVH.	Significant or controlling share in organisations likely or possibly seeking to do business with the NHS or QVH.	A position of authority in a charity or voluntary organisation in the field of health or social care.	Any connection with a voluntary or other organisation contracting for NHS or QVH services or commissioning NHS or QVH services.	Any connection with an organisation, entity or company considering entering into or having entered into a financial arrangement with QVH, including but not limited to lenders of banks.	Any "family interest": an interest of a close family member which, if it were the interest of that director, would be a personal or pecuniary interest.	Other
Non-executive and executive members of the board (voting)								
Jackie Smith Trust Chair	Directorship of WeNurses	Nil	Nil	Nil	Nil	Nil	Nil	Nil
Abigail Jago Director of Strategy & Partnerships and acting chief executive	Nil	Nil	Nil	Nil	Nil	Nil	Nil	Nil
Paul Dillon-Robinson Non-Executive Director	Trustee/ Director, Hurst Educational Trust Trustee/ Director, Association of Governing Bodies of Independent Schools	Independent consultant (self-employed) – see HFMA	Nil	Nil	Nil	Independent consultant working with the Healthcare Financial Management Association (including writing guidance, HFMA academy, one NHS finance, future focussed finance and coaching and training)	Nil	Nil

Kevin Gould Non-Executive Director	Director, Sharpthorne Services Ltd	Nil	Nil	Independent Member of the Board of Governors, Staffordshire University. Director for Grand Union Housing Group Director for Look Ahead Care & Support Trustee, Centre for Alternative technology	Director, Look Ahead Care & Support	Nil.	Nil	Nil
Karen Norman Non-Executive Director	Visiting professor, business school, University of Hertfordshire Visiting professor, School of Nursing, Kingston University and St George's, University of London Visiting consultant, School of Life and Health Sciences, University of Roehampton	Nil	Nil	Nil	Nil	Nil	Nil	Nil
Peter O'Donnell Non-Executive Director	Non-executive director for Nottingham Building Society	Nil	Nil	Trustee for Cardiac Risk in the Young	Nil	Nil	Nil	Nil

Shaun O'Leary Non-Executive Director	Nil	Nil	Nil	Chair and Trustee of St Wilfreds Hospice, Eastbourne	Nil	Nil	Nil	Nil
Russell Hobby Non-Executive Director	Director of 5 Lewes Crescent Mgt Co. RVHB Ltd	Nil	Nil	Chief executive officer of Teach First (education charity)	Nil	Nil	Nil	Nil
Tania Cubison 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 due to retire 17/04/2023 from this salaried post. He has signposted patients to me and the QVH.	Nil
Maria Wheeler Chief Finance Officer	Nil	Nil	Nil	Nil	Nil	Nil	Nil	Nil
Nicky Reeves Chief Nurse	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
Clare Pirie Director of Communications & Corporate Affairs	Nil	Nil	Nil	Nil	Nil	Nil	Nil	Nil
Abigail Jago Director of Strategy & Partnerships	Nil	Nil	Nil	Nil	Nil	Nil	Nil	Nil

Fit and proper persons declaration

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

Register of fit and proper person declarations

	Categories of person prevented from holding office						
	The person is an undischarged bankrupt or a person whose estate has had a sequestration awarded in respect of it and who has not been discharged.	The person is the subject of a bankruptcy restrictions order or an interim bankruptcy restrictions order or an order to like effect made in Scotland or Northern Ireland.	The person is a person to whom a moratorium period under a debt relief order applies under Part VIIA (debt relief orders) of the Insolvency Act 1986(40).	The person has made a composition or arrangement with, or granted a trust deed for, creditors and not been discharged in respect of it.	The person is included in the children's barred list or the adults' barred list maintained under section 2 of the Safeguarding Vulnerable Groups Act 2006, or in any corresponding list maintained under an equivalent enactment in force in Scotland or Northern Ireland.	The person is prohibited from holding the relevant office or position, or in the case of an individual from carrying on the regulated activity, by or under any enactment.	The person has been responsible for, been privy to, contributed to, or facilitated any serious misconduct or mismanagement (whether unlawful or not) in the course of carrying on a regulated activity, or discharging any functions relating to any office or employment with a service provider.
Non-executive and executive members of the board (voting)							
Jackie Smith Trust Chair	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Abigail Jago Director of strategy and partnerships and acting chief executive	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
Karen Norman Non-Executive Director	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Peter O'Donnell Non-Executive Director	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Shaun O'Leary Non-Executive Director	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Russell Hobby Non-Executive Director	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Tania Cubison Medical Director	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Maria Wheeler Chief Finance Officer	N/A	N/A	N/A	N/A	N/A	N/A	N/A
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
Clare Pirie Director of Communications & Corporate Affairs	N/A	N/A	N/A	N/A	N/A	N/A	N/A

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10.00-12.00

Agenda: session held in public				
WELCOME				**Time**
42-23	**Welcome, apologies and declarations of interest** *Jackie Smith, Trust Chair*			10.00
STANDING ITEMS		**Purpose**	**Page**	
43-23	**Patient story**	*Assurance*	-	10.02
44-23	**Staff story**	*Assurance*	-	10.12
45-23	**Draft minutes of the public meeting held on 4 May 2023** *Jackie Smith, Trust Chair*	*Approval*	11	10.22
46-23	**Matters arising and actions pending from the public meeting held on 4 May 2023** *Jackie Smith, Trust Chair*	*Review*	20	10.24
47-23	**Chair's report** *Jackie Smith, Trust Chair*	*Assurance*	21	10.25
48-23	**Chief executive's report** *Abigail Jago, acting chief executive*	*Assurance*	24	10.30
GOVERNANCE				
49-23	**Risk management and corporate risk register** *Clare Pirie, director of communication and corporate affairs* *Nicky Reeves, chief nurse*	*Review*	31	10.35
50-23	**Well led report – recommendations and organisational response** *Jackie Smith, Trust Chair* *Clare Pirie, director of communication and corporate affairs*	*Approval*	54	10.45
51-23	**Establishment of strategic development committee** *Clare Pirie, director of communication and corporate affairs* *Abigail Jago, director of strategy and partnerships*	*Approval*	61	10.55
52-23	**Standing orders, standing financial instructions and scheme of delegation and reservation of power** *Clare Pirie, Director of communication and corporate affairs*	*Approval*	68	11.00
53-23	**Audit assurance** *Kevin Gould, non-executive director and committee Chair*	*Assurance*	196	11.05
TRUST STRATEGY				
Key strategic objectives 1 and 2: outstanding patient experience and world-class clinical services				
54-23	**Quality and Safety report** *Nicky Reeves, Chief Nurse*	*Assurance*	198	11.07

55-23	**Six monthly nursing workforce review** *Nicky Reeves, chief nurse*	*Assurance*	215	11.14
56-23	**Quality and governance assurance** *Karen Norman, non-executive director and committee Chair*	*Assurance*	226	11.19
Key strategic objective 4: financial sustainability				
57-23	**Financial performance** *Maria Wheeler, chief finance officer*	*Assurance*	232	11.22
Key strategic objective 3: operational excellence				
58-23	**Operational performance monthly report** *Shane Morrison-McCabe, director of operations*	*Assurance*	243	11.29
Key strategic objective 5: organisational excellence				
59-23	**Workforce report** *Clare Pirie, director of communication and corporate affairs*	*Assurance*	258	11.36
60-23	**Staff survey results** *Clare Pirie, director of communication and corporate affairs*	*Assurance*	268	11.43
61-23	**Financial, operational and workforce performance assurance** *Paul Dillon-Robinson, non-executive director and committee Chair*	*Assurance*	284	11.48
62-23	**Digital assurance** *Kevin Gould, non-executive director and Committee Chair*	*Assurance*	287	11.51
MEETING CLOSURE				
63-23	**Any other business (by application to the Chair)** *Jackie Smith, Trust Chair*	*Discussion*	-	11.54
MEMBERS OF THE PUBLIC				
64-23	*We welcome relevant, written questions on any agenda item from our staff, our members or the public. To ensure that we can give a considered and comprehensive response, written questions must be submitted in advance of the meeting (at least three clear working days). Please forward questions to Leonora.may1@nhs.net clearly marked "Questions for the board of directors". Members of the public may not take part in the Board discussion. Where appropriate, the response to written questions will be published with the minutes of the meeting.* *Jackie Smith, Trust Chair*			
65-23	*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.* *Jackie Smith, Trust Chair*			

Document:	Minutes (DRAFT)	
Meeting:	**Board of Directors (session in public)** **10.00-12 noon 4 May 2023** **Education centre, QVH**	
Present:	Jackie Smith	Trust Chair (voting) (Chair)
	Gary Needle (GN)	Senior independent director (voting)
	Paul Dillon-Robinson (PDR)	Non-executive director (voting)
	Kevin Gould (KG)	Non-executive director (voting)
	Karen Norman (KN)	Non-executive director (voting) (via MS Teams)
	Tony Chambers (TCH)	Interim chief executive (voting)
	Stuart Rees (SR)	Interim Chief finance officer (voting)
	Tania Cubison (TC)	Medical director (voting)
	Shane Morrison- McCabe (SMM)	Director of operations (non-voting)
	Clare Pirie (CP)	Director of communications and corporate affairs (non-voting)
	Abigail Jago (AJ)	Director of strategy and partnerships (non-voting)
In attendance:	Leonora May (LM)	Deputy company secretary (minutes)
	Liz Blackburn (LB)	Deputy chief nurse (deputising for chief nurse)
	Sheila Perkins (SP)	Freedom to speak up guardian [until 8-23]
	Jennifer O'Neill (JON)	Guardian of safe working [until 9-23]
Apologies:	Nicky Reeves (NR)	Chief nurse (voting)
	Lawrence Anderson (LA)	Interim director of workforce and OD (non-voting)
Members of the public:	Two public governors, one member of public, one patient and their spouse for item 2-23 and one member of staff	

Welcome

1-23 — **Welcome, apologies and declarations of interest**

The Chair opened the meeting welcoming members of the Board, attendees, staff and members of public observing the meeting including two public governors. SP and JON were welcomed to the meeting.

The Chair reminded members of the public that they were invited to observe the meeting in public but not to participate in discussions.

Apologies were received from NR and LA and the meeting was declared as quorate.

There were no declarations of interest other than those already recorded on the register of interests.

Standing items

2-23 — **Patient story**

The Board welcomed a QVH patient and his spouse to the meeting to share their experience of QVH.

The patient explained that he had raised a complaint following a surgical procedure on his ear because he thought that the surgeon may not have followed the guidelines regarding discussing options with patients; the surgeon did not speak to him during the operation.

The patient outlined the following four concerns regarding his complaint and how it was subsequently handled:

- That his initial letter of complaint was not handled well, and that the Trust has accepted that. He stated that following his initial letter of complaint, the patient experience manger contacted the surgeon and junior doctor that were present for the operation regarding the complaint but no one else

	- The patient followed up his initial letter of complaint but did not hear back for more than two months after being told that he would receive a response within 15 days. By this time, those present in the operating room had no recollection of the event that caused the initial complaint - The patient highlighted that where there is a complaint against a surgeon and a junior doctor might be a witness, this may put the junior doctor in a difficult position. He highlighted the importance of the Board establishing and maintaining a no blame culture in this regard - The patient thought that in dealing with complaints it is important for the Trust to make a judgement on the correct version of events based on the 'balance of probabilities' and emphasised that in his view it is not sufficient to respond to complaints to say that regrettably there are different recollections of what happened. He thought that the Trust may miss opportunities to stop bad practice in the future with this kind of response JS apologised to the patient on behalf of the Board for his experience during the surgery and with the subsequent complaint process. She reminded that the Board that patient stories offer valuable insight into patient experience and lessons that can be learnt. TC confirmed that the patient's points regarding encouraging those in junior positions to speak up and making a judgement on events based on the 'balance of probabilities' is understood and that she is aware that behaviour has an impact on patient safety. She referenced the 'Civility Saves Lives' campaign and evidence that behaviour and the way that care givers talk to patients has a direct impact on the quality of care. This campaign is being shared with medical staff at QVH. She committed to speaking to the surgeon concerned and ascertaining whether additional training or other intervention is required to ensure that this does not happen to another patient. Regarding the way in which the complaint was handled, LB confirmed that the lessons learnt from this complaint will be used to consider how the process can be improved in the future. The Board extended thanks to the patient for sharing his experience at QVH and wished him well.
3-23	**Draft minutes of the public meeting held on 2 March 2023** The Board noted that the following amendments will be made to the minutes: - The second paragraph of 235-23 will be amended to 'The Board sought assurance regarding the deliverability of the plan as presented and SMM confirmed that she is confident in the methodology behind building the assumptions but that there are a number of risks to delivery including workforce, increased demand for key services and industrial action' - 236-23 will be amended to 'the national 52 week and 78 week standards are being replaced by a 65 week standard from April 2023' Subject to the above amendments being made, the Board **agreed** that the draft minutes of the public meeting held on 2 March 2023 were a true and accurate record of that meeting and **approved** them on that basis.
4-23	**Matters arising and actions pending from the public meeting held on 2 March 2023** There were four pending actions and the Board noted that: - 172-22 (WRES and WDES)- the due date has been amended to 6 July 2023 due to LA's absence - 228-23 (corporate risk register (CRR))- the due date has been amended to 6 July 2023 due to ongoing work with an independent risk specialist to refresh the register

	SMM provided the following verbal update for action 225-23 (impact of strike action), and the action will be marked as complete. She reported that there have been four strike periods this year to date and that the update included the most recent RCN strike. For the three periods of RCN action and the junior doctors action: - The total number of patients rescheduled, as reported nationally, was 706 outpatient appointments and 103 operative procedures - The actual number of patients not treated on days of industrial action was higher than this as we were not booking patients in the normal way when it became clear that strikes were likely, in order to reduce the disruption to patients from the required rescheduling processes. The total figure for the impact of industrial action, based on our usual activity, would be approximately double the numbers. SMM confirmed that the Trust put on a number of additional weekend and week day sessions to catch up and have now recovered the position and that the Trust is now where it would have been with no strikes and no additional sessions (including the most recent action). She reported that there are no reports of any clinical harm to patients as a result of delays due to industrial action. Board members sought clarity regarding whether there had been an impact on patients and SMM confirmed that only patients that were already booked were rescheduled and that there will be a knock on impact on future patients that have not yet been booked. In response to a question regarding the impact strike action might have on the delivery of the operational plan, SMM confirmed that there are some risks related to delivery but that there are good processes in place to mitigate them and that she will escalate concerns regarding the deliverability of the plan as appropriate. The Board **noted** the update.
5-23	**Chair's report** JS presented the report to the Board, highlighting that: - Deloitte had finished the Trust's well led review and the Board would have a discussion regarding action planning and priorities at its public meeting on 6 July 2023 - Recruitment for two non-executive directors to replace KG and GN, a substantive chief executive officer, chief people officer and chief finance officer is ongoing JS extended thanks to those governors who are stepping down at the end of June when their term of office ends. The Board **noted** the contents of the report.
6-23	**Chief Executive's report** TCH presented the report to the Board, highlighting that: - Improvement works to the main corridor are complete and this will have a positive impact on patients and staff. TCH extended thanks for the estates team for all of their work on this project - The Trust had ended 2022/23 and started 2023/24 where the Board expected it to. The focus for 2023/24 will be regarding how the organisation uses its assets including getting 'best value' to address productivity challenges. The Trust will also need to keep a close focus on workforce as previously there had been growth but no increase in productivity. The system plan for NHS Sussex is challenging and the ask for delivery of efficiency savings of 5.5% is thought to be significant - The NHS will be 75 years old on 5 July 2023 and the Trust will be holding celebrations

	A Board member queried whether, given the changes in the financial regime, the Board should still consider KSO4 financial sustainability to be its highest rated risk, currently scored at 20. In response, SR confirmed that it is his view that KSO4 financial sustainability should be rescored to 12, that it is no longer the Trust's highest risk and that this would be actioned following the meeting. In response to a question regarding the impact of the system efficiency ask, TCH confirmed that each acute provider within the Sussex system has put in plans for delivering elective activity with a target of reaching 109% of 2019/20 volumes. QVH was the only provider within the system to submit a 109% response to the ask, with others seeking to deliver 100%. There is an opportunity for QVH to support others in the system to deliver. Discussion was had regarding NHS Sussex provider collaboratives and progress with strategic development. TCH said that there is good work happening in Sussex neighbourhoods but that the Sussex 'place' is yet to be fully described. The Board **noted** the contents of the report.
Governance	
7-23	**Freedom to speak up guardian report** SP presented the report stating that there had not been much activity during the last six months, and that it appeared staff were raising concerns through other mechanisms such as 'tell Nicky' or via their senior managers. The Board considered and discussed the contents of the report as follows: - The Board acknowledged the pertinent point made earlier in the meeting by the patient regarding resistance to speaking up due to 'hierarchy' and the need to address this - SMM thought that a reduction in administrative staff raising concerns might be an indication that ongoing work to address issues within a particular team had had a positive impact - JS expressed the view that not much activity could be concerning and an indicator that staff may not feel safe to speak up - Discussion was had regarding the importance of triangulation of all speaking up/ raising concerns data to provide a full picture of concerns being raised and CP confirmed that the chief nurse is triangulating freedom to speak up and 'tell Nicky' data which will be presented to the appropriate Board sub-committees The Board **noted** the contents of the report. [SP left the meeting]
8-23	**Guardian of safe working report** JON presented the report to the Board, highlighting the key issues and positives as set out on the front cover to the report. She confirmed that to the best of her knowledge, the rotas remain safe and she is not aware of any current issues. A Board member asked JON about the reasons why she cannot be certain that the rotas are safe. In response she highlighted some risks such as junior doctors driving home after a shift and mental illnesses which the Trust needs to be mindful of. The Board noted that maxillofacial registrars on long cancer cases sometimes work extra hours, and that the human resources team are looking at the rota to see if this can be accommodated in a compliant way with compensatory time off In response to a question regarding whether there might be a cultural issue that does not support exception reporting,

	JON confirmed that the registrars were completing additional hours because it is good for their training. The Board **noted** the contents of the report.
9-23	**Corporate risk register (CRR)** LB presented the report to the Board, highlighting that during the period one risk had been added to the CRR, two risks had been closed and one had been rescored. The Board noted that the executive team are completing a refresh of the CRR with the support from an independent risk professional and that the refreshed CRR would be presented to the Board at its next meeting. JS emphasised the need for the CRR to be agile and a document that Board members recognise as painting an accurate picture at a point in time. The Board **noted** the contents of the report.
10-23	**Self-certification of NHS provider licence 2022/23** CP presented the report to the Board. TC queried the inclusion of paediatric surgery in the commissioner requested service list and CP agreed to follow up outside of the meeting. In response to a question regarding the independent review recommendations, CP confirmed that all recommendations had been completed bar recommendation 9 (licence conditions to be developed into a Trust policy) due to an ongoing process related to a governor. The Board: - **Agreed** that it has complied with the standard and additional NHs provider licence conditions, it has taken all precautions necessary to comply with the licence, NHS Acts and NHS Constitution, it has complied with required governance arrangements and it has reasonable expectation that required resources will be available to deliver the designated commissioner requested services over the next financial year but specific factors may cast doubt on this - **Approved** the Trust's self-certification statement for publication on its website
11-23	**Code of Governance for NHS provider trusts** CP presented the report to the Board, highlighting that the new code of governance came into effect from 1 April 2023, and that the main changes relate to a focus on system working, culture and equality diversity and inclusion. She confirmed that the deputy company secretary had completed a detailed gap analysis against the new code of governance. Any gaps were listed in appendix one to the report with a proposed action plan to ensure compliance. The Board noted that the Trust would be non-compliant with E.2.2 for 2023/24, as its levels of remuneration for the Chair and non-executive directors is higher than the remuneration structure published by NHSE and there is no intention to reduce the remuneration. The Trust will explain this approach in its 2023/24 annual report and accounts. PDR thought that some of the proposed actions did not meet the code provision, for example he thought that the action for A.2.1 should have been more focussed on value for money. He agreed to provide detailed feedback outside of the meeting. The Board **noted** the contents of the report.
12-23	**Audit assurance**

	KG presented the report to the Board who **noted** the contents.
Trust strategy	
Key strategic objective 4: financial sustainability	
13-23	**Board assurance framework KSO4** SR presented the KSO4 board assurance framework, highlighting that the risk score will be reviewed and reduced in light of the new financial regime. The Board **noted** the contents of the report.
14-23	**Financial performance monthly report** SR presented the report to the Board, highlighting that the Trust's year end position was break even with £11m in cash. He confirmed that all capital for 2022/23 had been spent and thanked teams for work completed to achieve this. The Board reflected on the issue regarding the amount of unspent capital at quarter four of 2022/23 and lessons learnt to be taken forward for this financial year. SR thought that the budgets were not spent early enough because teams were unaware of their budget allocation until later on in the year. He confirmed that for the current financial year, teams would be notified of their budget before the end of quarter one (June), and that the team have improved the monitoring process. Discussion was had regarding efficiencies and the Board noted that efficiency schemes year to date were largely focussed on targeting 100% of spend. SR confirmed that teams are engaging well with this and confirmed that he is confident 4% recurrent efficiencies will be delivered this year. The Board **noted** the contents of the report.
15-23	**2023/24 financial plan and budget** SR presented the report to the Board highlighting that there are some risks to the delivery of 109% of 2019/20 activity levels and 5.5% efficiencies, including recent industrial action. The Board sought assurance regarding the deliverability of the plan given the impact of recent and future industrial action. TCH confirmed that the executive management team are closely monitoring progress against the plan. Month end at April 2023 had shown 85% delivery against the plan and this was thought to be largely attributable to strike action. SMM confirmed that she is confident in the deliverability of the plan and stated that there was a need to focus on workforce including recruitment and retention and productivity in order to achieve it. The Board requested future trajectories against the plan in future reporting instead of a focus on what has been achieved for previous months. The Board **approved** the 2023/24 financial plan and provisional budget.
Key strategic objective 5: organisational excellence	
16-23	**Board Assurance Framework KSO5** CP presented the KSO3 board assurance framework and confirmed that there had been no changes since the last meeting. The Board **noted** the contents of the report.
17-23	**Workforce monthly report** CP presented the report to the Board, highlighting that:

	- There are some ongoing challenges within the workforce team, including staff sickness and leavers which are having a big impact - Attracting a new Chair for the ethnically diverse staff (EDS) network has been challenging and external expertise has been sought to help with this - Detailed scrutiny of appraisal data has shown a number of staff with appraisals outstanding for more than six months. She confirmed that action is being taken to address these promptly and reporting to the executive team has been established The Board considered and discussed the contents of the report as follows: - Concern was raised regarding appraisal compliance and the Board agreed that this should be addressed alongside quality assurance with some urgency given that appraisals have a direct impact on organisational culture. The Board agreed the need to identify the action and resource required to address this issue urgently and report back to the Board at its next meeting. **Action: CP** - The Board agreed the importance of continued work placement opportunities for nursing and medical staff in order to help to tackle recruitment and retention issues. CP agreed to explore if there are further work placement opportunities that can be sought and offered - TCH highlighted that staff networks are an important part of the Trust's culture and highlighted that there are risks associated with not having a Chair in place for the EDS network. It will be important to ensure that the network can continue to provide diversity challenge to recruitment processes. The Board agreed with a suggestion that executive leads be identified for current and new staff networks The Board **noted** the contents of the report.
Key strategic objective 3: operational excellence	
18-23	**Board assurance framework KSO3** SMM presented the board assurance framework related to KSO3 to the Board, highlighting that a number of patients are finding it difficult to get to appointments due to cost of living pressures. The Board **noted** the contents of the report.
19-23	**Operational performance monthly report** SMM presented the report to the Board, highlighting that: - Year-end performance was positive with zero 78 week patients and achieving the 72 day cancer standard - During this financial year there will be a strong focus on elective recovery and elective opportunities to increase income - Performance in the minor injuries unit has been good - Sleep referrals have more than doubled and the team are working closely with system colleagues to help with capacity, funding and outsourcing but the Trust is unlikely to achieve the national diagnostic standard The Board considered and discussed the contents of the report as follows: - The Board commended the team on the positive year end position and thanked all those involved in achieving this - Discussion was had regarding patient waiting times and whether the Trust communicates national targets to patients in order that they know what to expect regarding the timing of their treatment. TC highlighted that every patient treated is triaged and prioritised based on their condition and urgency and that clinicians are managing expectations regarding waiting times. She stated that many patients who have waited for more than a year have no changing or slow developing issues. The Board took assurance from this

	- In response to a question regarding the strategic direction for the Trust's sleep service, TCH confirmed that this thinking will form part of the Trust's clinical strategy, recognising that outsourcing is not a feasible long term solution The Board **noted** the contents of the report.
20-23	**Financial, operational and workforce performance assurance** PDR presented the report to the Board, highlighting that the committee will focus on theatre productivity and outpatient activity during the year as it recognises that it is critical to the delivery of the 2023/24 finance and operating plan. The committee is also looking to make some changes to the way it works with more of a focus on future trajectories with less detail and shorter papers. The Board **noted** the contents of the report.
21-23	**Digital assurance** KG presented the report to the Board, reporting that there will be a change in the timeline for the electronic patient record (EPR) business case and implementation which is likely to be pushed back to the autumn of 2023. The Board **noted** the contents of the report.
Key strategic objectives 1 and 2: outstanding patient experience and world-class clinical services	
22-23	**Board assurance framework KSO1 & KSO2** LB presented the board assurance framework for KSO1, highlighting that the Trust's Covid guidance for asymptomatic staff had been updated in line with national guidance. TC presented the board assurance framework for KSO2 and reported that recruitment was going well, including for historically hard to recruit to positions. There is a need to continue to conduct interviews in a timely manner to ensure that the correct candidates are secured for the roles. The Board **noted** the contents of the reports.
23-23	**Quality and safety report** LB presented the report to the Board and highlighted that: - One serious incident was declare during the period and this relates to an unexpected death - The flu vaccination campaign is complete and 85% of the workforce have either received a vaccination or opted out. Work to understand why members of staff opted out continues - MRSA screening for trauma cased dropped in February but improved in March. Elective screening has dropped below the threshold for March and actions are in place to address this The Board **noted** the contents of the report.
24-23	**EPRR core standards and statement of readiness** LB presented the report to Board, reporting that the Trust has achieve substantial compliance during the assurance exercise. There are four standards which require action and one of them has been completed. The Board **noted** the contents of the report.
25-23	**Quality and governance assurance**

	KN presented the report to the Board who noted that the committee had met three times since its last assurance report. She highlighted the results of the external EPRR assessment as a commendable achievement. The Board were supportive of a suggestion that the committee should complete periodic deep dives into formal patient complaints and KN and NR agreed to take this forward. **Action KN NR** The Board **noted** the contents of the report.
Meeting closure	
26-23	**Any other business (by application to the Chair)** JS highlighted that this was GN's last Board meeting as senior independent director for the Trust, as his second and final term would come to an end at the end of June 2023. She extended thanks to GN for his enormous contribution to QVH during his six years in post and commended him for his wisdom, knowledge of the NHS, strategic thinking and supportive approach to Board colleagues. There was no further business and the meeting closed.
Members of the public	
27-23	**Questions from members of the public** There were none.
28-23	**Exclusion of members of the public** 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.

Matters arising and actions pending from previous meetings of the Board of Directors - PUBLIC								
ITEM	**MEETING Month**	**REF.**	**TOPIC**	**AGREED ACTION**	**OWNER**	**DUE**	**UPDATE**	**STATUS**
1	Nov-22	172-22	WRES and WDES	Provide the Board with an update in improvements made to the workplace following reports of bullying and harassment from staff with protected characteristics, as evidenced in the WRES and WDES data.	**LA**	~~**4 May 2023**~~ ~~**6 July 2023**~~	November 2022: Scheduled on Board agenda for 4 May 2023 meeting April 2023: Scheduled on Board agenda for 6 July 2023 meeting June 2023: The Trust has engaged external equality, diversity and includsion support to review the QVH WRES and WDES, to run a series of confidential one-to-one conversations for people with a disability and people from Ethnic minority groups framed on the indicators of WRES and WDES, and to work with the leadership team to develop an action plan which will go to the July finance and performance committee. July 2023: Action superseeded by 2022/23 WRES and WDES reports which will be presented to the Board at its meeting on 7 September 2023. Action marked as completed.	Complete
2	Mar-23	228-23	Corporate risk register (CRR)	Refresh of the CRR including consideration regarding how strategic risks are documented and measured, consideration regarding risk targets, dates and residual risk and refresh of individual risks.	**NR, executive team**	~~**4 May 2023**~~ ~~**6 July 2023**~~	March 2023: EMT have been asked to review their risks and have been advised on the process for doing this April 2023: An independent risk specialist has been engaged to support the refresh of the risk register, working with executive Board members. This work is being completed during April and May and the Board will receive a refreshed risk register at its 6 July 2023 meeting June 2023: detailed update on risk work completed to date will be reported to the Board at its meeting on 6 July 2023 and that will supercede this action. Action marked as completed.	Complete
3	Mar-23	232-23	Gender pay gap annual report	Provide the Board with the annual gender pay gap report much sooner after year end (March) in order that the Trust can respond to the data and trends in a more timely fashion.	~~**LA**~~ **CPO**	~~**6 July 2023**~~ **7 September 2023**	March 2023: 2022/23 report scheduled on Board agenda for 6 July 2023 meeting June 2023: Gender pay gap annual report and actions postponed until September due to resource constraints.	Pending
4	May-23	17-23	Workforce monthly report	Executive team to consider action and resource required to urgently address outstanding appraisals and quality of appraisals. Report back to Board at its next meeting.	**CP, executive team**	**6 July 2023**	June 2023: Appraisal update included in workforce report to Board for 6 July 2023 meeting.	Complete
5	May-23	25-23	Quality and governance assurance	Quality and governance committee to complete periodic deep dives into formal patient complaints.	**KN, NR**	**6 July 2023**	May 2023: Regular deep dive item scheduled on Q&GC work planner	Complete

Report cover-page					
References					
Meeting title:	Board of Directors				
Meeting date:	6/7/2023		**Agenda reference:**	**47-23**	
Report title:	Chair's report				
Sponsor:	Jackie Smith, Trust Chair				
Author:	Jackie Smith, Trust Chair				
Appendices:	None				
Executive summary					
Purpose of report:	To update the Board of Directors on Chair, non-executive director and governor activities since the last meeting				
Summary of key issues	Highlights include: - Appointment of James Lowell as substantive chief executive officer - Three new non-executive directors joining the Board - New public and staff governors from 1 July 2023				
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:	47-23
Date of meeting:	6 July 2023
Report from:	Jackie Smith, Trust Chair
Report author:	Jackie Smith, Trust Chair
Date of report:	21 June 2023
Appendices:	None

Chair's report

Appointments

Following a period of some change, the Trust has made important Board level appointments. Our three new non-executive directors have been spending some time observing meetings and familiarising themselves with issues before their official 1 July start date. I am looking forward to the range of senior skills and experience Russell Hobby, Peter O'Donnell and Shaun O'Leary will bring to the Board as they join Karen Norman and Paull Dillon-Robinson in ensuring we have appropriate challenge and robust decision making.

We are also looking forward to James Lowell, who has been appointed as our substantive chief executive officer, taking up the role in September. James is currently chief operating officer for South London and Maudsley NHS Foundation Trust and place executive lead for Southwark on the Board of South East London Integrated Care System. Abigail Jago, director of strategy and partnerships is the acting chief executive until James arrives.

On 3 July Maria Wheeler joined the Trust as our substantive chief finance office; there is more detail in the acting chief executive's report and this will be Maria's first QVH Board meeting.

On 1 July we welcomed six new public governors and three new staff governors. Four of our current public governors have been re-elected for a second term, including Chris Barham who will continue in the role of lead governor for another year.

Service visits

As part of our work to ensure Board members are visible throughout the organisation, I am linked with Peanut ward, our children's ward. This is a valuable way of ensuring we have a very direct connection with the frontline and I appreciate the honesty with which staff discuss the challenges and the joys of their work. I hope these conversations also support the team's understanding of Trust level issues. My last discussion with the team was particularly focussed on the activity camp they run, called CREW, for children who have stayed on Peanut ward, giving them the chance to connect with others who might have experienced similar life-changing injuries.

Since the last Board meeting, I have also spent some time meeting staff in health records and learning more about that vital but hidden service.

Regional and national links

I have been in regular contact with Chairs in Sussex, including the Chair of the ICB, and with my peers in the wider south east region. These relationships are important to explore issues and develop their thinking and leadership collaboratively.

I am also an inspector for the CQC and served on an inspection team during June. As a Board we are very aware of the need to ensure that QVH not only provides excellent services and a great place to work, but also that we can demonstrate awareness of areas where we can do better and evidence progress.

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

Report cover-page					
References					
Meeting title:	Board of Directors				
Meeting date:	06/07/2023		**Agenda reference:**	**48-23**	
Report title:	Chief executive's report				
Sponsor:	Abigail Jago, acting chief executive officer and director of strategy and partnerships				
Author:	Clare Pirie, director of communications and corporate affairs Abigail Jago, acting chief executive officer and director of strategy and partnerships				
Appendices:	Appendix one: media report Appendix two: performance dashboard				
Executive summary					
Purpose of report:	To update the Board on progress against objectives and provide an update on any external issues which may have an impact on the Trust's ability to achieve targets				
Summary of key issues	• Appointment of chief finance officer • Strategy development and quality improvement progress				
Recommendation:	It is recommended that the Board **notes** the contents of the report.				
Action required	Approval	**Information**	Discussion	Assurance	Review
Link to key strategic objectives (KSOs):	**KSO1:**	**KSO2:**	**KSO3:**	**KSO4:**	**KSO5:**
	Outstanding patient experience	***World-class clinical services***	***Operational excellence***	***Financial sustainability***	***Organisational excellence***
Implications					
Board assurance framework:					
Corporate risk register:					
Regulation:					
Legal:					
Resources:					
Assurance route					
Previously considered by:	NA				
	Date:		Decision:		
Next steps:	NA				

Report to:	Board Directors
Agenda item:	48-23
Date of meeting:	06 July 2023
Report from:	Abigail Jago, acting chief executive officer and director of strategy and partnerships
Report author:	Clare Pirie, director of communications and corporate affairs Abigail Jago, acting chief executive officer and director of strategy and partnerships
Date of report:	19 June 2023
Appendices:	Appendix one: media report Appendix two: performance dashboard

Chief executive's report

Appointment of chief finance officer

Maria Wheeler is joining QVH as our chief finance officer on 3 July. Maria has worked in the NHS for twenty-two years and has experience of both provider and commissioner organisations, most recently at Princess Alexandra Hospital. QVH attracted a good choice of candidates for this role and the appointment process was supported by staff who took part in stakeholder panels on the interview day. Maria will be the executive lead for our finance, procurement and estates functions.

The substantive role of Chief People Officer (CPO) is in active recruitment at the time of writing, with interviews planned for late July. Rob Stevens joins us from Guys and St Thomas to cover the interim CPO role whilst we progress the substantive procurement.

Strategy development

Work continues to progress the development of the future strategy for QVH. An engagement plan is now in place and moving forwards. In the last month this has involved the engagement of over 250 key stakeholders both internally and externally. The clinical baseline assessment has continued with key clinical and operational teams which will provide the basis of the co-designing sessions which are being planned for later summer. There has been broad support for the focus on the three populations that the Trust serves including local neighbourhood / place level, Sussex and the wider region including Kent and Surrey. Work is continuing in regard to the development of the Trust digital strategy, a key enabler, with a draft strategy now developed.

Quality improvement work

A Board seminar took place to discuss the considerations and approach for the implementation of a quality improvement framework. An organisational readiness assessment is currently underway and exploration of potential improvement partnership opportunities. In parallel an improvement project has been initiated to improve the recruitment process and minimise on boarding delays.

QVH staff awards

We are looking forward to the annual QVH staff awards on the evening of 6 July. This is always a wonderful celebration of the care, compassion and expertise for which QVH is well known. We are very grateful to QVH Charity for supporting these

awards, with recognition of the strong connection between staff recognition and motivation and excellent patient care.

Industrial Action
Since the last Board meeting there has been further junior doctor industrial action. I am grateful to all our staff who helped with planning and worked to keep our patients safe. We continue to plan for further industrial action that has been announced for July.

We value our staff and understand the importance of good pay and conditions for individuals and their families, as well as wider NHS staff retention and recruitment. Pay is a matter for Government and the trade unions, and everyone wants to see a resolution as soon as possible to ensure the NHS can continue to focus on delivering world class patient care to all those who need it.

Green week in theatres
Our staff in theatres held a Green Theatre Week in June to help spread the message that it is important to find ways to be more sustainable whilst keeping our patients safe and well treated. Staff were invited to generate suggestions for helping theatres be more eco-friendly, save money and be more efficient. The team also held a plant sale with proceeds donated to QVH Charity as a thank you for funding the theatre's wellbeing garden.

British Association of Oral and Maxillofacial Surgeons Surgery Prize
Brian Bisase, QVH consultant maxillofacial surgeon, received the prestigious British Association of Oral and Maxillofacial Surgeons (BAOMS) Surgery Prize 2022 at the BAOMS Annual Scientific Meeting in June. The award was made in recognition of the significant contribution that Brian has made to oral and maxillofacial surgery and to the Association. We are very proud of the calibre of staff at QVH and this was well deserved national recognition for Brian.

ICS shared delivery plan
The Sussex Shared Delivery Plan (SDP) sets out the year one implementation priorities of the Sussex Improving Lives Together strategy which articulates the ambition across health and care in Sussex over the next five years. The SDP includes feedback from NHS England, Joint Health & Wellbeing Boards, System Oversight Board and Sussex Health and Care Assembly and will also be signed off at individual provider boards going forward. Commitments include work to tackle health inequalities, supporting the reduction of waiting lists and optimising the use of community diagnostic centres. The plan will be widely communicated across Sussex in due course. As a provider within the Sussex integrated care system QVH will be driving forward the relevant initiatives within the delivery plan.

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

QVH media update – April 2023

Help us to help you
Queen Victoria Hospital's minor injuries unit was named in a number of public service media mentions initiated by NHS Sussex, to encourage people to use services wisely over the Easter bank holiday weekend. This included Sussex Express; a follow-up in Sussex Express, v2 Radio and The Argus.

Cracking idea for fundraising
QVH Charity's Easter fundraising appeal, offering supporters the chance to take part in a virtual Easter egg hunt in exchange for a donation, was highlighted in an article by UK Fundraising. The piece described how a number of charities are using Easter as a way to generate much needed funds.

Happy birthday QVH Macmillan Centre
News of the 11th birthday of the QVH Macmillan Centre was shared by Sussex Express, as the team not only looked back at the incredible support they have been able to offer people living with and beyond cancer, but thanked the dedicated volunteers who donate their time to support the service.

Hospital food
Queen Victoria Hospital was named in an article by the Daily Mail as the tenth worst hospital for patient food. The results were part of a nationwide poll of patients and staff who were asked to score the meals based on the choice of food available, how hot it was served and how it tasted. The hospital scored 97.42 per cent, only a fraction behind tenth 'best' University Hospitals of Morecambe Bay NHS Foundation Trust: 97.80 per cent. The top scoring hospital was private provider Bupa Group which scored 100 per cent. The story was also carried by ITV Meridian and FinnoExpert.

Industrial action by junior doctors
Queen Victoria Hospital was mentioned by a series of media outlets as part of a list of trusts whose junior doctors had chosen to participate in industrial action. This included The Mirror; Sussex Express; and V2 radio. This was followed with a call in local media for people to use services wisely, including signposting to the Queen Victoria Hospital minor injuries unit in Sussex Express and V2 radio, as trusts recovered from the period of industrial action.

Industrial action by nurses
The decision by members of the Royal College of Nursing (RCN) to take industrial action resulted in some mentions of Queen Victoria Hospital as a participating trust in Nursing Times; The Mirror; Daily Mail; Yahoo News; and also more local outlet The Argus. This was followed at the end of the month in articles by the Daily Mail and a follow-up by the same outlet.

Dog owners life saved after e-scooter blaze
A number of media outlets mentioned Queen Victoria Hospital in relation to patient Kevin Record. Kevin's family explained how he sustained "20 per cent burns" to his body after his e-scooter overheated and set fire to his home. He was awoken by his dog who sadly passed away in the incident. Titles to specifically mention Kevin's connection to the hospital included The Mirror; Daily Mail; Lad Bible; National World News; and Kent Online (plus follow up piece with quote from Kevin).

Ad hoc media mentions
A contract extension for the provider of a digital component of the hospital's community diagnostic centre received a series of mentions in financial sector websites. This included Proactive Investors; MarketScreener (and a follow-up mention); MarketWatch; and the company's own website.

Press releases
In April we published the following press release:

- QVH Macmillan Centre marks 11 years of support for people with cancer

We also published the following updates on our website:

- Arrangements during junior doctor industrial action – April 2023
- Our latest visiting guidance
- Arrangements during the RCN industrial action – Sunday 30 April to Monday 1 May 2023

QVH media update – May 2023

Chance to nominate an outstanding member of staff
Sussex Express helped Queen Victoria Hospital on its hunt for a worthy winner (or winners) of its Outstanding Patient Experience Award, calling patients to get involved. The hospital encouraged anyone who had been a patient or visited in the last year to tell them about someone who showed them exceptional care and compassion. This included a reminder just before the deadline.

Industrial action by nurses
Queen Victoria Hospital was named by the Daily Mail in a list of trusts whose Royal College of Nursing (RCN) colleagues voted to take industrial action beginning 1 May. This included an article about why nurses are striking and a follow-up the following day.

Chief nursing information officer
Laura Pullan joining Queen Victoria Hospital as chief nursing information officer (CNIO) was mentioned on the Digital Health website in a roundup of movers and shakers. She will split her week supporting the Trust on its digital journey and continuing her digital nurse specialist role at Sussex Community NHS Foundation Trust.

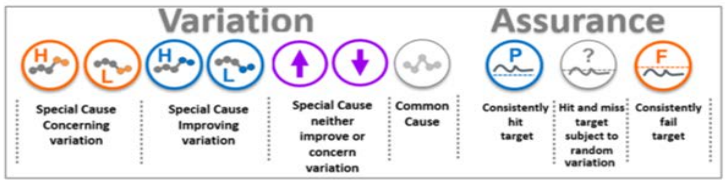
Press releases
In May we published the following press release

- Thank an exceptional member of QVH staff by nominating them for an award

We also published the following updates on our website

- Queen Victoria Hospital appoints new non-executive directors

Integrated dashboard



KSO1 and KSO2

	KPI	Latest Month Reported	Latest Month Value	Target	Variation	Assurance	Notes & Comments
IPACT	Clostridium Difficile acquired at QVH post 72 hrs after admission	May 23	0	3			No cases for last 4 months -
IPACT	MRSA acquired at QVH post 48 hrs after admission	May 23	0	0			No cases in 18 month reporting period
IPACT	Lab confirmed cases of E-Coli in QVH Admitted Patients	May 23	0	0			One case in 18 month reporting period
IPACT	Lab confirmed cases of Gram-negative BSIs	May 23	0	0			No cases in 18 month reporting period
PSS	Serious Incidents (SIs) reported in month	May 23	0	0			
PSS	Never Events reported in month	May 23	0	0			
PSS	Number of complaints in Month	May 23	6	-			
FFT	FFT likely/very likely to recommend Inpatients	May 23	100%	90%			
FFT	FFT likely/very likely to recommend Outpatients	May 23	96%	90%			
FFT	FFT likely/very likely to recommend MIU	May 23	98%	90%			
FFT	FFT likely/very likely to recommend Day Surgery	May 23	98%	90%			
FFT	FFT likely/very likely to recommend Sleep	May 23	95%	90%			
FFT	FFT likely/very likely to recommend Hand /Plastics Trauma	May 23	98%	90%			

KSO3 and KSO5

	KPI	Latest Month Reported	Latest Month Value	Target	Variation	Assurance	Notes & Comments
Performance	MIU <4Hrs	May 23	100%	95%			
Performance	Diagnostic Waits <6weeks All	May 23	74%	99%			As reported including Sleep
Performance	Diagnostic Waits <6weeks sleep only	May 23	49.9%	-			For information only - Sleep performance
RTT	Total RTT Waiting List Size	May 23	16844	-			
RTT	52 week	May 23	322	359			
RTT	65 week	May 23	61	0			
RTT	78 week	May 23	5	0			
Cancer	62 Day	Apr 23	84%	85%			
Cancer	Faster Diagnosis (FDS)	Apr 23	84%	80%			
Workforce	Vacancy Rate	May 23	1.0%	8.0%			
Workforce	Turnover Rate	May 23	12.9%	10.0%			
Workforce	Sickness rate	Apr 23	4.1%	3.0%			
Workforce	Appraisal rate	May 23	85.5%	90.0%			
Workforce	MAST	May 23	93.0%	90.0%			

KSO4 – Headline data

**variation and assurance provided by finance team – no SPC applied

	KPI - KS04 Financial Stability	Month Reported	Value	Target	*Variation	*Assurance	Notes & Comments
Finance	Income	May-23	95,933	95,933			Currently no adverse impacts to outturn year to date
Finance	Pay Expenditure	May-23	(60,560)	(60,560)			Currently no adverse impacts to outturn year to date
Finance	Non Pay Expenditure	May-23	(35,373)	(35,373)			Currently no adverse impacts to outturn year to date
Finance	Surplus/(Deficit)	May-23	0	0			Currently no adverse impacts to outturn year to date
Finance	Capital Underspend/Overspend	May-23	0	0			Capex is on plan despite a slow start in the 1st half of the year
Finance	Recurrent CIPs	May-23	37	2,100			The required CIPs are being met non-recurrently via underspends
Finance	Agency Spend % (of Total Pay)	May-23	2.91%	3.75%			Agency Spend remains below ICS mandated target
Finance	FTE	May-23	1,015	1,065			

Report cover-page					
References					
Meeting title:	Board of Directors				
Meeting date:	06/07/2023	**Agenda reference:**	**49-23**		
Report title:	Risk management and corporate risk register				
Sponsor:	Clare Pirie, director of communications and corporate affairs Nicky Reeves, chief nurse				
Author:	Clare Pirie, director of communications and corporate affairs Karen Carter Wood, head of risk and patient safety Leonora May, deputy company secretary				
Appendices:	Appendix one: corporate risk register				
Executive summary					
Purpose of report:	The purpose of this report is to update the Board on work undertaken to date to transform our approach to risk management				
Summary of key issues	- The need for transformation was highlighted in the Trust's well-led review, and the CQC would expect the Trust to be able to demonstrate an effective risk management framework - The Board have undertaken risk management training, and training is planned for senior staff - The head of risk is working with risk owners and executive leads to improve the recording of risks on the corporate risk register which will inform the new board assurance framework that will be risk led - Board assurance framework fundamental overhaul is underway so has not been included in this set of Board papers - Board to complete risk appetite work in the autumn of 2023 - Audit committee will provide an increased level of scrutiny and assurance over the Trust's approach to risk management				
Recommendation:	The Board is asked to **discuss** and **note** the contents of the report.				
Action required	Approval	**Information**	**Discussion**	**Assurance**	Review
Link to key strategic objectives (KSOs):	**KSO1:**	**KSO2:**	**KSO3:**	**KSO4:**	**KSO5:**
	Outstanding patient experience	***World-class clinical services***	***Operational excellence***	***Financial sustainability***	***Organisational excellence***
Implications					
Board assurance framework:	Board assurance framework fundamental overhaul is underway so has not been included in this set of Board papers				
Corporate risk register:	The head of risk is working with risk owners and executive leads to improve the recording of risks on the corporate risk register which will inform the new board assurance framework that will be risk led				
Regulation:	CQC would expect the Trust to demonstrate an effective risk management framework				
Legal:	None				
Resources:	External support sought to support training and transformation of the Trust's approach to risk				
Assurance route					
Next steps:	NA				

Report to:	Board of Directors
Agenda item:	49-23
Date of meeting:	06 July 2023
Report from:	Clare Pirie, director of communications and corporate affairs Nicky Reeves, chief nurse
Report author:	Clare Pirie, director of communications and corporate affairs Karen Carter Wood, head of risk and patient safety Leonora May, deputy company secretary
Date of report:	25 June 2023
Appendices:	Appendix one: corporate risk register

Risk management and corporate risk register

Background

The Trust is currently in a process of rapid transformation of our approach to risk management, revising the scope, content and format of our recording of risk in order to give the Board a clear view of the most material risks facing the Trust and how effectively these are being managed.

The need for this transformation was highlighted in the Trust's well-led review, with three of the 19 recommendations focussed on improvements in this area. The Care Quality Commission would also expect the Trust to be able to demonstrate an effective risk management framework that captures the key risks and is consistent with operational concerns.

Key elements of the risk framework will be updated and reporting through the governance structure will be clarified. The aim is to facilitate a significant behavioural shift at executive and risk owner levels, with increased understanding of risk management throughout the organisation. External support has been procured to provide the additional capacity and expertise needed for this transformation.

Training and development

Board members undertook a full day workshop on risk management in June, working on the Board's role in risk management and how we can develop a culture in which risk and mitigation is well understood, used in everyday work and robustly reported.

The agreement on approach and shared understanding developed through that workshop are now being used in updating our policies and procedures, which will then support further development in the autumn for our senior staff on how we manage risk at QVH. It is planned that this training will become a regular part of our training calendar for senior staff.

Improving the corporate risk register

The head of risk is working with risk owners and executive leads to improve the recording of risks, including how we describe risks and the related actions and how we score risks. This is vital to ensure that risks are managed and escalated through the Trust appropriately. This is work in progress which will develop further by the September Board meeting. Similar detailed work on local risk registers will be developed in parallel, ensuring robust management of those risks which are scored lower and therefore not visible on the corporate risk register.

Clinical business units and back office directorates will regularly discuss the risks surfaced through the register in performance review meetings with executive directors. This will be a process of building shared understanding and appropriate accountability and responsibility for risk and actions to control risk at all levels in the organisation.

The executive team will review the corporate risk register every month, taking a thematic approach in order to dedicate sufficient time to collective moderation, challenge and executive team understanding of the risk register.

Board subcommittee deep dives into risks relevant to the committee's area of focus, will provide challenge and support for this updated corporate risk register approach as well as providing the Board with assurance over the ongoing management of those risks.

Building the Board Assurance Framework
The board assurance framework (BAF) brings together in one place all of the relevant information on the risks to the Board's strategic objectives. It was recognised that the previous QVH BAF was no longer fit for purpose and needs a fundamental overhaul in order to serve its assurance purpose. It has therefore not been included with this set of Board papers.

Work is underway to record the Board's current understanding of the internal and external environment within which the Trust operates and ensure that we have effective horizon scanning and risk capture processes in place to provide confidence that the Board is fully sighted on its key strategic risks. This will include consideration of wider system risks, and the role of the Trust both in escalating QVH risks to system partners and our contribution to mitigating wider system risks.

The risks set out in the corporate risk register will be mapped to these Board level strategic risks to produce a BAF which is risk led and focussed on assurance.

Risk appetite
In the context of a Board with significantly refreshed membership, we will also be undertaking further work as a Board to reconsider the organisation's appetite for risk, and reflect this in the updated BAF. Risk appetite is the amount and type of risk that an organisation is prepared to seek, accept or tolerate in pursuit of its objectives. The provision of healthcare involves risk and a major factor in successfully controlling risk is being assured that plans are in place to mitigate risks to within appetite and escalate those that are outside of appetite.

It is good practice for the Board to review its risk appetite annually and ensure that it remains reflective of the current environment within which the Trust operates. This will be built into the forward plan.

Documenting policy and processes
This work will be supported by a refreshed risk policy/strategy and an accountability framework ensuring clarity of roles. The updated policy and framework will be reviewed by the audit committee after executive director sign off.

We will also provide a standard operating procedure (SOP) for recording risks on the corporate risk register and local risk registers. The Trust is moving to a more consistent style of articulating its risk and risk owners will be trained on the SOP in order to ensure that they understand the rationale and benefits of having a consistent approach for identifying and describing risk, how to apply the risk assessment matrix for scoring, how to capture actions and how to create more specific progress updates.

Review and assurance on this transformation
Progress in this work is being overseen by the director of communications and corporate affairs, working closely with the Chief Nurse.

The audit committee is the forum through which the Board seeks assurance on governance, risk management and internal control, including scrutiny of risk management. It is proposed that the terms of reference for this committee should be reviewed to strengthen this function, and that the committee should be renamed the audit and risk committee. The committee will provide an increased level of scrutiny and assurance over the Trust's approach to risk management.

It is proposed that an internal survey of risk culture should be undertaken in winter 2023/34 following these changes. This will provide a baseline for an annual review. The audit committee will receive the results of this survey and the development plan.

A review of the risk management approach will be built into the internal audit plan for 2024.

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

Corporate Risk Register Report
(Data 22 April 2023 to 28 June 2023)

Corporate Risks added between 22/4/2023 and 28/6/2023: Eight

- there were some nursing recruitment risks added that subsequently where replace by a new 'overarching' risk
- reduced Consultant Histopathologist cover risk was escalated back onto the Corporate register following resignation of pathologist

Risk Score (CxL)	Risk ID	Risk Description	Rationale and/or Where identified/discussed
4x3=12	1303	Fire Safety works	Interim Head of Estates Exec approval: Interim DoF
3x4=12	1306	Recruitment and retention within Perioperative services (replaces Risk ID1077)	Chief Nurse and Theatre Manager Chief Nurse exec approval
3x5=15	1302	Burns unit nursing staffing	Chief Nurse and Deputy Chief Nurse
3x4=12	1307	QVH Eye Bank: no budgeted establishment for Quality Manager	General Manager Exec sign off: Dir of Operations
3x5=15	1168	Significantly reduced Consultant Histopathologist cover	Escalated from local risk register, returning to corporate risk register Laboratory Manager and Dir of Operations
4x4=16	1317	Community Diagnostic Centre	Director of strategy and partnerships
3x4=12	1319	Recruitment challenges: Nursing and Allied Health Professionals	Chief Nurse
3x4=12	1285	Climate related risks to infrastructure	Escalated from local risk register to corporate risk register Chief Nurse

Corporate Risks closed this period: seven

- all risks were closed as a result of amalgamating staff challenges into one overarching new risk

Risk Score (CxL)	Risk ID	Risk Description	Rationale and/or Where identified/discussed
3x4=12	1077	Recruitment and retention in theatres	Reviewed and updated to new risk ID1306
3x5=15	1239	Canadian Wing Staffing	Replaced by new overarching 'staffing' risk ID1319
3x5=15	1302	Burns unit nursing staffing	Replaced by new overarching 'staffing' risk ID1319

Risk Score (CxL)	Risk ID	Risk Description	Rationale and/or Where identified/discussed
3x4=12	1306	Recruitment and retention within Perioperative services	Replaced by new overarching 'staffing' risk ID1319
3x5=15	1199	Inability to deploy a flexible CCU workforce due to recruitment challenges	Replaced by new overarching 'staffing' risk ID1319
3x5=15	1238	Peanut Ward Staffing	Replaced by new overarching 'staffing' risk ID1319
3x5=15	1225	Head & Neck Staffing	Replaced by new overarching 'staffing' risk ID1319

Corporate Risks rescored this period: three

- Two high scoring finance risks rescored in view of improving financial outlook

Risk ID	Service / Directorate	Risk Description	Previous Risk Score (CxL)	Updated Risk Score (CxL)	Rationale for Rescore
1250	Corporate Affairs	Additional licence conditions	4x4=16	4x3=12	Discussed at March audit committee and then April Board seminar. Risk score reduced as likelihood of breach reduced.
1294	Finance and Estates	Financial Sustainability: contract alignment	5x4=20	4x3=12	Trust position is not now unsustainable and the risk of non-alignment of the contract income has mainly dissipated
877	Financial services	Financial sustainability	4x5=20	4x3=12	Year End results have been finalized and the Trust achieved a breakeven position for Income and Expenditure

Risk Register Heat Map:

The heat map below shows the 35 corporate risks open on the trust risk register as at the 28 June 2023.

Three corporate risks are currently within the higher grading category:
ID1264 Risk to operational of pathology services, IT related
ID1268 Significantly increased referral numbers to sleep service
ID1317 Community diagnostic centre

	No harm 1	Minor 2	Moderate 3	Major 4	Catastrophic 5
Rare **1**					
Unlikely **2**					
Possible **3**				**12** ID: 834, 877, 1226, 1250, 1267 1290, 1286, 1291, 1293, 1294, 1303, 1306	**1** ID:1292,
Likely **4**			**14** ID: 1040, 1245, 1247, 1249, 1253, 1254, 1255, 1272, 1285, 1295, 1296, 1297, 1307, 1319	**3** ID1264, 1268, 1317	**0**
Certain **5**			**5** ID1189, 1221, 1231, 1266, 1168	**0**	**0**

ID	Opened	Risk Title	Hazard(s)	Controls in Place	Executive Lead	Risk Owner	Risk Type	Current Rating	Target Rating	Progress/Updates	KSO
1319	20/06/2023	Recruitment challenges: Nursing and Allied Health Professionals	1. Risk to patient safety due to insufficient numbers of registered staff to meet the dependency of the patients□ □ 2. Risk to operational delivery due to insufficient numbers of registered staff to support patient flow particularly through Critical Care and peri op□	1. Enhanced bank pay to encourage uptake of shifts□ 2. Use of agency staff to provide "line booked" consistent support□ 3. Use of "break glass" agency in key high risk areas to maintain safety□ 4. Engagement with Health Education England to develop innovative roles to allow QVH to "grow their own" workforce□ 5. In extremis, activity reduced to maintain safety□ 6. Exit interviews to understand reasons for staff leaving□ 7. Bank and Waiting List Initiative task and finish group in place□ 8. Onboarding Task and Finish group in place□	Nicola Reeves	Liz Blackburn	Patient Safety	12	9		KSO1 KSO3 KSO5
1317	18/05/2023	Community Diagnostic Centre	Failure to deliver CDC programme	Activity and income - working with primary care and commissioners to improve access and ensure referrer engagement and use of service□ Long term funding - CDC revenue to be agreed annually in line national process□ Estates - working with key stakeholders to develop a plan to ensure timeline meets the delivery requirements of new build □ Digital - working with key stakeholders to develop a plan and to ensure a value for money digital solution is in place by January 2024□ Workforce - workforce plan in place and collaborating with other CDCs□ Capital equipment purchasing - procurement process underway□ Strategic risk - governance structure in place to ensure project aims and delivery are monitored and risks are managed appropriately	Abigail Jago	Kathy Brasier	Compliance (Targets / Assessments / Standards)	16	9		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
1309	05/05/2023	Fire Damper monitoring and connection	The Fire Dampers are not currently monitored or connected to a fire damper monitoring panel and in turn connected to the Fire Alarm system. The main area of concern is the main theatres plant rooms, although all fire dampers throughout the trust should be included as there is no service contract currently set up on any fire dampers.	Currently there are no controls in place. □ The Fire Team are fully aware of the situation and have initiated surveys and budget cost to solve the issue.	Stuart Rees	Hugh Barter	Estates Infrastructure & Environment	15	10		KSO3
1307	11/05/2023	QVH Eye Bank: no budgeted establishment for Quality Manager	At the last MHRA inspection in September 2022 this was noted as a major failing / finding resulting in the provision of this role being an essential and unavoidable requirement.□ Termination of Medicines and Healthcare products Regulatory Authority (MHRA) and Human Tissue Authority (HTA) Licenses by the regulators. □ An independent Quality Manager is required to separate the functions of production and Quality Assurance which are currently performed by a single employee. □	Bank Quality Manager available, since April 2023, from Histology Team as is required□ Quality Management duties are currently undertaken by Eye Bank Head of Department who also carries out a production role and means that certain duties and functions are compromised.□ The Quality Manager role was put forward as part of Business Planning for 22/23 - not approved, further information required / sought	Shane Morrison-McCabe	Marc Tramontin	Compliance (Targets / Assessments / Standards)	12	6	**06.06.23** - POAP updated and benchmarking narrative supplied to Director of Ops for presentation at EMT. Bank employment covering requirements currently.	KSO1 KSO2 KSO3
1303	11/04/2023	Fire Safety works	Various Fire Safety works to be undertaken, including smoke detector location identification, installation of new fire safety panels new signage.	Work is being undertaken to identify and locate correct locations for smoke detectors and ensure this is recorded correctly on the Fire Panel in switch.	Stuart Rees	Hugh Barter	Compliance (Targets / Assessments / Standards)	12	9		KSO3

ID	Opened	Risk Title	Hazard(s)	Controls in Place	Executive Lead	Risk Owner	Risk Type	Current Rating	Target Rating	Progress/Updates	KSO
1297	28/02/2023	Shortage of Clinical Cover: Plastics	The Plastics Business Unit are presently short 1.6 WTE Skin Consultants (one of which also provides 2.5 PAs of weekly breast surgical activity), 1 WTE Microfellow, and 1 WTE Burns consultant.	A POAP has been written for backfilling 10.5 PAs of consultant time (a new job plan that needs Royal College approval).□ Two agency request forms have been completed and questions answered and returned to EMT. Two agency candidates are being interviewed this week: one for the 6.5 PA backfill and the other for the 10.□ A previous Associate Specialist has volunteered to return to the Trust , after having to terminate his contract prematurely. This post could potentially be used to backfill the Burns gap.□ A POAP is in process to backfill the 10 PA Skin/Breast post, which was formerly Cancer Alliance Funded.□ Cancer Alliance money has been released for a 7.5 PA consultant post, for which a POAP has been written and require further action to	Shane Morrison-McCabe	Phillip Connor	Patient Safety	12	9		KSO3
1296	11/01/2023	Electrical Power Distribution Network QVH: Operational Non Conformity	A dead fault short circuit could occur on the electrical distribution network at the QVH. □ There is a risk that the Trust fails to deliver an effective and timely solution to ensure a efficient power supply is out in place, consequences include further cancellation of patient appointments resulting in reputation damage and income loss.□	The risks have been assessed by an independent specialist, outcomes used to inform an action plan .e.g. specialist equipment to be procured along with a major fault level study to be instated and applied at the QVH. Safer systems of work and training are to be instituted.□ Spike monitoring currently underway.□ Regular testing of generators introduced.□ Business continuity plan in place, with testing on quarterly basis.	Stuart Rees	Hugh Barter	Estates Infrastructure & Environment	12	6	25/01/2023: To procure and undertake electrical distribution remediation study & fault level discrimination calculations and protection setting requirements by end of February 23.□ 11/04/2023: Work to be undertaken through Chris Dann (Estates Officer)and an Electrical consultant Norman Bromley to identify what are the issues and how these can be resolved to support the Trust Electrical infrastructure. This will also include the knowledge and experience of Alan Parry the electrical contractor used by the Trust over the years.	KSO2

ID	Opened	Risk Title	Hazard(s)	Controls in Place	Executive Lead	Risk Owner	Risk Type	Current Rating	Target Rating	Progress/Updates	KSO
1295	12/12/2022	Green Plan - delivery of project	Ineffective set up and delivery of the Green Plan project results in lack of progress against Trust and national objectives, breach of NHS provider contract requirements, loss of opportunity for accessing investment, and reputational damage	Green Plan actions monitored at monthly meeting, and reported bi-annually to F&P□ Agreed project workstreams	Clare Pirie	Clare Pirie	Compliance (Targets / Assessments / Standards)	12	6	Update April 2023□ QVH Green Plan work includes key elements in NHS Provider contract:□ - Removal of volatile gases in anaesthesia - delivered □ - Sustainability requirements added to tender documents - delivered□ - Renewable energy purchasing outstanding and under review. □ Other initiatives identified:□ - Cars for burns outreach will be replaced with zero or ultra-low emissions cars on contract renewal in 2024. □ - Procurement of onsite EV charging for installation paused due to lack of estates resource. □ - Option for staff to purchase higher emissions cars on salary sacrifice removed, zero emissions only. □ - Working up costed plans to decarbonise the site through insulation, solar panels, ground source heat pump - paused due to lack of estates resource.□	KSO4 KSO5
1294	28/11/2022	Financial Sustainability: contract alignment	Risk of deficit from 23/24 financial year due to convergence adjustment and inflationary cost pressures exceeding allocation impacting Trust ability to invest in services□	Annual Business planning with board approval and executive review of investments and cost pressures. Performance management monthly meetings to review and highlight financial and activity positions. Audit committee reports on internal controls in place. Monthly financial performance to Board and Finance and Performance Committee. Strengthened contract monitoring and efficiency programme process. Business case review group embedding.□	Stuart Rees	Jeremy Satchwell	Finance	12	8	May 2023: reviewed - □ 22/23 Financial results breakeven Income and expenditure, cash of £11.7m and investments of £6.5m.□ Breakeven Plan for 23/24 submitted delivering 109% of 19/20 activity and 5.5% efficiency. QVH now in position to be enabler for Sussex ICB to deliver strategic plans and targets.□ □ Trust position is not now unsustainable and the risk of non-alignment of the contract income has mainly dissipated.□ Rescored□	KSO4
1293	24/11/2022	Potential risk to compliance with national cleaning specifications	Increased Risk of infections in clinical areas due to reduced staffing levels.Risk of increased pressures within team. Increased risk of sickness within the team due to pressures	Clinical areas to be prioritised over non-clinical areas Business Continuity Plan in place□	Nicola Reeves	Paul Addison	Compliance (Targets / Assessments / Standards)	12	8	**June 2023** - Risk reviewed and reworded to reflect potential risk.	KSO3
1292	22/11/2022	Overarching Corporate Risk - Securing a sustainable future for QVH	There is a risk of not being able to secure a sustainable future for QVH resulting in potential impact on existing services.	Controls in place include the appointment of a Director of Strategy & Partnerships with the primary remit to develop and deliver the strategic plan. Clinical Services-stock take being carried out to inform clinical strategy	Tony Chambers	Abigail Jago	Compliance (Targets / Assessments / Standards)	15	10	March 2023 - Strategic road map development commenced to initiate a programme of work towards building a sustainable future for the organisation. □ January 2023 - Director of Strategy starts 06/02/2023□ November 2022 - Ongoing work around clinical services stocktake to be reviewed by Board. Recruitment of director of strategy in progress	KSO1 KSO2 KSO3 KSO4 undefined

ID	Opened	Risk Title	Hazard(s)	Controls in Place	Executive Lead	Risk Owner	Risk Type	Current Rating	Target Rating	Progress/Updates	KSO
1291	22/11/2022	Overarching Corporate Risk - Keeping our staff engaged, motivated and supported during a time of great change	Risk of not being able to keep our staff engaged, motivated and supported during a time of great change	Review of staff survey□ Early escalation of issues via exit interviews and "stay" interviews□ Listening and Engagement events with staff□ Partnership working forums with JCNC and JLNC□ EDS Staff Network□ Care First Employee Assistance Programme□ Staff Appraisal system□	Lawrence Anderson	Clare Pirie	Staff Safety	12	8	27/04/23: Process established for regular review of exit interviews. Feedback from staff ambassadors group, quarterly pulse survey and other sources kept under review.□ 24/01/2023: Better Place to Work Survey results being analysed with key recommendations to be put forward. Project Wingman on site to support staff engagement and recognition w/c 23 Jan for 2 weeks.□ Trust vacancy rates have fallen since June 2022 along with Turnover□ Staff Survey 2022 results due in Feb 2023 under embargo which will give us an understanding of areas of progress and concern□	KSO5
1290	22/11/2022	Possible impact of infection outbreak on maintaining patient and staff safety in a post covid health care setting	Risk to patient and staff safety due to Covid and other possible infection outbreaks.	Rigid IPACT measures in place and management of outbreak guidance reviewed in light of post covid learning.□	Nicola Reeves	Liz Blackburn	Patient Safety	12	8	**June 2023** - Risk reviewed following Corporate risk refresh□ April 2023 - Reduction in Covid screening as per national guidance. Lateral Flow tests in place for specific high risk cases.□ March 2023 - Risk reviewed. Trust moving to a BAU approach regarding management of infection control outbreaks. Risk 1210 closed as actions are incorporated in this risk□ February 2023 - Plans to reduce asymptomatic testing of staff continue. Small numbers of positive staff and patients continue to be seen but not creating operational issues at time of review.□ January 2023 - Reviewed, continue to see small numbers of covid positive patients and staff. Optigene lab will be "mothballed" in April 2023 □ December 2022 - Risk reviewed. Challenges remain in the "post covid" health economy for QVH. Impacts from staff sickness due to covid and positive patients attending have been seen during December.	KSO1 KSO2

ID	Opened	Risk Title	Hazard(s)	Controls in Place	Executive Lead	Risk Owner	Risk Type	Current Rating	Target Rating	Progress/Updates	KSO
1286	28/11/2022	Inability to provide full pharmacy services due to vacancies and sickness	Delays to indirect clinical services (e.g. updating policies/ guidelines/ audit/ training/ incident reviews)□ Unable to move forward with non-clinical initiatives e.g EPMA introduction□ Delays in projects e.g. DMS and unable to support new services□ Loss of established staff with organization memory and staff able to undertake certain tasks.□ Increase in incidents	1. Some bank in place to help.□ 2. Regularly chase agencies for any potential candidates.□ 3. Adverts on TRAC.□ 4. Recently vacated band 4 technician post to go on TRAC internally for those in training.□ 5. Staff working as team to ensure immediate work covered.□ 6. Chief Pharmacist working addition bank hours.□ 7. Direct clinical work a priority.□ 8. Have capped number of clinical trials department can take on to 3□	Shane Morrison-McCabe	Judy Busby	Compliance (Targets / Assessments / Standards)	12	8	**8/6/23** Met with Director of Operations on 30/5/23 to discuss concerns regarding proposed establishment. new band 7 pharmacist started 5/6/23, still awaiting full Oc Health clearance regarding vaccination so dispensary based until fully cleared.□ 25/5/23 Budget proposed by business planning involves loss of 2.85 WTE. If this is implemented then some services will have to be reduced / cut permanently - priority will be given to patients safety. Risk of staff resigning, already stressed, overworked and demoralized as shown by staff survey. Will result in poor skill mix.□ 10/5/23 Band 7 still not cleared by Oc Health, but handed in notice at other hospital and hopefully will start beginning June. Band 3 and 4 posts filled. To go out to advert for band 2 vacant post (2WTE. Progressing with band 8b business plan on an page. Still no applicants for band 8a antimicrobial post. No further applicants for other vacant band 7 post despite making band 6 to 7 progression to encourage newly qualified.band □ 3.5.23 Risk reviewed - Director of Operations.□ 30/3/23 Still chasing Oc Health for band7 offered in Jan. Other vacant band 7 and band 3 put on TRAC for advertising. Working on	KSO1 KSO2 KSO3 KSO4 KSO5
1285	17/10/2022	Climate related risks to infrastructure	The potential risk of climate change on the estate and infrastructure which may impact patient and staff safety and the ability to provide a service which leads to business continuity issues	All building projects need to take climate change in to account to future proof and protect against business continuity incident. In addition reduction in the Trusts carbon footprint with the use of solar panels, electric car charging etc. Review of areas where heat particularly needs to be carried out. Risk assessment of air conditioning units in high risk areas	Nicola Reeves	Hugh Barter	Estates Infrastructure & Environment	12	6	**June 2023** - Ongoing roof replacement work to address water ingress linked to increased heavy rain and thunderstorms. Clinical areas are still at risk of overheating during heatwave, risk reviewed and score increased to 12□ March 2023 - Risk reviewed. No changes □ January 2023 - Reviewed no changes	KSO1

ID	Opened	Risk Title	Hazard(s)	Controls in Place	Executive Lead	Risk Owner	Risk Type	Current Rating	Target Rating	Progress/Updates	KSO
1272	12/08/2022	Plastics Administration Team Resources	Challenges in delivering timely/adequate cover of our services such as theatre scheduling, Clinic typing and oncology scheduling and general patient pathway administration.□	Interim plans with the appointment of Bank staff; band 2, band 3 to support where needed. □ Substantive staff undertaking bank hours to help cover the backlog of work.□ Daily huddle to coordinate priority of workload through team□ Service Manager assisting at Band 4 level with oncology administrative processes.□ Support offered by other surgical services to help with scheduling.□ Service going out to agency, in light of shortage in Bank labour.□	Shane Morrison-McCabe	Phillip Connor	Patient Safety	12	9	25/01/2023 - the risk remains an ensuring, given that there have been 3 resignations in the department in the last two weeks and, in spite of having gone out to advert, there appears to be a very limited pool of people available to appoint. This has been a persistent problem for a good deal of time. The service may need to go to Bank or agency in the short-term to provide cover, in order to avoid burnout within the admin' team. Exit interviews will be performed with leavers to support retention of staff going forward. Conversations will be had with HR to explore what further can be done to improve upon its current recruitment strategy. □ 21/11/2022 - Finished recruiting to Schedulers, Admin' Support, Rota Team, Service Co-ordinators and a Service Manager. There is presently 1 WTE vacancy against the Medical Secretary line (although this will need to be confirmed to be completely certain). Whilst the service are waiting for individuals to come into post, the Service is using Bank to cover the gaps - for which we have a number of colleagues who can support. At this point it would be reasonable to scale down the risk score to meet the target level.□ October 2022 - Risk reviewed. Successful recent recruitment. Situation under constant	KSO1 KSO2 KSO3
1268	19/07/2022	Significantly Increased Referral Numbers to Sleep Service	Referral numbers to Sleep Services have doubled in comparison to previous rates and currently over 600 per month for a sustained period.	Recruiting to new posts, although that in itself is a risk. Outsourcing of some overnight diagnostic tests where clinically appropriate. Consultant triages referrals to prioritise most urgent.	Shane Morrison-McCabe	Philip Kennedy	Compliance (Targets / Assessments / Standards)	16	8	**26.06.23** Initial meeting held with NHSE/ICB and awaiting follow up clinical network session. Meeting scheduled with UHSx to discuss their plans for re-opening OPD service 03.05.23 Still awaiting date for ICB task and finish group. Referrals remain at high level. Another new Consultant recruited.□ 30.03.23 No dates for task and finish group received from ICB, chasing e-mail sent. Additional medical staffing recruited and maximizing use of external diagnostic capacity.□ 06.03.23 Capacity & demand report completed and shared with Trust. To increase use of external companies to support diagnostic testing. Consultant post out to advert. Meeting held with Commissioners and NHSE who are setting up a task and finish group to map services across region and undertake analysis of demand.□ 31.01.23 Referral rates continue at almost double those of previous years. External report due shortly but internal capacity is not enough to meet demand. To continue with	KSO1 KSO2 KSO3 KSO4

ID	Opened	Risk Title	Hazard(s)	Controls in Place	Executive Lead	Risk Owner	Risk Type	Current Rating	Target Rating	Progress/Updates	KSO
1267	19/07/2022	Recruitment Challenges for Sleep Physiology and Technical team	Physiology/Technical team has had significant difficulties in recruiting to vacant posts. Trust has agreed to increase establishment following external review of service and benchmarking tools. Service may have long-standing vacant posts if cannot fill them all.	Seeking to apply Financial recruitment incentive for new starters. have sourced agency staff to support service. Consultant triages new referrals to ensure most urgent cases are prioritised.	Shane Morrison-McCabe	Philip Kennedy	Compliance (Targets / Assessments / Standards)	12	9	**26.06.23** On-going recruitment programme due to leavers but approaching full establishment based on original benchmarking exercise.□ □ 03.05.23 New starters confirmed for May and June but other posts to be advertised due to leavers. Staffing model to be reviewed in light of increased referrals□ □ 30.03.23 New starters confirmed for April and further interviews arranged. □ □ 06.03.23 Significant progress with several new starters expected by end of April. 2 posts out to advert with 2 more to be advertised. If all are filled, this would bring us up to the agreed establishment following external review and benchmarking exercise. □ □ 31.01.23 Recruitment at all bands continues - unfortunately 1 chosen B7 candidate has withdrawn so re-advertised. □ 28.11.22 On-going recruitment process. Adverts placed for all teams and interviews to be set up. Number of staff in post is increasing and vacancies reducing. □ 25/10/22 Continuing to explore recruitment & retention options, including agency. Attended	KSO1 KSO2 KSO3 KSO4
1266	24/06/2022	Ophthalmic electronic patient record (EPR) - absence	The absence of a functioning Ophthalmic EPR prevents us from participating in the RCOphth National Ophthalmology Database (NOD) Audit which allows for quality assurance of NHS cataract surgery.□ □ QVH participated in the NOD for the first 3 years, but withdrew from year 4 onwards as free use/licensing of Medisoft (one of the principle Ophthamic EPR systems) was withdrawn.	At present, we perform an annual partial retrospective audit, the most recent covering a 5 month period with an aim to audit PCR rate in line with RCOphth requirement in order to assess quality of care. To identify complications, multiple sources need to be utilized - cataract complications book: checking when vitrectomy used, theatre log books were used to check description of surgeries and the Ophthalmic implants book which is used across all theatres at QVH.	Shane Morrison-McCabe	Andre Litwin	Compliance (Targets / Assessments / Standards)	15	9	**06.06.23** - General manager highlighted continued risk within Digital Strategy workshops and in strategic documents being developed. Any risk mitigation will be dictated by the digital strategy.□ 3.5.23 - Risk reviewed by Director of Operations and remains a risk. EMT and F&P fully aware.□ 17th March 2023: No further update□ 31st January 2023: GM engagement in digital strategy meetings and highlighted the importance of an Ophthalmology electronic solution. Further progress will be dictated by the digital strategy.□ 29th November 2022: How the Ophthalmology EPR sits within the information technology and systems workstreams needs to be decided and funding identified to ascertain when this project can commence.□ 27th October 2022: Due to the development of the QVH Digital strategy, the ophthalmology electronic system has been paused until April 2023. Once the capacity allocation to the Trust has been obtained, this project will be re-started.□ October 22 - Options appraisal being submitted to F&P end f October - prioritization within programme of works required.□ September 22 - Continuation of the below.	KSO2 KSO5

ID	Opened	Risk Title	Hazard(s)	Controls in Place	Executive Lead	Risk Owner	Risk Type	Current Rating	Target Rating	Progress/Updates	KSO
1264	20/06/2022	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 other network workstreams: Potential for risk to increase if workstreams are delayed □ Limited mitigation until new LIMS in place □	Tony Chambers	Fiona Lawson	Compliance (Targets / Assessments / Standards)	16	8	**June 23**: LIMS build in progress - operational service design document drafted between supplier and all Trust organisations involved. Final review and sign off due end June 23. Project is resource dependent and same resource for QVH is also leading all other workstreams of the Sussex Pathology Network which is an added risk to success of this programme. □ 20 Feb 23: Network-wide LIMS contract has been awarded. Programme board established, QVH represented by Pathology services manager, SRO and CIO. System build and implementation phase to commence Mar 23. Go live with new system expected Mar 24.□ 24th Jan 23: procurement of network wide LIMS underway□ 25th October 2022: some loss of funding from NHSE; going out to Tender (short timeframe for procurement process). MD presentation at EMT 25/10/22. □ 22nd August 22: Project manager now in post to ensure that QVH has the additional capacity for the pathology network workstream.□ 1st August 22: Progression of LIMS workstream within NS7 Pathology Network. There is still potential for risk to increase if workstream is delayed as current LIMS is at end of support 1st Jan 2023. There is limited	KSO2 KSO3 KSO5
1255	17/02/2022	Sterile Services provision failures	Our off site sterile services provider 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 the sterile service provider 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 the sterile service provider.	Shane Morrison-McCabe	Claire Ziegler	Compliance (Targets / Assessments / Standards)	12	9	**15.6.23** QVH continues to have adverse incidents where there are incomplete kit and expired items that have not been returned. This is being chased through escalation processes. There is a contract review meeting 19.6.23. KPIs and the service specification will be revised to explore a tendering process in the next 8-12 months.□ 27.4.23 Sterile services contract monitoring meetings are now being held monthly, pre-contract reports set out data and performance against contract. Performance has been improving with fewer errors, daily scanning and updating is carried out, weekly operational meeting is held by QVH with Sterile service provider and any issues are being successfully mitigated and resolved there.□ 31.10.22 - Remedial action plan requested from service provider; meeting scheduled for 2.11.22 with provider CEO, QVH DoOps and Chief of Finance. □ 05.07.2022 - paper presented outlying the current challenges was presented by Director of Operations at F&P. Outcome was to provide a further details regarding the options available. A paper will be presented to EMT in the week commencing 11th July 2022.	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	16/02/2022	Speech and Language Therapists Staffing (Inpatients and Outpatient/Community Services)	QVH SLT team has significant level of vacancies within substantive staffing.□ 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. Ongoing additional bank hours of substansive Community SLT - 0.2WTE 2. Patients with Urgent triage are prioritised at weekly caseload meeting 3. Regular team meetings, triage and debrief sessions for staff 4. Resourcing team in collaboration with Therapy manager and Principal SLT looking at boosting advertising of post 5. Clinical staff have delegated roles to admin who is progressing well although new into post□ 6.Clinial Lead has reduced input in roles internally, AFC panel, mediation etc. 7. Monitoring activity and demand, bi-monthly	Shane Morrison-McCabe	Sarah Holdsworth	Compliance (Targets / Assessments / Standards)	12	9	**June/23**:Bank worker started 0.4wte. Advertisement for permanent fill of vancant SLT post, no applicants therefore re-advertised. The vacancy rate in SLT staff not encouraging with large workforce gap with 23% unfilled nationally and multiple unfilled vacancies in our nearest competitors. Breaching- urgents 10 patients. Previously discussed golden handshake as potential recruitment tactic, however no information on whether this has been approved for use outside nursing. □ May/23: Full waiting list review completed by SLT to minimise risk of long waiting times- 44 patient on waiting list 26 routine and 18 urgent - 13 urgent Breaching. Re prioritisation completed. Bank worker identified, bank request form awaiting approval. Vacant Band 7 position (1WTE) from 15/5/23. Advertise externally by 12/5/23.□ March/23: Principle SLT started 1WTE. Band 7 SLT Resigned after maternity leave. Small amount ofgency and Bank still continues.□ Feb/23- Start date for Principal SLT 1WTE / 06/03 returner from Mat leave 13/2. Will leave only 0.3WTE of establishment vacant. Waiting list full review scheduled for waiting list	KSO1 KSO2 KSO5
1253	15/02/2022	Waiting List managment: Plastics	There is a risk that patients are not scheduled for surgery in a timely way because their waiting list form is on Evolve but not on Patient Centre.□	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	25/01/2023 - have emailed Head of Elective Access to ask if the V-look up needs to be revived. □ 24/08/2022 - sent email querying the status of this risk on the risk register, in light of the quality control (V-Look), that is now in place. □ 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

ID	Opened	Risk Title	Hazard(s)	Controls in Place	Executive Lead	Risk Owner	Risk Type	Current Rating	Target Rating	Progress/Updates	KSO
1250	24/01/2022	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.□ □ March 2023 updated controls: Board and CoG fully aware of the additional licence conditions, and the requirement to operate in accordance with statutory roles and responsibilities. This is considered in the setting of agendas and the conduct of the meeting.□ □ The objective (target risk) -	Clare Pirie	Leonora May	Compliance (Targets / Assessments / Standards)	12	12	April 2023:□ Discussed at March audit committee and then April Board seminar. Risk score reduced as likelihood of breach reduced.□ □ March 2023: □ Chair and company secretary have had initial conversation with NHSE re process for review of licence conditions. Next step is for Board to consider progress and challenges in context of well led review, at April Board seminar. □ Updated controls - see Controls□ □ December 2022: □ The trust is under two additional licence conditions:□ The first relates to ensuring that the Trust has sufficient and effective Board leadership capacity and capability in place, and effectively functioning Council of Governors. □ The second condition relates to the Council of Governors working effectively with the Board, and operating in accordance with their statutory roles and responsibilities. □ The Trust has made progress on both these issues, including appointing a substantive Chair, there is however more work required.□ □ 26/9/22: Independent Review action plan	KSO3 KSO5
1249	17/01/2022	Sentinel Lymph Node Biopsy (SLNB) 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 leading to longer waits for patients and potential for clinical harm.□	Weekly SLNB meeting with Clinical Director, Clinical Lead for Skin, General Manager, Service Manager, SLNB Co-ordinator, and Clinical Nurse Specialists.□ □ Weekly tracking of non-admitted and admitted SLNB pathways.□ □ CNS 'safety netting', encouraging SLNB patients to look for recurrences and flag if identify them. CNSs also encouraging patients to maintain follow-up/surveillance cycle - as opposed to suspending because they are in expectation of treatment. Cost pressure as being done as additional hours.□ □ Weekend and in-week clinics and theatre lists being added.□ □ Sussex ICS Task and Finish Meeting in place. Support in validating long waiting patients to ensure we are doing everything we can to keep them safe.□ □	Shane Morrison-McCabe	Phillip Connor	Patient Safety	12	6	3.5.23. Risk reviewed and remains in place - Director of Operations.□ 03/03/2023 - there are presently 3 patients awaiting TCI dates for SLNB and a further 27 who are scheduled for surgery in March. The service has enough baseline capacity and flexibility to cope with the surgical demand for the service; the issue at this stage is the outpatient dimension of the pathway. Whilst there are lots of actions under way to improve the pathway, the headlines are that the ICB are working with QVH to create a better pathway for SLNB patients and QVH are working in the mean-time to generate additional outpatient capacity, including increasing alignment of CNSs to consultant clinics.□ 30/01/2023 - Additional CNS hours to support pathway will be implemented as a cost pressure whilst the pathway is reviewed.□ 20/01/2023 - have updated the list of controls in order to clearly reflect the breadth of mitigations that are currently in place, as well as the work that is ongoing to strengthen it. Another note of condition of PTL: there are presently 13 patients waiting for SNLBs and 7 are past their breach date, which is a massively improved position since backlog accrued during period where no isotope	KSO1

ID	Opened	Risk Title	Hazard(s)	Controls in Place	Executive Lead	Risk Owner	Risk Type	Current Rating	Target Rating	Progress/Updates	KSO
1247	10/01/2022	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	25/01/2023 - emailed Service Manager to clarify if there are any issues with process. □ 22/11/2022 - Medical Secretaries are printing the list of patients off instead of letting the consultants triage online. Will re-convene a meeting to discuss next steps for ensuring consultants use Evolve.□ 24/08/2022 - Evolve Triage Worklist roll-out initiated W/C 15 August. Need to confirm review date, in order to gauge effectiveness of programme.□ 25/7/22 Delay to roll out of Evolve Triage Worklist due to workload pressures. Updated user guide created and roll out by mid/end August. Incidents still being reported on no first appointments booked for some patients.□ 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	KSO3
1245	10/01/2022	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	4	26/01/2023 - the Rota Manager and Rota Co-ordinator remain in post. There are a number - 4 - vacancies that need to be recruited to for April for the services SpRs, owing to the shortfall in names that were received from the deanery. The advert closes next week and, from the number of applicants that have come through, it seems likely that sufficient cover will be found. The service is also going out for a Hand Fellow and Junior Clinical Fellows, all of which also close next week. A business case has been submitted for 2 X further deanery funded SpRs. And work is ongoing to transition the service over to activity manager. It is hoped that by the next meeting, the service will be ready to submit a POAP to the Business Case Review Group, with support from the Medical Director.□ 22/11/2022 - we have now successfully recruited a Rota Manager and a band 4 Rota Co-ordinator. We are currently building rotas out into February now and the latest GMC survey indicates a marked improvement in rota management. We are introducing a third Rota Co-ordinator to the service in order to ensure that a Rota Co-ordinator can offer direct, responsive support to the rota service. We are also in the process of discussing the contract for Activity Manager in order to	KSO3

ID	Opened	Risk Title	Hazard(s)	Controls in Place	Executive Lead	Risk Owner	Risk Type	Current Rating	Target Rating	Progress/Updates	KSO
1231	04/10/2021	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	09/01/23 update: Late tertiary referrals continues to be a key risk to cancer performance, for the 62 Day Referral to Treatment target (24 Day target) and the 62 Day backlog trajectory. Both are closely monitored by the Cancer Board. Late referrals are a data item on the weekly ICB data pack. 16/11 update: Late tertiary referrals continues to be a key risk, receiving late referrals from 10 trusts across Kent, Surrey and Sussex. Continuing to closely monitoring the trusts 24 day performance at Cancer Board and in the weekly ICB submissions. □ 27.10.22 The issue of late tertiary referrals has been raised by the DoOps to ICS & NHSE colleagues at the Quarterly Assurance meeting held on 12th October. In addition, it is raised at the Planned Care Leads meeting to ensure system DGH peers expedite patient assessment and referral to QVH in line with the new system policy. □ 20/10 update: late tertiary referrals continues to be a key risk, receiving late referrals from 10 trusts across Kent, Surrey and Sussex. Continuing to closely monitoring the trusts 24 day performance at Cancer Board and in the weekly ICB submissions. □ 01/06 update: trust continuing to receive late	KSO3
1226	13/07/2021	Adult Burns - Delivery of commissioned services whilst not meeting all national standards/criteria	-Lack of key services and support functions onsite (renal replacement facilities, on site labs, other acute medical and surgical specialties when needed urgently)	-Operating at Unit level -Adult Burns inpatient peer review has taken 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	Mr Paul Drake	Patient Safety	12	8	March 2023 - Satisfactory peer review outcome. Work in progress to define model of care moving forwards in collaboration with commissioners and ODN. Capacity challenged due to critical care staffing issues. Patients reviewed on case by case basis to ensure appropriate admission□ December 2022 - Peer review completed, awaiting formal outcome although favorable feedback was given on the day.□ October 2022 - Peer review of service to be carried out 09/11/2022. Spec comm awaiting this outcome.□ 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	KSO1 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
1221	07/06/2021	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	**8/6/23** Stewardship group met 24/5/23 with first meeting of new chair. No other medical representation from QVH. Some work started on reviewing guidelines and gaps□ 10/5/23 CQUIN for 2023-24 regarding IV to oral switch.□ 24/4/23 Antimicrobial Stewardship Game arrived. Plan for limited audit discussed ? head and neck cancer and hand trauma as high use areas. 4/4/23. Microbiologists agreed to twice weekly teams meeting DMD (ML)to take forward. 30/3/23 Deputy Medical Director leading on projects regarding guidelines.Ordered Antimicrobial Stewardship board game which looking to incorporate into junior doctor training and also for other staff. 6/3/23 Discussing POAP for combined post tomorrow at BCRG□ 9/2/23 Awaiting updated inpatient chart to be in place. Still unable to recruit into AM pharmacist post. Plan on page for combined theatre/AM pharmacist post submitted as part of business planning. New audit requested after higher profile of antimicrobial issues□ 4/1/23 Inpatient chart sent to printers with update regarding dates for antimicrobial prescriptions.□ 24/11/22 Audit of basic antimicrobial	KSO1 KSO2
1189	08/12/2020	Workforce succession planning: radiology	There is a risk that the radiology dept may not have adequate staffing levels. This could impact the following:□ - diagnostic turnaround times for imaging and report - poor DM01 performance. - Poor staff and patient safety metrics - higher instances for errors (datix reportable) - higher attrition rates with poor wellbeing metrics - worse financial position if reliant on agency/locum staff - less resiliency - CDC expectation of 7 day working. Not possible currently.	- monitoring staff levels and asking for bank / agency if needed - advent of apprentice roles - training US post available to assist with shortfall and succession planning - team engagement for career conversations/ wellbeing check ins - HEE funding for course	Shane Morrison-McCabe	Sarah Solanki	Compliance (Targets / Assessments / Standards)	15	9	**13-06-2023** - fixed term 6 month locum to support service during onboarding - TRAC application on system. Deep dive paper into workforce succession risk went to F&P in May. Outcome was that it has been acknowledged that this is a strategic issue and wider than radiology. Workforce planning now coming under strategy exec team and 1st meeting held with multiple professions. 11-05-2023 - POAP submitted to Exec to take forward for temporary agency cover for medical vacancy. 6PA per week for 3-6months. We may have someone interested in consultant role - visiting next week. 8A - interviewed and 3rd time lucky - role offered. Band 5 vacancy interviewed and offered too. 3.5.23 - Risk reviewed and remains in place due to inability to consistently fill key posts. Director of Operations.□ 27-03-2023 - no further T&F group meetings have yet been held for the strategic work force plan. Consultant leaves 31st March. Operational lead vacancy for band 8a not appointed too. 2 rounds out to advert, 1 round of interviews - not appointable. Job back out to advert. 1 person coming for a visit this week.	KSO1 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
1168	20/12/2019	Significantly reduced Consultant Histopathologist cover	Significantly reduced Consultant Histopathologist cover causing failure to meet turn around times and national cancer targets.□	Locum Consultant currently employed until mid January 2020□ Previous consultant covering additional cases on bank basis□ Plans in place for remote reporting by Skin lead at neighbouring trust for ad hoc work.	Shane Morrison-McCabe	Fiona Lawson	Compliance (Targets / Assessments / Standards)	15	6	**June23**: Substantive H&N Pathologist due to leave 10th August - locum cover being sought as interim solution.□ May 2023: resignation of substantive H&N Pathologist, risk rescored to 15 and back onto the CRR□ 20 Feb 23 - Newly qualified advanced practitioner in Dermatopathology currently working on Stage D of reporting portfolio and continuing to help support the department with skin reporting. □ 24th Jan 23: existing staff member completed required reporting exams for skin - now an advanced practitioner in Dermatopathology and able to report most case types independently which alleviates some of this vacancy pressure. □ October 2022: discussed at CPG, awaiting update.□ September 22: exploring potential use of 'frozen section remote reporting' system - MD, consultants and Histo manager reviewing. □ August 22: Failed recruitment campaigns x 4 since Feb 22; national shortage and specialist nature of work means lack of applicants with relevant skills or qualifications.□ Cover being provided on bank basis by specialists and part-time Consultant but when on annual leave the cover is limited and TATs	KSO2 KSO3
1040	13/02/2017	Age of X-ray equipment in radiology	- Poor patient care due to decrease image quality and higher radiation doses. □ - More risk of inaccurate diagnosis if poor image quality□ - Less resiliency in equipment if only a single piece of kit - could lead to service failure for a particular type of imaging. □ - more errors due to dose or quality issues.□ - less maneuverability in older kit meaning increase likelihood of manual handling injury. □ - financially expensive repairs on equipment that keeps failing□ - Lower Staff morale□ - workload and throughput - older kit means slower to process etc. □ - kit being used beyond economic state of repair or beyond recommended age of replacement. □ - potential to harm reputation	All equipment is under a maintenance contract, and is subject to QA checks by the maintenance company and by Medical Physics.□ □ Funding has helped support some replacements such as US/Xray room 2. □ Other kit is now ageing and approaching recommended age of replacement.□ □	Shane Morrison-McCabe	Sarah Solanki	Patient Safety	12	2	11-05-2023 - no update as MES project has not moved forward. Options appraisal for MES being refreshed at the moment by PM and RSM/GM. □ 3.5.23 - Risk reviewed by the Director of Operations and remains a risk.□ 27-03-2023 MES board held - financial team advised that ICB did not approve any additional capital so finance for MES not secure. EMT had approved the project in December with further approval at F&P in January. With this in mind - new head of financial services has asked for indicative costs for the kit should we have critical failure in the interim period for MES project. Buyers have been contacted regarding approaching supply chain. MES PM appointed and on-boarding finalised last week. MRI new model scanner approved, CCN completed and Req raised/ CCN completed. X-ray room vesting certificate received and sent back today. Needs receipting by 31st March. □ □ 27-02-2023 Interviews held for MES PM. Suitable candidate found. Awaiting sign off for on-boarding. Phase 2 documents reviewed. Mini c arm delivered and on site. MRI company have pitched a new scanner for 18 month renewal. POAP raised regarding this. 1	KSO1 KSO2 KSO3

ID	Opened	Risk Title	Hazard(s)	Controls in Place	Executive Lead	Risk Owner	Risk Type	Current Rating	Target Rating	Progress/Updates	KSO
877	21/10/2015	Financial sustainability	1) Failure to achieve key financial targets would adversely impact the NHSI "Financial Sustainability Risk rating and breach the Trust's continuity of service licence. 2)Failure to generate surpluses to fund future operational and strategic investment	1) Annual financial and activity plan 2) Standing financial Instructions 3) Contract Management framework 4) Monthly monitoring of financial performance to Board and Finance and Performance committee 5) Performance Management framework including monthly service Performance review meetings 6) Audit Committee reports on internal controls 7) Internal audit plan	Stuart Rees	Jeremy Satchwell	Finance	12	8	May 2023: 2022/23 Year End results have been finalized and the Trust achieved a breakeven position for Income and Expenditure, Cash in the Bank of £11.7m and invested the available capital of £6.5m. The Trust has also submitted a breakeven plan for 23/24 which achieves 109% of 19/20 activity and delivers 5.5% efficiency. This is pleasing result and provides a firm foundation for further investment and development from the ICB. QVH is now recognized as being a key enabler to the strategic development of the Sussex ICS and as such has demonstrated it has a sustainable future.□ September 2022: Month 6 YTD Breakeven and Breakeven Forecast Outturn for year end. Development of in year and longer term financial improvement projects continuing. Efficiency improvement plans to be further worked up with key stakeholders to support longer term financial sustainability. Additional work to evaluate the underlying financial risks and options for mitigation where these are available.□ August 2022: YTD breakeven position for month 3. Further work is ongoing with regards to forecasting for the year and also review of the planning for 23/25 in line with national guidelines. In addition the Trust has started	KSO4
834	09/09/2015	Non compliance with some of the national guidelines for paediatric care.	Unavailability of an onsite Paediatrician to review a sick child causing □ 1. Harm to child 2. Damage to reputation 3. Litigation	1. Service Level Agreement with UHSx 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. No inpatient burns cases 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 - Spring 2023 Audit of all transfers out carried out on monthly basis and reviewed during Paediatric meeting.□	Tania Cubison	Dr Sarah Bailey	Patient Safety	12	4	March 2023 - Date for SLA review being negotiated.□ December 2022 - SLA being reviewed. Telephone advice and guidance in place when UHSx team are not on site. □ 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:	06/07/2023		**Agenda reference:**	**50-23**	
Report title:	Well led review – recommendations and organisational response				
Sponsor:	Jackie Smith, Trust Chair Clare Pirie, director of communications and corporate affairs				
Author:	Clare Pirie, director of communications and corporate affairs				
Appendices:	N/A				
Executive summary					
Purpose of report:	In line with national guidance, the Trust has commissioned a leadership and governance review using the NHS Improvement well-led framework. This paper updates the Board on the key themes and organisational response				
Summary of key issues	Work is underway to address the recommendations. We recognise the work to be done, particularly in the development of the strategy for QVH which is the highest priority for the Board				
Recommendation:	The Board is asked to **discuss** and **note** the contents of the report.				
Action required	Approval	**Information**	**Discussion**	**Assurance**	Review
Link to key strategic objectives (KSOs):	**KSO1:**	**KSO2:**	**KSO3:**	**KSO4:**	**KSO5:**
	Outstanding patient experience	***World-class clinical services***	***Operational excellence***	***Financial sustainability***	***Organisational excellence***
Implications					
Board assurance framework:	The well led review is an important contribution to Board assurance and identification of gaps in assurance				
Corporate risk register:	Themes of the review include risk management. The review will be considered in the development of the board level strategic risks.				
Regulation:	The well led inspection is a national requirement				
Legal:	None				
Resources:					
Assurance route					
Next steps:	Continued work to implement the recommendations.				

Report to:	Board of Directors
Agenda item:	50-23
Date of meeting:	06 July 2023
Report from:	Jackie Smith, Trust Chair Clare Pirie, director of communications and corporate affairs
Report author:	Clare Pirie, director of communications and corporate affairs
Date of report:	25 June 2023
Appendices:	Appendix one: Well led review recommendations

Well led review – recommendations and organisational response

Background

In line with national guidance, the Trust has commissioned a leadership and governance review using the NHS Improvement well-led framework.

The review was carried out by Deloitte and included a desktop review of relevant documentation, a board effectiveness survey that was completed by all Board members, a governor survey, interviews with each member of the Board and with a sample of senior staff, observation of Board, subcommittee and business unit performance review meetings, four staff focus groups and telephone interviews with external stakeholders. Field work was carried out in the winter of 2022/23, followed by a workshop with the Board to collectively explore the feedback.

The reviewers commented that the review was managed by the trust in an organised and professional way, and all staff involved in the review were unfailingly helpful and welcoming.

At the time of the review the Board was going through some transition in membership, but recent recruitment has brought a level of stability that should allow the Board to address the various strategic, cultural and operational challenges that have been identified by the review. The review identified six key themes.

Theme 1: Developing the Board

At the time of the review the executive team had a high reliance on interims and the reviewers commented on limitations in experience of best practice and the need to modernise processes. Board members recognised the need to improve cohesion, and the appointment of new non-executive directors and substantive executives is an opportunity for the Board to reset the organisation as it formulates anew strategy and sets direction for the Trust.

Theme 2: Raising the profile of divisions

The clinical business unit structure at QVH needs updating in line with modern good practice. The reviewers described the need to establish triumvirate working, with clear roles, responsibilities and accountabilities in divisional leadership teams. Clinical leaders need sufficient time for their leadership roles. Performance review meetings should be divisionally led forums.

Theme 3: Strategic engagement

In line with the recommendations of the review, the Trust is commencing a major programme of engagement to win the hearts and minds of stakeholders as it sets the strategy and reinvigorates values. This requires a full engagement plan with careful communications and active listening.

Theme 4: Governance flows
Given the scale of strategic change required the strategic development committee is being established to cover the broad remit of strategic developments including digital, green plan and organisational strategy. The reviewers recommended additional improvements to provide clarity on the role of various governance forums from ward to Board.

Theme 5: Risk management
The reviewers noted that while the Trust has the key components of a risk management framework and uses key risk management tools, this could be improved and risk management could be more thoroughly embedded at directorate and business unit level. This work is now underway.

Theme 6: Stakeholders
Recommendations include raising the visibility of Board members with staff and delivering a more structured approach to engagement on patient pathways and within services; this work has now begun. External stakeholders see the Trust as a willing partner and there is opportunity for a greater external focus; the director of strategy and partnerships was a vacant role at the time of the review and the director is now playing an important role in increasing external focus.

In addition, the reviewers made a number of comments about the culture of the organisation. This included a building of momentum around equality, diversity and inclusion, a number of initiatives linked to staff wellbeing, and a culture of learning from incidents. There is an opportunity to build on this, and to review the many mechanisms that the Trust has for hearing staff concerns ensuring the value of each is clear.

Recommendations for improvement
The review generated 19 recommendations; these are all recognised by the Board as important areas of focus. Appendix A sets out these recommendations with a brief summary of action being taken against each.

Appendix one: Well led review recommendations

Recommendation	Organisational response
Developing the Board **1.** The planned executive team development programme should include a focus on building team cohesion and modern working practices aimed at promoting cross-portfolio multi-disciplinary working amongst EDs.	Dedicated executive team activities will be a critical part of building shared ownership and effective delivery; an executive development programme is being implemented.
2. The planned board development programme should include a combination of functional development activities to enhance leadership and governance, and 'softer' activities aimed at understanding individual preferences and ways of working, with a view to building team relationships and cohesion.	With a period of relative stability ahead, board development activities will include a focus on building board cohesion, impact and effectiveness to position the Board to develop and deliver the Trust strategy.
Raising the profile of divisions **3.** The Trust should more clearly define the divisional structure to reinforce the role, responsibilities, and accountabilities of divisional leadership teams with a view to enhancing triumvirate working and raising the profile and status of the divisional leadership teams.	The tier two leadership structure needs to be defined more clearly, particularly the accountabilities and responsibilities within clinical business units. While the scale of the Trust has made this challenging, strengthened triumvirate working (clinical director, head of nursing, operational lead) would bring clear benefits in operational effectiveness and improving the line of sight for Board assurance. Initial discussions have commenced and this is an area for further work.
4. The Trust should actively promote the status of clinical leadership roles and ensure that clinical leaders have sufficient time 'ringfenced' to fulfil their leadership role and that a leadership development structure is in place to develop capability.	The Trust would benefit significantly from building clinical leadership capacity and capability, supporting clinical leaders to operate in a meaningful way. It is important that the role of clinical leader is actively promoted, with sufficient time to be effective and appropriate infrastructure to support their leadership development. This is an area for further work.
5. The Trust should modify the style and approach of PRMs to ensure that they are a divisionally led forum where divisional leaders can highlight risks and gain support from a multi-disciplinary executive team to help unblock any issues or challenges. This should be done in a way that fosters a more mature	Performance review meetings are being refreshed to ensure that they are led by the clinical business unit or corporate service team, who are supported to raise key risks and ask for support from the executive team where required. The aim is to empower the teams, whilst also instilling a greater sense of ownership and accountability.

approach to the divisional to executive relationship.	
6. The Trust should introduce a periodic programme of agenda items at board committees that are aimed at giving the Board greater assurance over activities at the divisional level, as well as giving divisional leaders greater exposure to the board to support succession planning.	Periodic updates from business unit leaders at committees and Board meetings would enhance assurance and be empowering for senior leaders. This is an area for further work, which will be supported by a performance and accountability framework.
Strategic engagement **7.** The Trust should develop a detailed engagement and communications plan aimed at winning the hearts and minds of stakeholders as it sets a new strategic direction for the Trust. This should be developed in a way that recognises the value of the process in building consensus, as opposed to merely developing a document. Prior to commencing this exercise, the Board should organise a facilitated board development session aimed at fully aligning board members regarding the requirements; recognising the need for a multi-disciplinary executive approach to strategy development; and clarifying the resourcing requirements to deliver this major change programme.	The Board has committed to pursuing a new strategic direction and is putting resources in place to facilitate this. The director of strategy and partnerships joined the Trust in February and the Board is aligned on the development approach being taken. The first phase of engagement has involved conversations with more than 250 staff connected with informing the clinical services baseline and the planned approach to strategy development, as well as seeking feedback on engagement commitments from key stakeholders such as governors. There is good momentum in starting the process of engagement, with the aim of building trust and confidence, creating a positive environment for change in which ideas and fears can be heard.
Governance flows **8.** The Board should consider expanding the remit of the Digital Committee and refocus on Strategic Development to include aspects such as organisational development, the Green Plan, and the organisational strategy. In addition, Terms of Reference should be updated to clarify the role of F&P and Q&G in relation to workforce and we would advise renaming Q&G to exclude reference to governance	A strategic development committee is being established to bring together scrutiny and assurance on key strategic workstreams including the development of the organisational strategy, the digital agenda and the Green Plan. The terms of reference of subcommittees will be reviewed, with a renamed quality and safety committee and an audit and risk committee with clear remits.
9. Each Committee Chair and Executive Director lead should spend time considering the level and format of information required by the committee based on the risks being considered.	Work has begun to present committee and Board papers with a narrative that makes clear issues of concern and areas of outstanding performance, with an evidence based data pack appended. The aim is to support an appropriate level of discussion focussed on assurance that priorities are being addressed and risk appropriately managed.

10. Conduct a mapping exercise of reporting and information flows between all key forums within the organisation from 'ward to board', which can also be used to assess the impact of all the forums to determine if any are superfluous or need greater focus.	Establishing the golden thread linking the Board through the subcommittees and EMT to business unit or organisational wide governance forums is vital. This mapping exercise will follow once the subcommittee terms of reference have been refreshed and the role of HMT reviewed.
11. Review the role, remit, and membership of the Hospital Management Team forum to maximise the engagement and accountability impact of senior leaders.	It is recognised that HMT has become overly focused on information sharing and would benefit from a higher degree of engagement and ownership. This is an area for further work, which will be supported by a performance and accountability framework.
Risk management **12.** Consider the appropriateness of portfolios ownership of the Board Assurance Framework and Corporate Risk Register, and the independence requirements of the Trust Secretary role.	A significant transformation programme is underway in risk management. This will include a new approach to the BAF and a refreshed approach to the CRR.
13. The Board should enhance the content and the format of both the Board Assurance Framework and the Corporate Risk Register to ensure they are fully reflective of the good practices identified in this report.	As above.
14. The review of organisational governance structures in R10 should consider the governance process for the escalation of risk to a single executive led risk management group to enable detailed analysis, mitigation and identification of key themes across the organisation	The executive team are now devoting time on a monthly basis to risk management, taking a thematic approach to collective moderation, challenge and understanding.
15. The Trust should review the role of the central governance function in relation to the communication of guidelines regarding the application of risk management, supported by more formal training in risk management techniques	The risk management transformation programme will include a refreshed risk policy/strategy and an accountability framework ensuring clarity of roles. The Board has undertaken formal training and training is being put in place for senior staff to develop a culture in which risk and mitigation is well understood, used in everyday work and robustly reported.
Stakeholders **16.** The Trust should consider available mechanisms to raise the visibility and profile of NEDs and the ED group with staff. In addition to increased service visits, this could	Board visibility with staff was reduced during the pandemic and a programme is now in place to ensure every Board member is supported to build a direct connection with a specific service as well as

potentially include enhanced use of webinars, newsletter profiling and other online communications. In addition, there may be opportunities for wider NED in-person engagement through activities such as aligning members with divisions or facilitating occasional meetings between NEDs and staff groups	to have meaningful opportunities for talking to staff and patients in other areas.
17. The Trust should develop a stakeholder engagement plan that maps out all key external relationships and develop a prioritised plan for engaging externally. This plan should consider the combined role of EDs, NEDs and divisional leaders	Stakeholder mapping has been developed connected with the strategy development work. Board members and other senior staff will all have an important role to play in engaging externally to ensure the Trust continues to be a valued system partner and that the strategy is developed with the support of patients, staff, wider communities and partners
18. The Trust should consider an investment in developing a more structured approach to patient engagement activities to ensure a consistent approach across services.	The Trust has a consistently high response rate to the Friends and Family Test and collects feedback from patients at discharge. The patient engagement strategy is being updated and this will include consideration of how to achieve more systematic engagement through patient pathways and services.
Other **19.** The Board should consider its approach to Freedom to Speak Up by undertaking a self-assessment, including the value of the 'Ask Nicky' reporting mechanism in the light of the need to foster a more mature approach to the division and executive relationship.	The mechanisms for hearing staff concerns will be reviewed to ensure they have appropriate governance and that the intelligence received is appropriately triangulated and acted on.

Report cover-page					
References					
Meeting title:	Board of Directors				
Meeting date:	06/07/2023	**Agenda reference:**	**51-23**		
Report title:	Establishment of strategic development committee				
Sponsor:	Clare Pirie, director of communication and corporate affairs Abigail Jago, director of strategy and partnerships and acting CEO				
Author:	Leonora May, deputy company secretary				
Appendices:	Appendix one: strategic development committee terms of reference (ToR)				
Executive summary					
Purpose of report:	The Board is asked to consider the recommendation that a strategic development committee is formally established as a sub-committee of the Board.				
Summary of key issues	- Strategic development committee established to provide detailed oversight of the development of the Trust strategy, its enabling strategies and strategic projects and programmes - Digital committee to become a sub-committee of the strategic development committee - The Board considered the establishment of the committee and provided input into its remit at its seminar at the beginning of June 2023 - The Board will retain its responsibility for defining the strategic aims and objectives of the Trust and the Board will continually contribute to the development of a strategy				
Recommendation:	The Board is asked to - **Approve** the establishment of the strategic development committee as a sub-committee of the Board - **Approve** the strategic development committee's terms of reference - **Approve** the disbanding of the digital committee as a sub-committee of the Board				
Action required	**Approval**	Information	Discussion	Assurance	Review
Link to key strategic objectives (KSOs):	**KSO1:**	**KSO2:**	**KSO3:**	**KSO4:**	**KSO5:**
	Outstanding patient experience	***World-class clinical services***	***Operational excellence***	***Financial sustainability***	***Organisational excellence***
Implications					
Board assurance framework:	Board assurance framework fundamental overhaul is underway and will include overarching strategic risks				
Corporate risk register:	1292- Overarching corporate risk- securing a long term future for QVH				
Regulation:	Well led Governing documents- standing orders, reservation of powers and scheme of delegation				
Legal:	None				
Resources:	None				
Assurance route					
Previously considered by:	Board seminar June 2023				
Next steps:	First meeting 19 July 2023				

Report to:	Board Directors
Agenda item:	51-23
Date of meeting:	6 July 2023
Report from:	Clare Pirie, director of communication and corporate affairs Abigail Jago, director of strategy and partnerships and acting CEO
Report author:	Leonora May, deputy company secretary
Date of report:	26 June 2023
Appendices:	Appendix one: Strategic development committee ToR

Establishment of strategic development committee

Introduction

The Board is asked to consider the recommendation that a strategic development committee is formally established as a sub-committee of the Board in line with the standing orders, and that the digital committee, currently a sub-committee of the Board, will become a sub-committee of the strategic development committee.

Background

Whilst the Board should have oversight of strategy development, the significant work required to develop the Trust wide strategy and enabling strategies will require more detailed committee oversight. The well led review suggests that a strategic development committee should be established for that purpose. The committee remit includes Trust strategy, digital, Green Plan and organisational development in line with the recommendation of the well-led review.

The Board considered the establishment of the committee and provided input into its remit at its seminar at the beginning of June 2023.

Establishment

The Trust's standing orders provide that the Board of Directors shall approve the appointment, membership and terms of reference of its sub-committees.

S5.7 of the Trust's standing orders have been updated to include the strategic development committee as a sub-committee of the Board and remove the digital committee. The standing orders are scheduled for approval later in the agenda.

The reservation of powers and scheme of delegation have been amended to give the strategic development committee authority to provide strategic oversight and direction regarding the planning and development of the Trust wide organisational strategy including work related to the clinical and enabling strategies. The Board will retain its responsibility for defining the strategic aims and objectives of the Trust and the Board will continue to contribute to the development of a strategy. The terms of reference for the committee are attached to the report as appendix one, and the reservation of powers and scheme of delegation is scheduled for approval later in the agenda.

Meetings

It is proposed that the strategic development committee will meet monthly and will be chaired by a non-executive director (initially the Trust Chair). The purpose, duties and responsibilities and membership of the committee are set out within the terms of reference in more detail.

Next steps
The first meeting of the strategic development committee will be held on 19 July 2023. It is recognised that there is a need to avoid duplication between sub-committees and to review the remit of all committees in more detail. The Board will be asked to consider committee membership, remit, frequency etc. for all of its sub-committees to ensure effectiveness at its meeting on 7 September 2023.

Recommendation
The Board is asked to**:**

- **Approve** the establishment of the strategic development committee as a sub-committee of the Board
- **Approve** the strategic development committee's terms of reference
- **Approve** the disbanding of the digital committee as a sub-committee of the Board

Terms of reference
Name of governance body
Strategic Development Committee
Constitution
The strategic development committee ("the Committee") is a standing committee of the Board of Directors, established in accordance with the Trust's standing orders, standing financial instructions and Constitution.
Accountability
The Committee is accountable to the Board of Directors for its performance and effectiveness in accordance with these terms of reference. The Board will retain its responsibility for defining the strategic aims and objectives of the Trust and the Board will continue to contribute to the development of strategy.
Authority
The Committee is authorised by the Board of Directors to seek any information it requires from within the Trust and to commission independent reviews and studies if it considers these necessary.
Purpose
The purpose of the Committee is to: • Provide strategic oversight and direction regarding the planning and development of the Trust wide organisational strategy including work related to clinical and enabling strategies • Review matters related to strategy development such as workstream establishment, reporting and resourcing • Provide assurance and advice to the Board, making recommendations to support with strategic decision making • Support the Board with the development of strategy and enabling strategies and key strategic objectives, providing detailed oversight ensuring that the Board is appropriately sighted and provides input • Ensure the implementation and delivery of the strategy and enabling strategies and provide assurance to the Board in that regard • Identify information needed by the Board to help with strategic decision making and ensure that the Board is sighted on key strategic risks, issues and opportunities • Ensure alignment between the Trust strategy and enabling strategies and provide assurance to the Board in that regard To fulfil its purpose, the Committee will provide evidence based and timely advice to the Board to assist it in discharging its functions and responsibilities with regard to: • Strategic direction, planning and related matters • Development and implementation of the strategy and enabling strategies • Key strategic risks, issues and mitigating actions • Strategic communication and engagement • Organisational development and culture

- Finance, workforce, digital services, estates and facilities, the green plan and other enabling services
- Strategic investment

Duties and responsibilities

Duties

Strategy

- Detailed oversight of the development of strategy and key strategic objectives of the Trust, making recommendations related to this to the Board
- To provide appropriate oversight and support to ensure appropriate resourcing and alignment of the strategy development
- Detailed oversight of the development of the clinical strategy and enabling strategies which might include but are not limited to digital, estates and facilities and the green plan, making recommendations related to these to the Board
- Oversight of the implementation and delivery of the Trust strategy, clinical strategy and enabling strategies once approved by the Board
- To ensure and provide assurance to the Board that the Trust's strategy, clinical strategy and enabling strategies align with the strategic ambitions of the NHS locally and nationally
- Detailed oversight of the development of quality improvement methodology in alignment with the development of strategy and key strategic objectives
- Identify and make recommendations to the Board in relation to strategic communications and engagement
- To ensure appropriate consideration of OD and culture requirements in regard to the development and implementation of the strategy

Risks and opportunities

- To identify and monitor key strategic risks, issues and mitigations and escalate to the Board
- To identify, review and recommend strategic opportunities to the Board

Responsibilities

The committee will be responsible for oversight of all strategic projects and programmes across the Trust which might include but are not limited to quality improvement and health inequalities to ensure objectives are aligned and resources are being effectively managed.

The committee will make recommendations to the Board of Directors in relation to:

- The Trust strategy, enabling strategies and key strategic objectives
- Strategic business cases and investment opportunities
- Strategic communication and engagement

Chairing

The Committee shall be chaired by a non-executive director.

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

Meetings

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

The Committee will meet monthly.

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

Secretariat

The Deputy company secretary or their nominee shall be the secretary to the Committee and shall provide administrative support and advice to the chair and membership. The duties of the secretary shall include but not be limited to:

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

Membership

Members

The following postholders are members of the Committee and shall have full voting rights

- Three non-executive directors (one of which will be Chair)
- Chief executive
- One executive director

Attendees

- The secretary to the Commitee (for the purposes described above)
- The following posts shall be invited to attend meetings of the Committee as required according to the agenda, in full or in part, but shall neither be a member nor have voting rights.

- Chief Finance Officer
- Chief Nurse
- Deputy Medical Director
- Chief People Officer
- Director of Operations
- Chief Information Officer
- Deputy Director of Strategy and Partnerships
- Any member of the Board of Directors or senior manager considered appropriate by the chair of the Committee.

Quorum

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

Attendance

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

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

Papers

Papers to be distributed to members and those in attendance at least three clear days* in advance of the meeting.

Reporting

Minutes of the Committee meetings shall be recorded formally and ratified by the Committee at its next meeting.

The Chair shall prepare a report of the latest Committee meeting for submission to the Board of Directors at its next formal business meeting. The report shall draw attention to any issues of concern and any significant opportunities.

Review

These terms of reference shall be reviewed annually or more frequently if necessary. The review process should include the company secretarial team for best practice advice and consistency.

The next scheduled review of these terms of reference will be undertaken by the Committee in January 2023 in anticipation of approval by the Board of Directors at its meeting in March 2024.

***Definitions**

In accordance with the Trust's constitution, 'clear day' means a day of the week not including a Saturday, Sunday or public holiday.

Report cover-page					
References					
Meeting title:	**Board of Directors**				
Meeting date:	**6 July 2023**		**Agenda reference:**	**52-23**	
Report title:	Review of Standing Orders, Standing Financial Instructions and Reservation of Powers and Scheme of Delegation (RoP SoD)				
Sponsor:	Clare Pirie, director of communication and corporate affairs				
Author:	Leonora May, deputy company secretary				
Appendices:	Appendix one: Standing Orders Appendix two: standing Financial Instructions Appendix three: Reservation of Powers and Scheme of Delegation				
Executive summary					
Purpose of report:	To present the Standing Orders and associated documents for their annual review and approval as recommended by the audit committee.				
Summary of key issues	The main changes to the documents relate to the establishment of the Strategic Development Committee which the Board is asked to approve earlier during the agenda. Other updates include: - The addition of information regarding the roles and responsibilities of the Council of Governors and a description of how disagreements between the Council of Governors and Board of Directors will be managed in the RoP SoD. This is in line with B.12.17 of the Code of governance for NHS provider trusts which came into effect from 1 April 2023 - References to NHS Improvement have been updated to NHS England - Job titles have been updated				
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:**	**KSO2:**	**KSO3:**	**KSO4:**	**KSO5:**
	Outstanding patient experience	***World-class clinical services***	***Operational excellence***	***Financial sustainability***	***Organisational excellence***
Implications					
Board assurance framework:	These documents support the delivery of all KSOs				
Corporate risk register:	None				
Regulation:	The regulatory framework requires the Board to adopt Standing Orders and a schedule of matters reserved for the Board for the regulation of Board proceedings and its business				
Legal:	The NHS Act 2006				
Resources:	None				
Assurance route					
Previously considered by:	Audit committee 14 June 2023				
Next steps:	Approval by the Board at its meeting on 6 July 2023 and thereafter publication of updated documents				

Report to:	Board of Directors
Agenda item:	52-23
Date of meeting:	6 July 2023
Report from:	Clare Pirie, director of communication and corporate affairs
Report author:	Leonora May, deputy company secretary
Date of report:	27 June 2023
Appendices:	Appendix one: Standing Orders
	Appendix two: Standing Financial Instructions
	Appendix two: Reservation of Powers and Scheme of Delegation

Review of Standing Orders, Standing Financial Instructions and Reservation of Powers and Scheme of Delegation

Introduction

The Trust's Standing Orders, Standing Financial Instructions and Reservation of Powers and Scheme of Delegation are presented to the Board for approval following their annual review.

Executive summary

The audit committee reviewed the Standing Orders and Scheme of Delegation and Reservation of Powers at its meeting on 14 June 2023 and agreed to recommend the changes to the Board for approval. The audit committee agreed to recommend the proposed changes made by the company secretary to the Standing Financial Instructions, but noted that the chief finance officer will discuss with the committee Chair and circulate to committee members the details of any further updates required to reflect changes to national guidance or approved policies during the year. There have been no further changes made to the document. Changes to the documents are highlighted on the front cover to this report, and the documents are appended for review.

The main changes to the documents relate to the establishment of the Strategic Development Committee which the board was asked to formally approve earlier during the agenda.

Other updates include:

- The addition of information regarding the roles and responsibilities of the Council of Governors and a description of how disagreements between the Council of Governors and Board of Directors will be managed. This is in line with B.12.17 of the Code of governance for NHS provider trusts which came into effect from 1 April 2023
- References to NHS Improvement have been updated to NHS England
- Job titles have been updated

Recommendation

The Board is asked to **approve** the proposed changes to the Standing Orders and associated documents as recommended by the audit committee.

The changes will take immediate effect and the updated documents will 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 ~~12 January~~6 July 2023

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. The Foundation Trust is governed by the National Health Service Act 2006 ("**the 2006 Act**"), the Constitution and the Licence granted by the Regulator ("**the Regulatory Framework**"). The functions of the Foundation Trust are conferred by the Regulatory Framework. The Regulatory Framework requires the Board of Directors to adopt Standing Orders for the Board of Directors for the regulation of its proceedings and business. The Foundation Trust must also adopt Standing Financial Instructions which set out various responsibilities of individuals.

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

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

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

1 Interpretations and definitions

1.1 Any expression to which a meaning is given in the 2006 Act or any regulations or orders made under the 2006 Act shall have the same meaning in these SOs and in addition, defined terms used in these SOs have the same meaning as in the Constitution unless the context requires otherwise, or a contrary intention is evident.

1.2 Save as otherwise permitted by law, at any meeting of the Board of Directors, the Chair of the Foundation Trust shall be the final authority on the interpretation of these SOs (on which he/she should be advised by the Secretary).

1.3 Words importing the singular shall import the plural and vice-versa in each case.

1.4 In these SOs:

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

Accounting Officer means the person who, from time to time, discharges the functions specified in paragraph 25(5) of Schedule 7 to the 2006 Act;

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

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

Chair means the person appointed in accordance with the Constitution to ensure that the Board of Directors and Council of Governors successfully discharge their overall responsibilities for the Foundation Trust as a whole. The expression "the Chair" shall include the Deputy Chair or any other Non-Executive Director appointed if the Chair or Deputy Chair is absent or is otherwise unavailable;

Chief Executive means the Chief Executive of the Foundation Trust;

Clear Day means a day of the week not including a Saturday, Sunday or public holiday;

Committee means a committee appointed by the Board of Directors;

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

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

Council of Governors means the Council of Governors as constituted in accordance with the Constitution and which has the same meaning as the Council of Governors in paragraph 7 of Schedule 7 to the 2006 Act;

Deputy Chair means the Deputy Chair of the Foundation Trust appointed in accordance with paragraph 36 of the Constitution;

Director means a member of the Board of Directors;

Executive Director means an executive member of the Board of Directors of the Foundation Trust;

Financial Year means each successive period of 12 months beginning with 1 April and ending with 31 March;

Foundation Trust means the Queen Victoria Hospital NHS Foundation Trust;

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

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

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

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

Non-Executive Director means a Non-Executive Director of the Foundation Trust;

Officer means an employee of the Foundation Trust or any other person holding a paid appointment or office with the Foundation Trust;

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

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

Secretary means a person whose function shall be to provide advice on corporate governance issues to the Board of Directors, Council of Governors and the Chair and monitor the Foundation Trust's compliance with the Regulatory Framework. The Secretary shall be appointed and removed by the Chief Executive and Chair of the Foundation Trust acting jointly;

Senior Independent Director means a Non-Executive Director appointed in accordance with paragraph 36 of the Constitution;

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

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

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

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

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

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

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

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

2 The Foundation Trust Board of Directors

Composition of the Board of Directors

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

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

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

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

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

Appointment and powers of the Deputy Chair

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

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

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

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

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

Appointment of a Senior Independent Director

2.9 The Board of Directors may appoint a Non-Executive Director to be the Senior Independent Director, for such period, not exceeding the remainder of their term as a member of the Board of Directors, as they may specify on appointment. The appointment for the Senior Independent Directors shall be made in accordance with paragraph 36 of the Constitution.

2.10 If a Non-Executive Director resigns from the office of Senior Independent Director (in accordance with paragraph 36.3 of the Constitution), the Board of Directors may appoint another Non-Executive Director as Senior Independent Director in accordance with the provisions of Standing Order 2.9.

3 Role of members of the Board of Directors

Corporate role of the Board of Directors

3.1 All business shall be conducted in the name of the Foundation Trust.

3.2 All funds received in trust shall be held in the name of the Foundation Trust as corporate trustee.

3.3 The powers of the Foundation Trust established under statute shall be exercised by the Board of Directors meeting in public session except as otherwise provided by paragraph 39 and Annex 6 (Conduct of meetings of the Council of Governors and the Board of Directors) of the Constitution.

3.4 The Board of Directors will function as a corporate decision-making body. Executive and Non-Executive Directors will be full and equal members. Their role as members of the Board of Directors will be to consider the key strategic and managerial issues facing the Foundation Trust in carrying out its statutory and other functions.

3.5 The Foundation Trust has the functions conferred on it by the Regulatory Framework. Directors acting on behalf of the Trust as corporate trustees are acting as quasi trustees. Accountability for Charitable Funds held on Trust is to the Charity Commission and to the Regulator. Accountability for non-charitable Funds held on Trust is only to the Regulator.

Chief Executive

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

~~Finance director~~Chief Finance Officer

3.7 The ~~finance director~~Chief Finance Officer shall be responsible for the provision of financial advice to the Foundation Trust and to members of the Board of Directors and for the supervision of financial control and accounting systems. The Chief Finance Officer~~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~~Chief Nurse

3.9 The ~~director of nursing~~Chief Nurse 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~~ Chief Nurse shall provide advice to the Chief Executive and the Board of

Directors on key strategic care quality issues and matters relating to the nursing workforce of the Foundation Trust.

Non-Executive Directors

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

Chair

3.11 The Chair shall be responsible for the operation of the Board of Directors and shall chair all meetings of the Board of Directors when present. The Chair has certain delegated executive powers. The Chair must comply with the terms of appointment and with these Standing Orders.

3.12 The Chair shall liaise with the Council of Governors and its appointments committee over the appointment of Non-Executive Directors and once appointed shall take responsibility either directly or indirectly for the Non-Executive Directors' induction, portfolio of interests, assignments and performance.

3.13 The Chair shall work in close harmony with the Chief Executive and shall ensure that key and appropriate issues are discussed by the Board of Directors in a timely manner with all the necessary information and advice being made available to the Board of Directors.

3.14 The Chair shall ensure that the designation of lead roles or appointments of members of the Board of Directors as required by the Regulator or as set out in any statutory or other guidance will be made in accordance with that guidance or statutory requirement.

Corporate role of the Council of Governors

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

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

3.16 The Board of Directors has resolved that certain powers and decisions may only be exercised by the Board of Directors meeting in formal session. These powers are set out in the Reservation of Powers and Scheme of Delegation and shall have effect as if incorporated into these Standing Orders.

3.17 Subject to the Regulatory Framework and such guidance or best practice as may be issued by the Regulator, the Board of Directors may make arrangements for the exercise of any of its functions by a Committee or sub-committee of the Board of Directors or by a Director or an officer in each case subject to such restrictions and conditions as the Board of Directors considered appropriate. The powers and decisions which the Board of Directors has delegated to Committees, sub-committees, Directors or Officers are set out in the Reservation of Powers and Scheme of Delegation.

4 Meetings of the Board of Directors

Calling meetings

4.1 Subject to Standing Orders 4.2 and 4.3 below, meetings of the Board of Directors shall be held at such times and places as the Board of Directors may determine.

4.2 The Chair may call a meeting of the Board of Directors at any time.

4.3 One third or more of the whole number of members of the Board of Directors may requisition a meeting in writing to the Chair. If the Chair refuses or fails to call a meeting within seven Clear Days of a requisition being presented, the members of the Board of Directors who signed the requisition may forthwith call a meeting of the Board of Directors.

Notice of meetings and the business to be transacted

4.4 Before each meeting of the Board of Directors, a written notice of the meeting, specifying the business proposed to be transacted at it, and signed by the Chair or by an Officer authorised by the Chair to sign on their behalf shall be delivered to every Director (this includes email), or sent by post to the usual place of residence of such Director, so as to be available to every Director at least four Clear Days before the meeting

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

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

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

4.8 In the event of an emergency giving rise to the need for an immediate meeting, failure to comply with the notice periods referred to in SO 4.4 and (where relevant SO 4.7 above) shall not prevent the calling of, or invalidate, such a meeting without the requisite notice provided that every effort is made to make personal contact with every Director who is not absent from the United Kingdom and the agenda for the meeting is restricted to matters arising in that emergency.

Setting the agenda

4.9 The Board of Directors may determine that certain matters shall appear on every agenda for a meeting and shall be addressed prior to any other business being conducted (“standing Items”).

4.10 A member of the Board of Directors who desires a matter to be included on an agenda, other than a Standing Item or a motion, should make their request in writing to the Chair at least ten (10) Clear Days before the meeting. Requests made less than ten (10) Clear Days before a meeting may be included on the agenda at the discretion of the Chair.

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

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

Agenda and supporting papers

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

Petitions

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

Notice of motion

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

Withdrawal of motion or amendments

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

Motion to rescind a resolution

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

Emergency motions

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

Motions: procedure at and during a meeting

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

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

4.19.1 an amendment to the motion; or

4.19.2 the adjournment of the discussion or the meeting; or

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

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

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

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

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

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

Written motions

4.21 In urgent situations and with the consent of the Chair, business may be effected by a member of the Board of Directors written motion to deal with business otherwise required to be conducted at a meeting of the Board of Directors.

4.22 If all members of the Board of Directors have been notified of the proposal and a simple majority of the member of the Board of Directors entitled to attend and vote at a meeting of the Board of Directors confirms acceptance of the written motion either in writing or electronically to the Secretary within five (5) Clear Days of dispatch then the motion will be deemed to have been resolved notwithstanding that the Directors have not gathered in one place.

4.23 The effective date of the resolution shall be the date that the last confirmation is received by the Secretary and, until that date a member of the Board of Directors who has previously indicated acceptance can withdraw and the motion shall fail.

4.24 Once the resolution is passed, a copy certified by the Secretary shall be recorded in the minutes of the next ensuing meeting where it shall be signed by the person presiding at it.

Chair of meeting

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

4.26 If the Chair is absent temporarily on the grounds of a declared conflict of interest the Deputy Chair of the Board of Directors, if present, shall preside. If the Chair and Deputy

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

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

Chair's ruling

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

Quorum

4.29 No business shall be transacted at a meeting of the Board of Directors unless at least one-third of the voting members of the Board of Directors are present, including at least one voting Executive Director and one Non-Executive Director.

4.30 In accordance with Annex 7 (Meetings of the Council of Governors and the Board of Directors – Electronic Communication) of the Constitution, members of the Board of Directors participating in meetings of the Board of Directors by telephone, video or computer link or other such agreed means shall count towards the quorum for so long as the members have the ability to communicate interactively and simultaneously with all members of the Board of Directors in attendance at the meeting, including all member attending by way of electronic communication.

4.31 An officer in attendance for an Executive Director member but without formal acting up status may not count towards the quorum.

4.32 If the Chair or another member of the Board of Director has been disqualified from participating in the discussion on any matter and/or from voting on any resolution by reason of a declaration of a conflict of interest that individual will no longer count towards the quorum. If a quorum is then not available for the discussion and/or the passing of a resolution on any matter, that matter may not be voted upon at that meeting. Such a position will be recorded in the minutes of the meeting. The meeting must then proceed to the next business. The above requirement for at least one Executive Director to form part of the quorum shall not apply where the Executive Directors are excluded from a meeting of the Board of Directors (for example when the Board of Directors considers the recommendations of the Remuneration Committee). The requirement for at least one Non-Executive Director to form part of the quorum shall not apply where the Non-Executive Directors are excluded from a meeting of the Board of Directors.

Voting

4.33 Subject to Standing Orders 4.38 to 4.41 or as otherwise provided by the Standing Orders, every question put to vote at a meeting shall be determined by a majority of the votes of the members of the Board of Directors present and voting on the question and in the case of the number of votes for and against a motion being equal, the Chair of the meeting shall have a second or casting vote.

4.34 At the discretion of the Chair, all questions put to the vote will be determined by oral expression or by a show of hands. Any voting member of the Board of Directors attending by telephone, video or computer link shall cast their vote verbally and such action shall be recorded in the minutes of the meeting.

4.35 If at least one-third of the voting members of the Board of Director so request, the voting (other than by paper ballot) on any question may be recorded to show how each members present voted or abstained.

4.36 A paper ballot may be used if a majority of the voting members of the Board of Directors present so request, in which case any person attending by telephone, video or computer link shall cast their vote verbally and such action shall be recorded in the minutes of the meeting. If a Director so requests, their vote shall be recorded by name.

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

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

Suspension of Standing Orders

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

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

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

4.42 The audit 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. ~~Digital Committee.~~Strategic Development 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 they will perform personally and shall nominate officers to undertake the remaining functions for which they will still retain accountability to the Foundation Trust.

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

6.7 Nothing in the Scheme of Delegation and Reservation of Powers shall impair the discharge of the direct accountability to the Board of Directors of the ~~Finance Director~~Chief Finance

Officer to provide information to and advise the Board of Directors in accordance with statutory requirements. Outside these statutory requirements, the ~~Finance Director~~ Chief Finance Officer shall be accountable to the Chief Executive for operational matters.

6.8 The arrangements made by the Board of Directors as set out in the Scheme of Delegation and Reservation of Powers shall have effect as if incorporated in these SOs, but for the avoidance of doubt, neither these SOs nor the Scheme of Delegation and Reservation of Powers form part of the Constitution.

Duty to report non-compliance with Standing Order

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

7 Declaration of interests

7.1 These Standing Orders and Standing Financial Instructions must be read in conjunction with paragraph 40 and Annex 8 (Conflicts of Interest of Governors and Directors) of the Constitution which shall have effect as if incorporated in this Standing Order.

7.2 Notwithstanding the application of paragraph 40 of the Constitution, all members of the Board of Directors should declare the nature and extent of all relevant and material interests on appointment to the Foundation Trust and thereafter at the beginning of each financial year and when a declaration becomes inaccurate, incomplete or obsolete. Directors' interests should be recorded in the Board of Directors' minutes. Any changes of interests should be declared at the next meeting of the Board of Directors following the change occurring, recorded in the minutes of that meeting and added to the register of interests.

7.3 It is the obligation of the Director to inform the Secretary of the Trust in writing within seven (7) days of becoming aware of the existence of a relevant or material interest. The Secretary will amend the register of interest of Directors.

7.4 If members of the Board of Directors have any doubt about the relevance of an interest, this should be discussed with the Secretary or Chair.

7.5 During the course of a Board of Directors meeting, if a conflict of interest is established, the Director concerned should withdraw from the meeting and play no part in the relevant discussion or decision. For the avoidance of doubt, this includes voting on such an issue where a conflict is established. If there is a dispute as to whether a conflict of interest does exist, a majority will resolve the issue with the Chair having the casting vote.

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

7.6 Subject to the provisions of this Standing Order, if the Chair or a member of the Board of Directors has any Pecuniary Interest, direct or indirect, in any contract, proposed contract or other matter is present a meeting of the Board of Directors at which the contract or other matter is the subject of consideration, they shall at the meeting and as soon as practicable after its commencement disclose the fact and shall not take part in the consideration or discussion of the contract or other matter or vote on any question with respect to it.

7.7 Subject to applicable legislation, the Regulator may, subject to such conditions as it may think fit to impose, remove any disability imposed by this standing order in any case in which it appears to it in the interests of the National Health Service that the disability should be removed

7.8 The Board of Directors may exclude the Chair or a member of the Board of Directors from a meeting of the Board of Directors while any contract, proposed contract or other matter in which they have a Pecuniary Interest is under consideration.

7.9 This standing order applies to a Committee or a sub-committee and a joint committee as it does to the Board of Directors and applies to a member of any such Committee (whether or not they are also a Director) as it applies to a member of the Board of Directors.

Interests of officers in contracts

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

7.11 A Director or Officer should also declare to the Secretary any other employment or business of other relationship of theirs, or of their spouse, civil partner or co-habitee that conflicts, or might reasonably be predicted could conflict with the interests of the Foundation Trust.

7.12 The Foundation Trust will require interests, employment or relationships so declared to be entered in a register of interests of members of staff.

Fit and proper person test

7.13 As established by Regulation 5 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 ("**the Regulations**"), the Trust has a duty not to appoint a person or to allow a person to continue to be an Executive Director or equivalent or a Non-Executive Director of the Trust under given circumstances known as the “fit and proper persons test”.

7.14 In accordance with its fit and proper person requirements policy, the Trust requires Executive and Non-Executive Directors of the Board of Directors to declare on appointment and thereafter annually that they remain a fit and proper person to be employed as a Director.

7.15 If members of the Board of Directors have any doubt about the Regulations or declarations, this should be discussed with the Secretary or Chair.

7.16 The consequences of false, inaccurate, or incomplete information by individuals subject to the Regulations may be their removal from office pending the outcome of an investigation.

Duty of candour

7.17 As established by Regulation 20 of the Regulations, the Trust has a duty to act in an open and transparent way with people who use services and other 'relevant persons' (people acting lawfully on their behalf) in general in relation to care and treatment.

7.18 In accordance with its being open / duty of candour policy, the Trust requires that all relevant Officers apply the following key principles of candour when communicating with patients, their families and carers following a patient safety incident, complaint or claim where a patient was harmed:

1. acknowledge, apologise and explain when things go wrong;

2. conduct a thorough investigation into the patient safety incident and reassuring patients, their families and carers that lessons learned will help prevent the patient safety incident recurring;

3. provide support for those involved to cope with the physical and psychological consequences of what happened.

Canvassing of and recommendations by Directors in relation to appointments

7.19 Directors or members of any Committee of the Board of Directors may be approached by candidates wishing to increase their understanding of the organisation during the appointment process. Informal discussions outside appointments panels or committees, whether solicited or unsolicited, should be declared to the appointing panel or committee.

7.20 Directors shall not solicit for any person any appointment under the Foundation Trust or recommend any person for such appointment; but this Standing Order shall not preclude a Director from giving written testimonial of a candidate's ability, experience or character for submission to the Foundation Trust.

Relatives of Directors or Officers

7.21 Candidates for any staff appointment under the Foundation Trust shall, when making an application, disclose in writing to the Chief Executive whether they are related to any Director or the holder of any office under the Foundation Trust. Failure to disclose such a relationship shall disqualify a candidate and, if appointed, render them liable to instant dismissal.

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

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

Register of sealing

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

11 Signature of documents

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

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

12 Miscellaneous

Standing Orders to be given to Directors and Officers

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

Documents having the standing of Standing Orders

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

Review of Standing Orders

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

Joint finance arrangements

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

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 ~~7 July 2022~~ 6 July 2023

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~~Chief Finance Officer ~~& 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~~Chief Finance Officer) 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 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 NHSE ~~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~~Chief Finance Officer

2.5.1 The ~~Director of Finance~~Chief Finance Officer 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~~Chief Finance Officer.

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~~Chief Finance Officer's role in audit

3.3.1 In relation to audit, the ~~Director of Finance~~Chief Finance Officer 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~~Chief Finance Officer 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~~Chief Finance Officer 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.~~Chief Finance Officer. The reporting system for internal audit shall be agreed between the ~~Director of Finance~~Chief Finance Officer, the Audit Committee and the Lead Internal Auditor. The agreement shall be in writing and shall be reviewed at least every three (3) years.

3.5 Role of external audit

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

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

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

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

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

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

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

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

3.6 Fraud and corruption

3.6.1 In line with their responsibilities, the Chief Executive and the Chief Finance Officer~~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 Chief Finance Officer~~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 Chief Finance Officer~~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 Chief Finance Officer~~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 Chief Finance Officer~~Director of Finance~~ and shall work with NHS Counter Fraud Authority.

3.6.7 The local counter fraud specialist and the Chief Finance Officer ~~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 Chief Finance Officer~~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 Chief Finance Officer~~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 Chief Finance Officer~~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 Chief Finance Officer~~Director of Finance~~ or the local counter fraud specialist, who will then inform the Chief Finance Officer ~~Director of Finance~~ and/or Chief Executive. Where a criminal offence is

suspected, the Chief Finance Officer ~~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 Chief Finance Officer~~Director of Finance~~ must immediately notify:

(a) the Board of Directors; and

(b) the auditor.

3.7 Staff expenses

3.7.1 The Chief Finance Officer~~Director of Finance~~ shall be responsible for establishing procedures for the management of expense claims submitted by Officers on forms approved by the Chief Finance Officer~~Director of Finance~~. The Chief Finance Officer~~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 Chief Finance Officer ~~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 Chief Finance Officer~~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 Chief Finance Officer~~Director of Finance~~ will prepare and submit to the Finance and Performance Committee, the Board of Directors and the regulator.

4.1.3 The Chief Finance Officer~~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 Chief Finance Officer~~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 Chief Finance Officer~~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 Chief Finance Officer~~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 Chief Finance Officer~~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 Chief Finance Officer~~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 Chief Finance Officer~~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 Chief Finance Officer~~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 Chief Finance Officer~~Director of Finance~~ will prepare annual accounts which must be certified by the Chief Executive. The Chief Finance Officer~~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~~Code of governance for NHS provider trusts issued by NHS England~~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 Chief Finance Officer~~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 Chief Finance Officer~~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 Chief Finance Officer~~Director of Finance~~.

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

6.6 The Chief Finance Officer~~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

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

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

7.3 The Chief Finance Officer~~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 Chief Finance Officer ~~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 Chief Finance Officer~~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 Chief Finance Officer~~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 Chief Finance Officer~~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 Chief Finance Officer~~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 Chief Finance Officer~~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 Chief Finance Officer~~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 Chief Finance Officer~~Director of Finance~~.

8 CONTRACTS FOR PROVISION OF SERVICES TO CUSTOMERS

8.1 The Chief Finance Officer~~Director of Finance~~, supported by other Officers (nominated by the Chief Finance Officer~~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 Chief Finance Officer~~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 Chief Finance Officer~~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 Chief Finance Officer~~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 Regulations prescribing procedures for awarding all forms of contracts shall have effect as if incorporated in these SFIs. 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.

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

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 Chief Finance Officer~~Director of Finance~~.

9.4 Formal competitive tendering

9.4.1 The Chief Finance Officer~~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 and communication by both Trust staff and suppliers are recorded within the system audit reports.

9.6 Contracting/tendering procedure

Invitation to tender

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

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.

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.

9.6.5 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 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

9.6.8 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

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).

9.6.14

Admissibility

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 Chief Finance Officer~~Director of Finance~~.

9.6.16 Where only one tender is sought and/or received the Chief Executive and Chief Finance Officer~~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 Chief Finance Officer~~Director of Finance~~ or their nominated Officer decides that there are exceptional circumstances i.e. uploaded in good time but delayed through no fault of the tenderer.

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

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.

9.6.21 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 Chief Finance Officer~~Director of Finance~~.

9.7 Financial standing and technical competence of contractors

9.7.1 The Chief Finance Officer~~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.

9.8 Awarding of contracts

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) Chief Finance Officer~~Director of Finance~~;

(d) Designated budget managers.

9.8.2 The levels of authorisation are in the SoD.

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.

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.

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

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 Chief Finance Officer~~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 Chief Finance Officer~~Director of Finance~~ and Head of Procurement;

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

9.11 Waiving of tenders

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 Chief Finance Officer~~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.

9.11.2 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.

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

9.11.4 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.

9.11.6 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)

9.12 Health care services

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.

9.12.2 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.

9.12.3 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.

9.12.4 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.

9.13 Compliance requirements for all contracts

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 regulations and other statutory provisions; and

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

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.

9.14 Disposals

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.

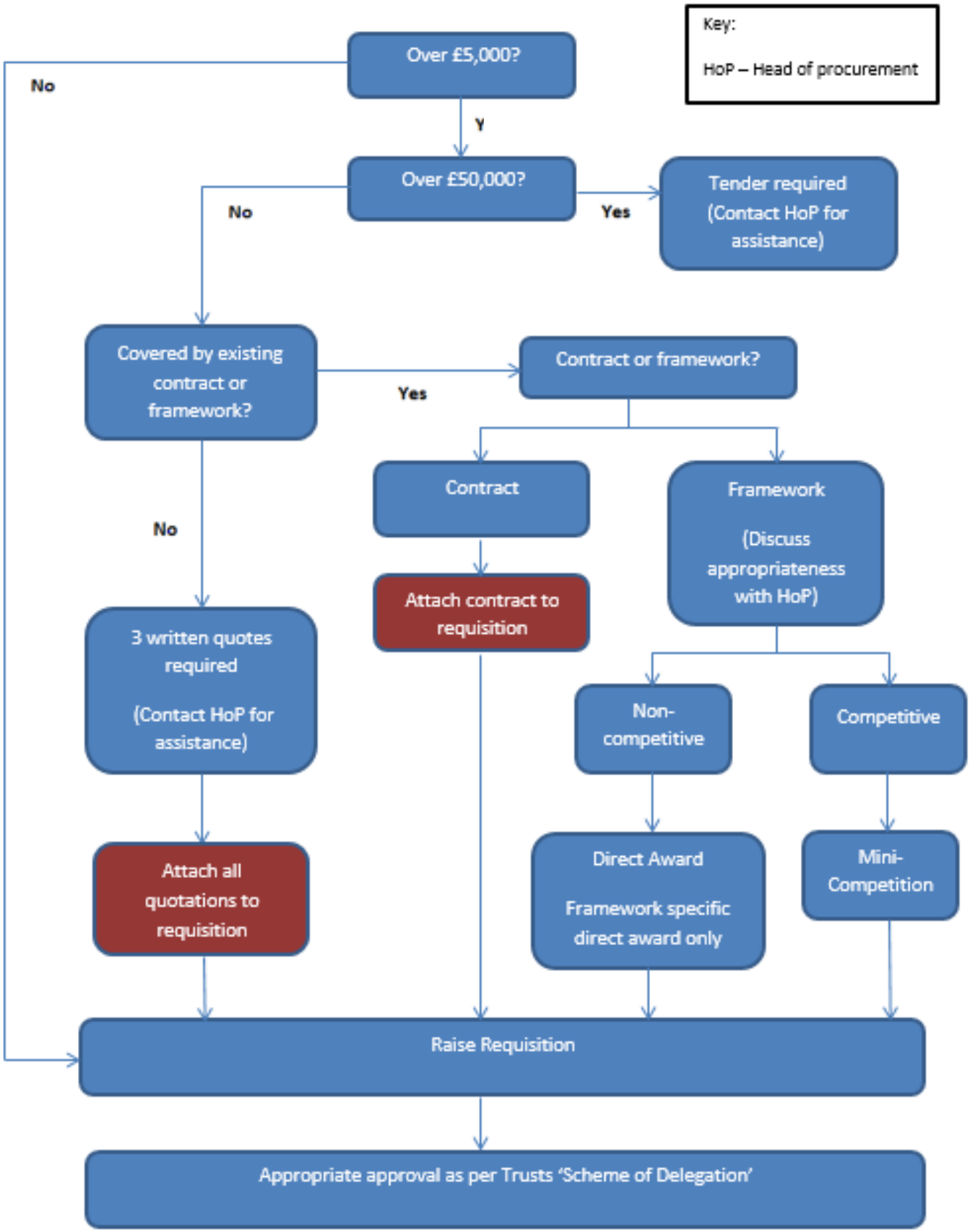
9.15 In-house services

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.

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

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.

Goods & Services Procurement Flow Chart



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 Workforce~~Chief People Officer and Chief Finance Officer~~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 Chief People Officer ~~Director of 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 Chief Finance Officer~~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 Chief Finance Officer~~Director of Finance~~, in conjunction with the Chief People Officer~~Director of 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 Chief Finance Officer~~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 Chief Finance Officer~~Director of Finance~~, the Deputy Director of Finance, the Chief People Officer ~~Director of Workforce~~ and/or the Deputy Director of 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 Chief Finance Officer~~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 Chief Finance Officer~~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 Chief Finance Officer~~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 Chief Finance Officer ~~Director of Finance~~ must be provided with a copy of all contracts and service level agreements.

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

11.3.1 The Chief Finance Officer~~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 Chief Finance Officer~~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 Chief Finance Officer~~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 Chief Finance Officer~~Director of Finance~~, ensuring that:

(a) contracts above specified thresholds are advertised and awarded in accordance with Public Procurement 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.

(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.

(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 Chief Finance Officer~~Director of Finance~~;

(e) all Officers shall adhere to the procedures regarding verbal orders developed by the Chief Finance Officer~~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.

(iii) the 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) persistent use of this method of purchasing goods or services to circumvent the ordering procedures will result in their withdrawal from use and if the circumstances warrant, the instigation of disciplinary procedures;

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

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

11.5 Prepayments

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

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

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

(c) the Chief Finance Officer~~Director of Finance~~ will need to be satisfied with the proposed arrangements before contractual arrangement proceed (taking into account the relevant provisions of these SFIs and the Public Procurement Regulations 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 Chief Finance Officer~~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 Chief Finance Officer~~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 Chief Finance Officer~~Director of Finance~~ in financial procedures, and purchases from petty cash or on purchase cards.

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;

(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

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.

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

11.6.6 The Chief Executive and Chief Finance Officer~~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 Chief Finance Officer~~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 Chief Finance Officer~~Director of Finance~~'s responsibilities for advising the Board of Directors concerning the performance of investments held.

12.1.3 The Chief Finance Officer~~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 Chief Finance Officer~~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 Chief Finance Officer~~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 Chief Finance Officer~~Director of Finance~~ or by an Officer acting on their behalf and in accordance with the SoD, as appropriate.

12.2.3 The Chief Finance Officer~~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 Chief Finance Officer~~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 Chief Finance Officer~~Director of Finance~~

13.2.1 The Chief Finance Officer~~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 Chief Finance Officer~~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 Chief Finance Officer~~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 Chief Finance Officer~~Director of Finance~~ shall also develop procedures covering the physical verification of assets on a periodic basis.

13.2.5 The Chief Finance Officer~~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 Chief Finance Officer~~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 Chief Finance Officer~~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 Chief Finance Officer~~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 Chief Finance Officer~~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 Chief Finance Officer~~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.

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.

15 DISPOSALS AND CONDEMNATIONS, LOSSES AND SPECIAL PAYMENTS

15.1 Procedures

15.1.1 The Chief Finance Officer~~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 Chief Finance Officer~~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 Chief Finance Officer~~Director of Finance~~;

(b) recorded by the condemning Officer in a form approved by the Chief Finance Officer~~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 Chief Finance Officer~~Director of Finance~~.

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

15.3 Losses and special payments

15.3.1 The Chief Finance Officer~~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 Chief

Finance Officer~~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 Chief Finance Officer~~Director of Finance~~ must immediately inform the police if theft or arson is involved.

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

15.3.5 The Chief Finance Officer~~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 Chief Finance Officer~~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 Chief Finance Officer~~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 Chief Finance Officer~~Director of Finance~~ shall maintain a Losses and Special Payments Register in which write-off action is recorded. The Chief Finance Officer ~~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 Chief Finance Officer ~~Director of Finance~~ in relation to information technology

16.1.1 The Chief Finance Officer~~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 Chief Finance Officer~~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 Chief Finance Officer~~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 Chief Finance Officer~~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 Chief Finance Officer~~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 Chief Finance Officer~~Director of Finance~~ shall periodically seek assurances that adequate controls are in operation.

16.3 Risk Assessments

16.3.1 The Chief Finance Officer~~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 Chief Finance Officer~~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 Chief Finance Officer~~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 NHS Resolution~~LA~~ 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 Chief Finance Officer~~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 Chief Finance Officer~~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 Chief Finance Officer~~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 ~~13 January~~6 July 2023

1. Introduction

1.1. The ~~*NHS foundation trust code of governance*~~ *Code of governance for NHS provider trusts 2022* requires the board of directors of NHS foundation trusts to ~~draw up~~have a "schedule of matters specifically reserved for its decisions" (~~2014, A.1.1~~B.2.17) ensuring that management arrangements are in place to enable the clear delegation of its other responsibilities.

1.2. The purpose of this document is to provide details of the powers reserved to the Board of Directors, and those delegated to the appropriate level for the detailed application of trust policies and procedures. However, the Board of Directors remains accountable for all of its functions, including those which have been delegated, and would therefore expect to receive information about the exercise of delegated functions to enable it to maintain a monitoring role.

1.3. All powers of the trust which have not been retained as reserved by the Board of Directors or delegated to a committee or sub-committee of the Board of Directors shall be exercised on behalf of the Board of Directors by the chief executive. The scheme of delegation identifies those functions, which the chief executive shall perform personally and those which are delegated to other Directors and Officers. All powers delegated by the Chief Executive can be re-assumed by him/her should the need arise.

1.4. Where the Trust Board or one of its committees has reached a decision under its terms of reference, the subsequent documentation committing the Trust to that decision will be signed by the Chair of the committee or the Chief Executive.

1.5. It should be emphasised that the financial delegations in themselves give no power to act. The power to act up to the limits prescribed, derives from approved annual plans and budgets and, where applicable, authorised capital and revenue business cases.

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~~Chief Finance Officer and, Medical Director and ~~Director of Nursing~~Chief Nurse).

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 Chief Finance Officer~~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
- Strategic development Committee

~~Digital 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;	SFIs 3.2, SO 5.6

		3.1.1.2 commission appropriate independent review and studies; 3.1.1.3 seek relevant information from within the Trust and from all Officers; 3.1.1.4 Obtain relevant legal or other independent advice and to invite professional with relevant experience and expertise to attend meetings of the Audit 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;	SFI 10.1, SO 5.6

		3.2.1.6 request the services and attendance of any other individuals and authorities within relevant experience and expertise if it considers this necessary to exercise its functions. 3.2.2 On behalf of the Board of Directors, the Committee has the following responsibilities: 3.2.2.1 to identify and appoint candidates to fill posts within its remit as and when they arise; 3.2.2.2 to be sensitive to other pay and employment conditions in the Trust; 3.2.2.3 to keep leadership needs of the Trust under review at executive level to ensure the continued ability of the Trust to operate effectively in the health economy; 3.2.2.4 to give full consideration to and make plans for succession planning for the Chief Executive and other Executive Directors; 3.2.2.5 to sponsor the Trust's leadership development and talent management programmes;	
3.3	**Charity committee**	3.3.1 The Committee will: 3.3.2 Ensure Funds Held on Trust (charitable funds) are managed in accordance with the Trust's SOs and SFIs, as approved by the Board of Directors. 3.3.3 Receive regular reports from the Chief Finance Officer ~~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 3.5.3 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 except for digital business cases.	
3.6	~~**Digital Committee**~~**Strategic Development Committee**	3.6.1 On behalf of the Board of directors, the committee will be responsible for providing strategic oversight and direction regarding the planning and development of the Trust wide organisational strategy including work related to clinical and enabling strategies and strategic projects and programmes. The committee will:	

		• 3.6.1.1 Provide oversight and support to ensure appropriate resourcing and alignment of the strategy development • 3.6.1.2 Provide detailed oversight of the development of enabling strategies which might include but are not limited to digital, estates and facilities and the green plan, making recommendations related to these to the Board • 3.6.1.3 Provide oversight of the implementation and delivery of the Trust strategy and enabling strategies once approved by the Board • 3.6.1.4 Ensure and provide assurance to the Board that the Trust's strategy and enabling strategies align with the strategic ambitions of the NHS locally and nationally • 3.6.1.5 Identify and make recommendations to the Board in relation to strategic communications and engagement • 3.6.1.6 E~~E~~nsure appropriate consideration of OD and culture requirements in regard to the development and implementation of the strategy • 3.6.1.7 I~~i~~dentify and monitor key strategic risks, issues and mitigations and escalate to the Board • 3.6.1.8 Identify, review and recommend strategic opportunities to the Board 3.6.2 The committee will make recommendations to the Board in relation to strategy, business development opportunities and business cases that are within the scope if its remit The Board will retain its responsibility for defining the strategic aims and objectives of the Trust and the Board will continue to contribute to the development of a strategy. ~~On behalf of the Board of Directors, the committee will be responsible for the oversight and scrutiny on the Trust's digital programme to include~~ ~~• 3.6.1.1 Delivery of the QVH information management and technology (IM&T) strategy, performance and development~~ ~~• 3.6.1.2 All digital projects and programmes across the Trust~~ ~~3.6.2 The committee will make recommendations to the Board of Directors in relation to IM&T and other digital business cases~~ ~~3.6.3 Digital activity is that related to the design, development and operation of complex IT and data systems.~~	

4. 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 Chief Finance Officer~~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 ~~4.6.2~~ Sitting on Committees of the Board of Directors.

5. Scheme of delegation of powers from standing orders

SO ref	Delegated to	Duties delegated
1.2	Chair	Final authority on the interpretation of the SOs.
1.2	Chief executive	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.

6. Scheme of delegation of powers from standing financial instructions

SFI ref	Delegated to	Duties delegated
1 Introduction		
1.2.1	Chair	Final authority on interpretation of the SFIs.
1.2.1	Chief Executive / Chief Finance Officer~~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.

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

SFI ref	Delegated to	Duties delegated
		• Reviewing schedules of losses and compensations and making recommendations to the board of directors; • Reviewing the information prepared to support the annual governance declaration statement.
3.2.3	Chair of the audit committee	Where audit committee considers there is evidence of ultra vires transactions or improper acts or important matters that the audit committee wishes to raise, the matter shall be raised at a full meeting of the board of directors.
3.3.1	Chief Finance Officer~~Director of finance~~	In relation to audit, the Chief Finance Officer~~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	Chief Finance Officer~~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.

SFI ref	Delegated to	Duties delegated
3.4.2	Internal audit	To review, appraise and report on compliance with policies, plans and procedures; adequacy of control, suitability of financial and management data and the extent to which the trust's assets and interests are accounted for.
3.4.3	Internal audit	To assess the process in place to ensure the assurance frameworks are in accordance with current guidance from the regulator.
3.4.4	Internal audit	To notify the Chief Finance Officer~~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 Chief Finance Officer~~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 Chief Finance Officer~~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	Chief Finance Officer~~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.

SFI ref	Delegated to	Duties delegated
3.6.4	Chief Finance Officer~~Director of finance~~	Ensure the trust's local counter fraud specialist receives appropriate training in connection with counter fraud measures.
3.6.5	Chief Finance Officer~~Director of finance~~	Be satisfied that the terms on which the services of a local counter fraud specialist from an outside organisation are provided are such to enable the local counter fraud specialist to carry out his functions effectively and efficiently.
3.6.7	Chief Finance Officer~~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	Chief Finance Officer~~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	Chief Finance Officer~~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	Chief Finance Officer~~Director of finance~~	To establish procedures for the management of expense claims submitted by officers.
3.7.2	Chief Finance Officer~~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.

SFI ref	Delegated to	Duties delegated
3.8.2	All	To notify the secretary of any gift, hospitality or sponsorship accepted (or refused) by any officer on behalf of the trust.
3.8.2	Secretary	To record in writing, notification of any gift, hospitality or sponsorship accepted (or refused) by officers on behalf of the trust.
3.9.1	Chief Finance Officer~~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 Chief Finance Officer~~director of finance~~ as soon as possible
4 Annual planning, budgets, budgetary control and monitoring		
4.1.1	Chief Executive	Compile and submit to the board of directors and the regulator, strategic and operational plans.
4.1.2	Chief Finance Officer~~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	Chief Finance Officer~~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 Chief Finance Officer~~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	Chief Finance Officer~~Director of finance~~	Ensure adequate training is delivered on an ongoing basis to enable the Chief Executive and other Officers to carry out their budgetary responsibilities.
4.4.1	Finance and performance committee	Submit budgets to the board of directors for approval.

SFI ref	Delegated to	Duties delegated
4.2.4	All directors	To meet their financial targets as agreed in the annual plan approved by the board of directors.
4.3	All	Ensure income and expenditure is contained within budgets. Ensure workforce is maintained within budgeted establishment unless expressly authorised. Ensure non-recurring budgets are not used to finance recurring expenditure. Ensure no agreements are entered into without the proper authority.
4.4.7	Board of Directors/ Chief Executive	Approval of expenditure for which no provision has been made in an approved budget.
5 Annual accounts and reports		
5.1	Chief Finance Officer~~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	Chief Finance Officer~~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	Chief Finance Officer~~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	Chief Finance Officer~~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.

SFI ref	Delegated to	Duties delegated
7.9	All	Duty to inform designated finance representatives of money due from transactions which they initiate/deal with.
7.12	Chief Finance Officer~~Director of finance~~	Approve arrangements for making disbursements from cash received.
7.14	All	Notify the Chief Finance Officer~~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	Chief Finance Officer~~Director of finance~~	Negotiating contracts with commissioners for the provision of services to patients in accordance with the annual plan.
8.4	Chief Finance Officer~~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	Chief Finance Officer~~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	Chief Finance Officer~~Director of finance~~	Establish procedures to carry out financial appraisals and shall instruct the appropriate requisitioning officer to provide evidence of technical competence.

SFI ref	Delegated to	Duties delegated
9.5.6	Chief Finance Officer~~Director of finance~~	Establish procedures to ensure that tenders are opened and documented appropriately and within an agreed timescale.
9.5.7	Chief Executive/ Chief Finance Officer~~director of finance~~	Approval of awarding of contracts for which tendering is deemed not strictly competitive.
9.5.8	Chief Executive/ Chief Finance Officer~~Director of finance~~	Where one tender is received will assess for value for money and fair price.
9.5.9	Chief Finance Officer~~Director of finance~~	Decision to accept tenders after the deadline but before opening of the other tenders.
9.6.1	Chief Finance Officer~~Director of finance~~	Enquiries concerning the financial standing and financial suitability of approved contractors.
9.10.4	Chief Finance Officer~~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.

SFI ref	Delegated to	Duties delegated
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 financ~~Chief Finance Officer~~e~~	Make arrangement for the provision of payroll services to the trust to ensure the accurate determination for any entitlement and to enable prompt and accurate payment to officers.
10.4.2	Chief Finance Officer~~Director of finance and director of human resources~~ and Chief People Officer	Responsible for establishing procedures covering advice to managers on the prompt and accurate submissions of payroll data to support the determination of pay.
10.4.3	Chief Finance Officer~~Director of finance~~	Issue detailed procedures covering payments to officers.
10.5.1	Chief Finance Officer ~~Director of finance, director of human resources~~ and Chief People Officer	Approve advances of pay.
11 Non-pay expenditure		

SFI ref	Delegated to	Duties delegated
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 Chief Finance Officer~~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	Chief Finance Officer~~Director of finance~~	Responsible for the prompt payment of accounts and claims.
11.3.1	Chief Finance Officer~~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 Chief Finance Officer~~director of finance~~ of accounts for payment. • Maintain a list of officers, including specimens of their signatures, authorised to certify any type of payment. • Delegate responsibility for ensuring that payment for goods and services is only made once goods/services are received. • Prepare and issue procedures regarding vat.

SFI ref	Delegated to	Duties delegated
11.4.1	All	Fully comply with the procedures and limits specified by the Chief Finance Officer~~director of finance~~.
11.5.1	Chief Finance Officer~~Director of finance~~	Approve proposed prepayment arrangements.
11.2.9	Chief Executive/ Chief Finance Officer~~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	Chief Finance Officer~~Director of finance~~	Produce an investment policy in accordance with any guidance received from the regulator.
12.1.3	Chief Finance Officer~~Director of finance~~	Prepare detailed procedural instructions on the operation of investment accounts and on the records to be maintained.
12.2.1	Chief Finance Officer~~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	Chief Finance Officer~~Director of finance~~	Applications for a loan or overdraft.
12.2.3	Chief Finance Officer~~Director of finance~~	Prepare detailed procedural instructions concerning applications for loans and overdrafts.

SFI ref	Delegated to	Duties delegated
12.2.4	Chief Finance Officer~~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	Chief Finance Officer~~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	Chief Finance Officer~~Director of finance~~	Implement procedures to comply with guidance on valuation contained within the treasury's guidance.
13.2.3	Chief Finance Officer~~Director of finance~~	Establish procedures covering the identification and recording of capital additions.
13.2.4	~~D~~Chief Finance Officer~~irector of finance~~	Develop procedures covering the physical verification of assets on a periodic basis.
13.2.5	Chief Finance Officer~~Director of finance~~	Develop policies and procedures for the management and documentation of asset disposals.

SFI ref	Delegated to	Duties delegated
13.3.1	Chief Executive	Responsible for the maintenance of registers of assets, taking account of the advice of the Chief Finance Officer ~~director of finance~~ regarding the form of any register.
14 Stores and receipts of goods		
14.1.1	Chief Executive	Delegate overall responsibility for the control of stores.
14.1.1	Chief Finance Officer~~Director of finance~~	Responsible for systems of control.
14.1.3	Pharmaceutical officer	Responsible for the control of any pharmaceutical stocks.
14.1.5	Chief Finance Officer~~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	Chief Finance Officer~~Director of finance~~	Agreed stocktaking arrangements.
14.1.7	Chief Finance Officer~~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	Chief Finance Officer~~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 Chief Finance Officer~~director of finance~~ of the estimated market value of the item to be disposed of.

SFI ref	Delegated to	Duties delegated
15.2.1	Chief Finance Officer~~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 Chief Finance Officer~~director of finance~~.
15.3.1	Chief Finance Officer~~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 Chief Finance Officer~~director of finance.~~
15.3.3	Chief Finance Officer~~Director of finance~~	Immediately inform the police if theft or arson is involved in a suspected criminal offence.
15.3.4	Chief Finance Officer~~Director of finance~~	Inform the trust's local counter fraud specialist (LCFS) and NHS Protect in cases of fraud or corruption.
15.3.5	Chief Finance Officer~~Director of finance~~	Notify the audit committee, LCFS and the external auditors of all frauds.
15.3.6	Chief Finance Officer~~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	Chief Finance Officer~~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.

SFI ref	Delegated to	Duties delegated
15.2.8	Chief Finance Officer~~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	Chief Finance Officer~~Director of finance~~	Responsible for the accuracy and security of the computerised financial data of the trust and shall: • Devise and implement any necessary procedures to ensure adequate and reasonable protection of the trust's data, programmes and computer hardware; • Ensure that adequate and reasonable controls exist over data entry, processing, storage, transmission and output; • Ensure that adequate controls exist such that computer operation is separated from development, maintenance and amendment; • Ensure that an adequate audit trail exists through the computerised system; • Ensure that new financial systems and amendments to current financial systems are developed in a controlled manner and thoroughly tested prior to implementation; and • Publish and maintain a freedom of information (FOI) publication scheme.
16.2.1	Chief Finance Officer~~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	Chief Finance Officer~~Director of finance~~	Periodically seek assurances that adequate controls are in operation.
16.3.1	Chief Finance Officer~~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	Chief Finance Officer~~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.

SFI ref	Delegated to	Duties delegated
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	Chief Finance Officer~~Director of finance~~	Provide detailed written instructions on the collection, custody, investment, recording, safekeeping, and disposal of patients' property (including instructions on the disposal of the property of deceased patients and of patients transferred to other premises) for all officers whose duty is to administer, in any way, the property of patients.
17.5	Senior officers	Inform officers, on appointment, their responsibilities and duties for the administration of the property of patients.
18 Retention of records		
18.1	Chief Executive	Maintain archives for all documents required to be retained in accordance with the regulator and/or secretary of state guidelines.
18.2	Chief Executive	Produce a records lifecycle policy, detailing the secure storage, retention periods and destruction of records to be retained.
19 Risk management and insurance		
19.1	Chief Executive	Ensure that the trust has a programme of risk management which shall be approved and monitored by the board of directors.
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	Chief Finance Officer~~Director of finance~~	Ensure that insurance arrangements exist in accordance with the trust's risk management policy.

SFI ref	Delegated to	Duties delegated
20 Funds held on trust (charitable funds)		
20.5	Chief Finance Officer~~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 Chief Finance Officer~~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 business cases and service developments and those within budgetary limits only.**		
2.1	**Revenue expenditure (5 year value)**	
	Up to £250,000	Chief Finance Officer~~Director of Finance~~ (recommended by EMT)
	£250,001 to £1,000,000	Chief Finance Officer~~Director of Finance~~ AND Chief Executive Officer (recommended by Hospital Management Team & Finance and

	Over £1,000,000	Performance Committee OR ~~Digital Committee for digital business cases~~Strategic Development Committee) Board of Directors
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 £250,000 £250,000 to £1,000,000	Chief Finance Officer ~~Director of Finance~~ (recommended by EMT) Chief Finance Officer~~Director of Finance~~ AND Chief Executive Officer (recommended by Hospital Management Team & Finance and Performance Committee OR ~~Digital Committee for digital capital expenditure and disposals~~Strategic Development Committee)

	Over £1,000,000	Board of Directors
3 Quotations, tenders and selection of suppliers Also refer to the Procurement Department for further guidance: in many cases goods and services will already have been subject to a competitive exercise and there may be no requirement for further quotations or competition.		
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 Chief Finance Officer~~Director of Finance~~) WTO GPA Directive Requirements (Relevant Director AND Chief Finance Officer~~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 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.	Chief Finance Officer~~Director of Finance~~, (when Chief Finance Officer~~Director of Finance~~ is unavailable, Chief Executive), or Chief Executive (when Chief Finance Officer~~Director of Finance~~ has commissioned the item)

	Waiver above the WTO GPA level will require final approval and authorisation by the Chief Executive Officer clearly stating the circumstances under which the Procurement Regulations are to be waived, following review at EMT and Audit Committee.	Chief Finance Officer~~Director of Finance~~, (when Chief Finance Officer~~Director of Finance~~ is unavailable, Chief Executive) or Chief Executive (when Chief Finance Officer~~Director of Finance~~ has commissioned the item)

3.3	**Opening tenders** Electronic tenders received through on line e-Tendering tool.	Head of Procurement or Chief Finance Officer~~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 Up to £10,000 Up to £50,000 Up to £250,000 Up to £1,000,000 Over £1,000,000	 Budget Manager Level 2 Manager (Officer) Responsible Director Chief Finance Officer~~Director of Finance~~ Chief Finance Officer~~Director of Finance~~ AND Chief Executive Board of Directors
4.2	**Approval of purchase invoices for revenue and capital** Up to £5,000 Up to £10,000 Up to £50,000 Up to £250,000 Up to £1,000,000	 Budget Manager Level 2 Manager (Officer) Responsible Director Chief Finance Officer~~Director of Finance~~ Chief Finance Officer~~Director of~~

	Unlimited	~~Finance~~ AND Chief Executive 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 Leases/arrangements up to £3,000,000 (total primary lease term payments or credit finance obligations) Over £3,000,000 (total primary lease term payments or credit finance obligations)	Deputy Chief Finance Officer~~Director of Finance~~ Chief Executive 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	Chief Finance Officer~~Director of Finance~~
	Signing of Landlord and Tenant Act notices relating to the acquisition or granting of leases	Associate Director of Estates & Chief Finance Officer~~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)	Chief Finance Officer~~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)	Chief Finance Officer~~Director of Finance~~
	Transfer or sale of assets to another organisation	Chief Finance Officer~~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 Chief Finance Officer~~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 Chief Finance Officer~~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 Chief Finance Officer~~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	 Chief Finance Officer~~Director of Finance~~ Chief Executive and Chief Finance Officer~~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~~Chief People Officer

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~~ Chief Finance Officer to the Regulator for Treasury approval.	~~Director of Workforce~~Chief People Officer Chief Executive
4.7	**Expenditure from charitable funds** Up to £2,000 Up to £20,000 Over £20,000	Two from relevant fund holder or~~Director of Finance~~ Chief Finance Officer, 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 Up to £50,000 Up to £100,000 Up to £250,000 Up to £1,000,000 Over £1,000,000	 Budget Manager Level 2 Manager (Officer) Responsible Director Chief Finance Officer~~Director of Finance~~ Chief Finance Officer~~Director of Finance~~ AND Chief Executive

		Board of Directors

6 setting of fees, charges and income		
6.1	Private patient, overseas visitors, income generation and other patient related services	Associate Director Business Development
6.2	Price of NHS contracts Setting fees and charges for contracts up to £50,000 per annum Setting fees and charges for contracts over £50,000 per annum	 Relevant director Chief Finance Officer~~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 Associate Director of Business Development Chief Finance Officer~~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	Chief Finance Officer~~Director of Finance~~ Chief Finance Officer~~Director of Finance~~ and Chief Executive Board of Directors

8. Roles and responsibilities of the Council of Governors

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

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

- In the first instance, the Chair, on the advice of the Secretary and other such advice as the Chair may see fit to obtain, shall seek to resolve the dispute
- If the Chair is unable to resolve the dispute, he/she shall appoint and chair a special committee comprising equal numbers of Directors and Governors to consider the circumstances and to make recommendations to the Council of Governors and the Board of Directors with a view to resolving the dispute

- If the recommendations (if any) of the special committee are unsuccessful in resolving the dispute, the Chair may refer the dispute back to the Board of Directors who shall make the final decision

Report cover-page					
References					
Meeting title:	**Board of Directors**				
Meeting date:	**06/07/2023**		**Agenda reference:**	**53-23**	
Report title:	**Audit committee assurance**				
Sponsor:	Kevin Gould, Audit committee Chair				
Author:	Ellie Simpkin, governance officer				
Appendices:	None				
Executive summary					
Purpose of report:	To provide assurance to the Board in relation to matters discussed at the Audit committee meeting on 14 June 2023				
Summary of key issues	• The committee received the final assessment provided to NHS England for the 2022/23 Data Security and Protection Toolkit. • The internal audit final annual report and head of audit opinion for 2022/23 and the local counter fraud service (LCFS) annual report for 2022/23 were presented. • The Committee reviewed the annual report and accounts and agreed to recommend these to the Board for approval.				
Recommendation:	The Board is asked to **note** the contents of this report.				
Action required	Approval	Information	Discussion	**Assurance**	Review
Link to key strategic objectives (KSOs):	KSO1: ***Outstanding patient experience***	KSO2: ***World-class clinical services***	KSO3: ***Operational excellence***	KSO4: ***Financial sustainability***	KSO5: ***Organisational excellence***
Implications					
Board assurance framework:	None				
Corporate risk register:	None				
Regulation:	None				
Legal:	None				
Resources:	None				
Assurance route					
Previously considered by:	Audit committee				
	Date:	14/06/23	Decision:		
Next steps:	None				

Report to:	Board Directors
Agenda item:	53-23
Date of meeting:	6 July 2023
Report from:	Kevin Gould, committee Chair
Report author:	Ellie Simpkin, governance officer
Date of report:	27 June 2023
Appendices:	None

Audit committee assurance

Introduction

This purpose of this report is to provide the Board with assurance on matters considered by the audit committee at its meeting on 14 June 2023.

Data security and protection tool kit

The committee received the final assessment provided to NHS England for the 2022/23 Data Security and Protection Toolkit (DSPT), an online self-assessment tool that allows organisations to measure their performance against the National Data Guardian's ten data security standards. All of the standards have been met for 2022/23.

Internal audit

Internal auditors RSM presented their final annual report and head of audit opinion for 2022/23. 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.

Counter fraud

The committee received the local counter fraud service (LCFS), annual report which provides summary of the fraud prevention, detection and investigation in 2022/23. The Counter Fraud Functional Standard Return resulted in an overall rating of 'green'. Management have agreed actions to address all the findings reported by the LCFS service during 2022/23.

Annual report and accounts

The Committee reviewed the annual report and accounts. After some discussion the Committee agreed to recommend these to the Board for approval.

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.

Recommendation

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

Report cover-page					
References					
Meeting title:	Board of Directors				
Meeting date:	06/07/2023		**Agenda reference:**	**54-23**	
Report title:	Quality and Safety Board Report				
Sponsor:	Nicky Reeves, Chief Nurse				
Author:	Nicky Reeves, Chief Nurse Tania Cubison, Medical Director Any Brownlie, Clinical audit and Outcome Specialist Jacqueline O'Mara, Clinical Audit and Outcome Specialist				
Appendices:	None				
Executive summary					
Purpose of report:	To provide updated quality information and assurance that the quality of care at QVH is safe, effective, responsive, caring and well led.				
Summary of key issues	The Committee's attention should be drawn to the following key areas detailed in the reports: • Launch of board engagement visits (formally sponsored chair) • Number of preliminary mortality reviews awaiting completion • Successful Nurses day celebration • ICB approval for downgrade of serious incident declared in March				
Recommendation:	Board is asked to **note** the content of this report				
Action required	Approval	Information	Discussion	**Assurance**	Review
Link to key strategic objectives (KSOs):	**KSO1:**	**KSO2:**	KSO3:	KSO4:	KSO5:
	Outstanding patient experience	***World-class clinical services***	*Operational excellence*	*Financial sustainability*	*Organisational excellence*
Implications					
Board assurance framework:	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:	none				
Assurance route					
Previously considered by:	Quality and Governance Committee				
	Date:	26 June 2023	Decision:	Approved	
Next steps:	NA				

Board Report

Contents

Executive Summary - Domain – Chief Nurse

HIGHLIGHTS & ISSUES

The deputy chief nurse led a wonderful celebration of nursing on international Nurses day (12th May) with the support of a number of the nursing workforce.

Board engagement ward visits (rebranded from Sponsored Chair). Members of the board are now allocated to a clinical area to build a relationship with colleagues and develop a thoughtful and open transfer of information. The relaunch of this process was discussed in the June EMT away day and two themes were identified. It was agreed feedback would be captured initially in the Q&S board report but that could be a role for a standalone report as the process embeds. In addition, there was agreement that links with non-clinical colleagues need to be developed in addition to the existing process. The chief nurse will lead this process with Board members and departmental leads

The following feedback has been received recently:

MIU – visited by Chief Nurse. Incredibly busy and offering a great service to the local population, frequently seeing in excess of 40 patients per day and on two occasions have seen over 70 cases per day. Among other issues, excessive temperatures in the MIU clinical areas were raised and steps are being taken to address with engagement of estates and infection prevention and control.

Allied Health Professional areas – visited by director of strategy, Imaging and Therapies visited

Therapies – attended monthly meeting. Team were keen to share some of the day to day challenges. All were keen to understand what was happening regarding the organisation and leadership as we move forwards. Concern raised that community facing services may not be as well understood compared to some of our specialist services and so our 3 population approach to the strategy was well received.

Imaging- Attended the huddle. There was interest in the new board appointments, the plans for the future, feedback was challenges with both heat and space.

Canadian Wing – visited by Karen Norman, non-executive director. Discussion about how to make the best use of future visits. The matron was enthusiastic and positive about the ward and also outlined some of the constraints of the environment and more general issues with staffing. She has been away on her Paralympic work (which sounds an amazing opportunity). She was appreciative of the support for this from the Trust. I have also had a walkabout on the newly refurbished ward with staff nurse Becky on national nurse day. The staff and patients were pleased with the upgrade, highlighting the flooring and improved storage areas.

Exception Report

Two serious incident (SI) reports declared in January 2023 will be reviewed at ICB scrutiny committee (16 June 2023) These are being seen following an ICB agreed extension to submission date. Head of Risk and General Manager who assisted with the compilation of the report to be in attendance – Both reports were approved

Following a detailed review and investigation, a request to downgrade the SI declared in March has been approved by the ICB.

There have been ongoing challenges with water ingress within the head and neck unit, critical care and burns ward following heavy rain. This has resulted in the areas being decanted to maintain patient safety and positive experience. All the staff involved in these moves have worked tirelessly to maintain excellent patient care.

Executive Summary - Domain – Medical Director

HIGHLIGHTS & ISSUES

Industrial Action

In April there were 4 more days of action from Junior Doctors. As before Safe Services were provided by consultants and SAS doctors working together. We prioritised trauma, urgent care, cancer and longer waiting patients. However, a number of operations and outpatient clinic appointments were rescheduled. There will be a further 3 days of industrial action in June and plans are in place.

Antimicrobial Stewardship

The plan to establish a regular teams meeting for microbiology is moving forwards although staffing in University Hospital Sussex had made this a challenge to deliver. The App Microguide that provides an easy access information source for staff has being reviewed by the Deputy Medical Director and microbiology sign off for the changes is awaited to ensure the microbiology advice available is up to date and tailored to QVH caseload.

Out of Hours Operating

There were 10 operations performed out of hours in April and May 23. They had average duration of 2.34hrs and range 45 mins – 7.5 hours. 8 patients were trauma/infection and 2 for flap salvage. All cases have been reviewed and deemed appropriate to be operated on out of hours.

Serious Incident

There was an inpatient death in March. We are undertaking an investigation supported by our external Medical Examiner the investigation is progressing well with good engagement with the family.

Safe Performance Indicators (1)

Metric Description	Target	Q1 2022/3	Q2 2022/3		Q3 2022/3			Q4 2022/3			Q1 2023/4		12 month total/ rolling average
		Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	
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	0	0	**2**	0	**1**	0	0	**1**	0	0	0	0	4
Gram negative bloodstream infections (including E.coli)	0	0	0	0	0	0	0	0	**1**	0	0	0	0	1
MRSA screening - elective	95%	98%	99%	99%	97%	97%	98%	96%	98%	95%	**93%**	97%	97%	97%
MRSA screening - trauma	95%	99%	99%	98%	98%	99%	98%	96%	97%	**90%**	99%	97%	98%	97%
Staff flu vaccine uptake	90%	Reported Oct - Feb	Reported Oct - Feb	Reported Oct - Feb	Reported Oct - Feb	**37%**	**53%**	**61%**	**66%**	**68%**	Reported Oct - Feb	Reported Oct - Feb	Reported Oct - Feb	
Offered/ Vacinated/ Vacinated EW	90%	Reported Oct - Feb	Reported Oct - Feb	Reported Oct - Feb	Reported Oct - Feb	nc	nc	nc	**84%**	**86%**	Reported Oct - Feb	Reported Oct - Feb	Reported Oct - Feb	
Incidents														
Never Events	0	0	**1**	0	0	0	0	0	0	0	0	0	0	1
Serious Incidents	0	0	0	0	0	0	**1**	0	**2**	0	**1**	0	0	4
Theatre metrics														
All patients: Number of patients operated on out of hours 22:00 - 08:00	5	**6**	**6**	2	1	2	4	3	4	**3***	**2***	**8**	2	38
Paediatrics under 3 years: Induction of anaesthetic was between 18:00 and 08:00	0	0	0	0	0	0	0	0	0	0	0	0	0	0
WHO quantitative compliance		99%	99%	99%	99%	99%	99%	99%	99%	99%	99%	99%	99%	99%
Non-clinical cancellations on the day		10	10	8	6	5	6	11	4	6	12	12	5	118
Needlestick injuries	0	**2**	**1**	**2**	**2**	**2**	**3**	**1**	**2**	**2**	**2**	0	**3**	22

Pressure ulcers (all grades)(Theatre metric)		0	0	0	0	0	0	0	0	0	1	0	0	1
Medication errors														
Total number of incidents involving drug / prescribing errors		**17**	**19**	**21**	**12**	**18**	**28**	**9**	**12**	**17**	**14**	**19**	**20**	**206**
No & Low harm incidents involving drug / prescribing errors		13	15	17	8	14	24	8	9	11	11	13	16	159
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		2.3	2.2	2.2	2.2	2.2	2.1	0.7	1.7	3.6	1.6	3.9	2.2	2.3
Pressure Ulcers Hospital acquired - category 2 or above		3	0	0	1	0	0	0	3	2	0	0	0	9
VTE initial assessment (Safety Thermometer)	95%	100%	96%	100%	100%	100%	100%	100%	95%	96%	100%	100%	100%	99%
Patient Falls														
Patient Falls assessment completed within 24 hrs of admission	95%	100%	100%	100%	100%	100%	100%	97%	95%	100%	100%	100%	96%	99%
Patient Falls resulting in no or low harm (inpatients)		2	0	1	2	4	1	1	4	5	5	0	0	25
Patient Falls resulting in moderate or severe harm or death (inpatients)		0	0	0	0	0	0	0	0	0	0	0	0	0
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
Transfers Out														
In-Patient Transfers Out - ≥16 years old									1	4	3	4	3	
In-Patient Transfers Out - <16 years old									1	0	0	1	1	
Out-Patient Transfers Out ≥16									2	0	0	0	1	
Paediatric Assessment Unit <16									0	0	0	0	0	
Total Transfer Out									4	4	3	5	5	

Mortalities Report			Q1 22/23	Q2 2022/23			Q3 2022/23			Q4 2022/23			Q1 20223/24	
			Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23
Mortalities within 30 days of an inpatient episode or outpatient procedure	Inpatient	No of on site mortalities	0	0	1	0	0	0	0	0	0	1	0	0
		No of mortalities elsewhere	4	1	0	2	1	0	2	0	4	3	1	1
	Outpatient		0	0	1	2	1	1	0	1	2	2	1	0
	All Elsewhere		4	1	1	4	2	1	2	1	2	5	2	1
Reviews		Completed Preliminary Reviews	3	1	1	4	1	1	0	0	1	1	0	0
		No of deaths subject to SJR	0	0	0	0	0	0	0	0	0	1	TBC	TBC
No of mortalities in patients with learning difficulties (inpatients only)			0	0	0	0	0	0	0	0	0	0	0	0

Safe Performance Indicators (2)

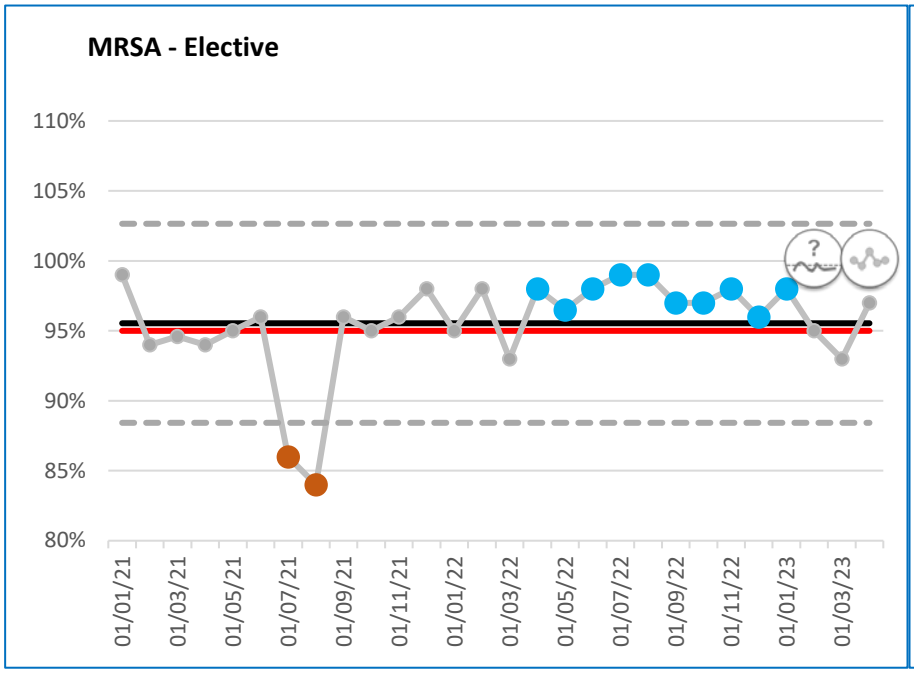
Variation/Performance Icons			
Icon	*Technical Description*	*What does this mean?*	*What should we do?*
	Common cause variation, NO SIGNIFICANT CHANGE.	This system or process is **currently not changing significantly**. It shows the level of natural variation you can expect from the process or system itself.	**Consider if the level/range of variation is acceptable.** If the process limits are far apart you may want to change something to reduce the variation in performance.
	Special cause variation of an CONCERNING nature where the measure is significantly HIGHER.	**Something's going on!** Your aim is to have low numbers but you have some high numbers – something one-off, or a continued trend or shift of high numbers.	**Investigate** to find out what is happening/ happened. Is it a one off event that you can explain? Or do you need to change something?
	Special cause variation of an CONCERNING nature where the measure is significantly LOWER.	**Something's going on!** Your aim is to have high numbers but you have some low numbers - something one-off, or a continued trend or shift of low numbers.	
	Special cause variation of an IMPROVING nature where the measure is significantly HIGHER.	**Something good is happening!** Your aim is high numbers and you have some - either something one-off, or a continued trend or shift of low numbers. Well done!	Find out what is happening/ happened. **Celebrate** the improvement or success. Is there **learning** that can be shared to other areas?
	Special cause variation of an IMPROVING nature where the measure is significantly LOWER.	**Something good is happening!** Your aim is low numbers and you have some - either something one-off, or a continued trend or shift of low numbers. Well done!	
	Special cause variation of an increasing nature where UP is not necessarily improving nor concerning.	**Something's going on!** This system or process is currently showing an unexpected level of variation – something one-off, or a continued trend or shift of high numbers.	**Investigate** to find out what is happening/ happened. Is it a one off event that you can explain? Do you need to change something? Or can you celebrate a success or improvement?
	Special cause variation of an increasing nature where DOWN is not necessarily improving nor concerning.	Something's going on! This system or process is currently showing an unexpected level of variation – something one-off, or a continued trend or shift of low numbers.	

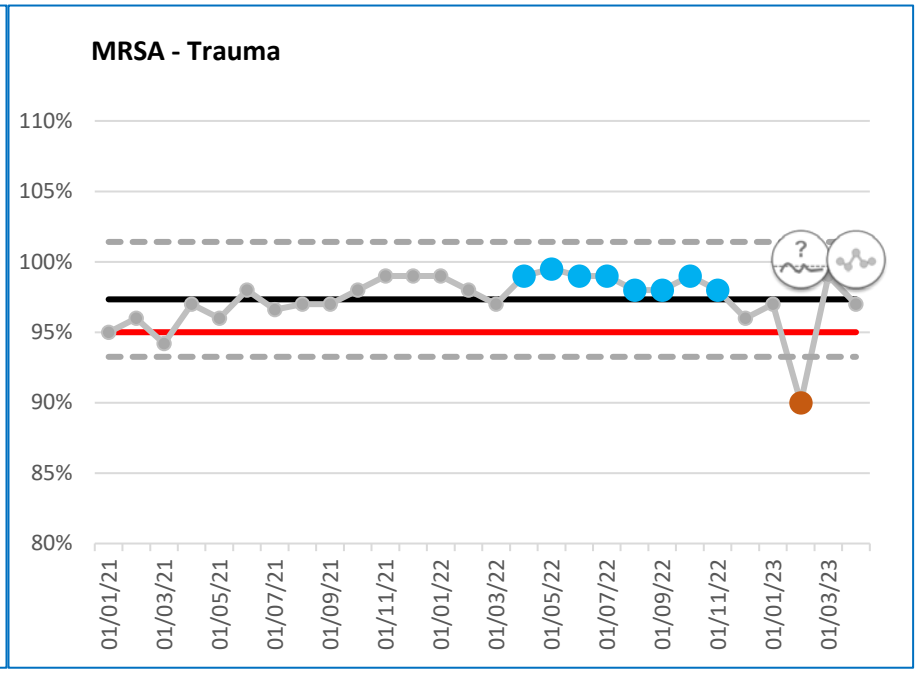
Assurance Icons			
Icon	*Technical Description*	*What does this mean?*	*What should we do?*
	This process will not consistently HIT OR MISS the target as the target lies between the process limits.	The process limits on SPC charts indicate the normal range of numbers you can expect of your system or process. If a target lies **within** those limits then we know that the target may or may not be achieved. The closer the target line lies to the mean line the more likely it is that the target will be achieved or missed at random.	Consider whether this is acceptable and if not, you will need to change something in the system or process.
	This process is not capable and will consistently FAIL to meet the target.	The process limits on SPC charts indicate the normal range of numbers you can expect of your system or process. If a target lies **outside of those limits in the wrong direction** then you know that the target cannot be achieved.	**You need to change something in the system or process if you want to meet the target.** The natural variation in the data is telling you that you will not meet the target unless something changes.
	This process is capable and will consistently PASS the target if nothing changes.	The process limits on SPC charts indicate the normal range of numbers you can expect of your system or process. If a target lies **outside of those limits in the right direction** then you know that the target can consistently be achieved.	**Celebrate the achievement.** Understand whether this is by design (!) and consider whether the target is still appropriate; should be stretched, or whether resource can be directed elsewhere without risking the ongoing achievement of this target.

KPI	Date	Measure	Target	Assurance	Variation	Comments for the latest period shown for each metric
MRSA - Elective	May-23	97%	95%			There is no significant change. We continue to achieve our target.
MRSA - Trauma	May-23	98%	95%			There is no significant change. We continue to achieve our target.
Serious Incidents	May-23	0	0			No trends identified
Total no of incidents involving drug/prescribing errors	May-23	20	0			We are seeing higher levels currently and are monitoring to understand the variation
Falls per 1000 bed days	May-23	4	7			There is no significant change. We continue to achieve our target.
QVH Accuired PU per 1000 bed days	May-23	0	0			Within normal limits, no concerns.
Complaints	May-23	6	0			Within normal limits, no concerns.
Mortalities	May-23	1	0			Within normal limits, no concerns.
Re-admission within 30 days	May-23	1%	2%			Within normal limits, no concerns.
Re-admission within 7 days	May-23	1%	1%			Within normal limits, no concerns.

Safe Performance Indicators (3) - MRSA

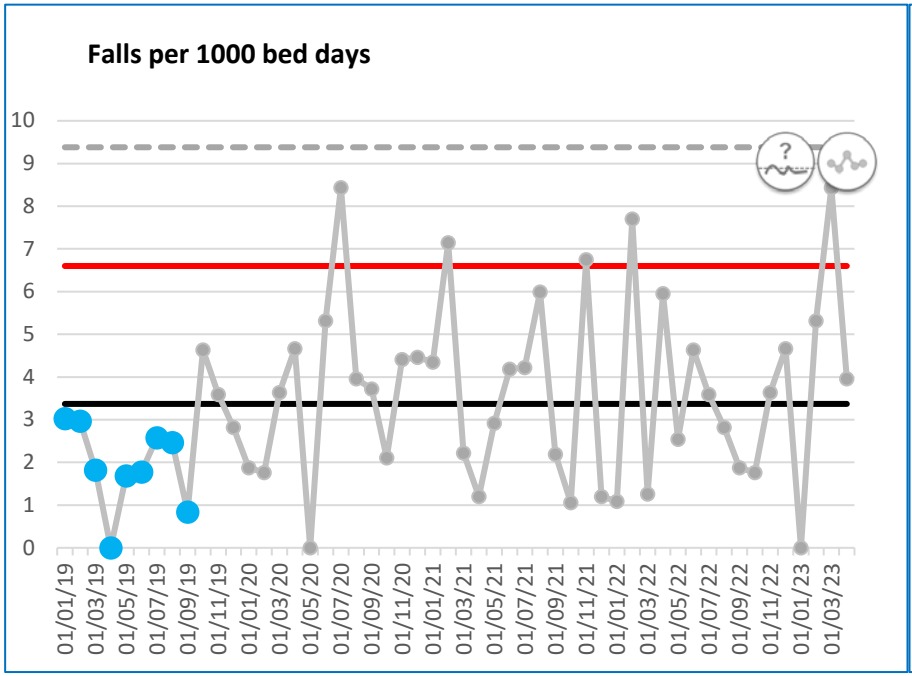
We are not yet completely confident that our processes will consistently meet our target and continue to monitor closely.

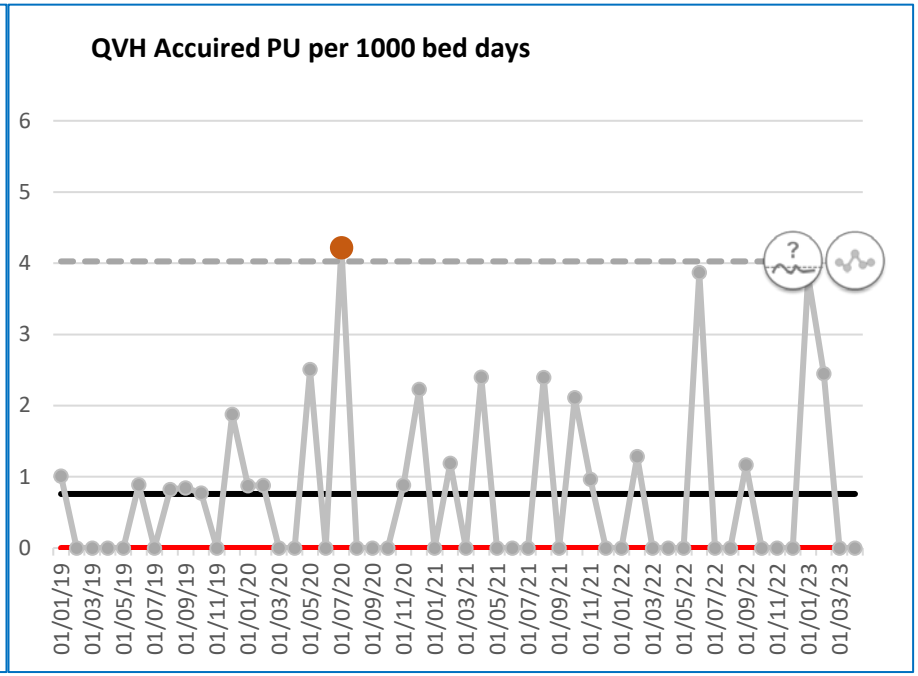




Safe Performance Indicators (4) – Falls & Pressure Ulcers

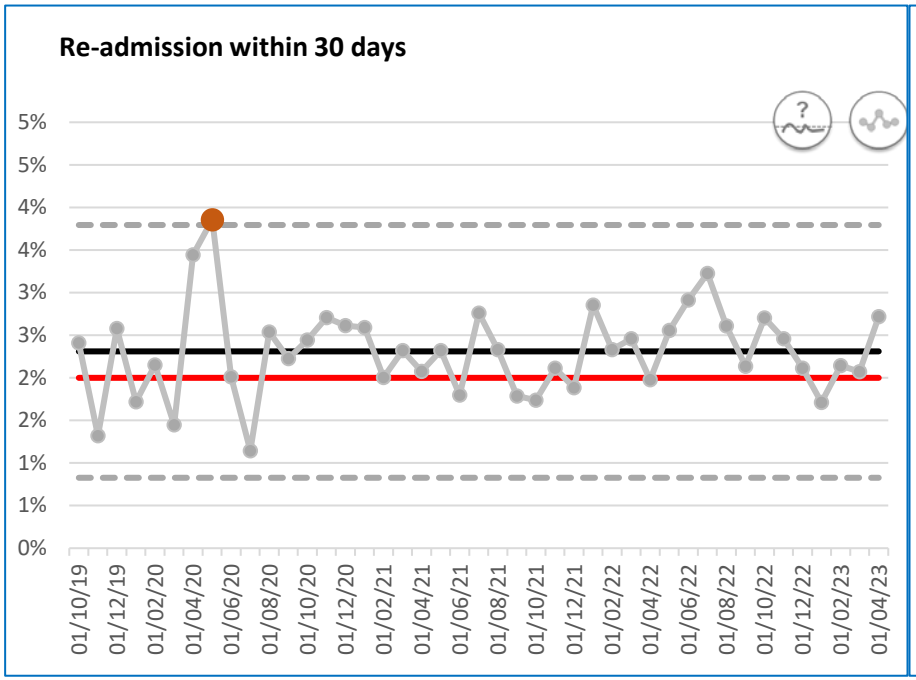
Our fall rate continues to be variable but within normal limits, our current process will continue to deliver this variability.
Pressure Ulcer continues within normal variability, with an average of less than 1 per month, per 1000 bed days. Again, our current process will continue to deliver variability with the expected range.

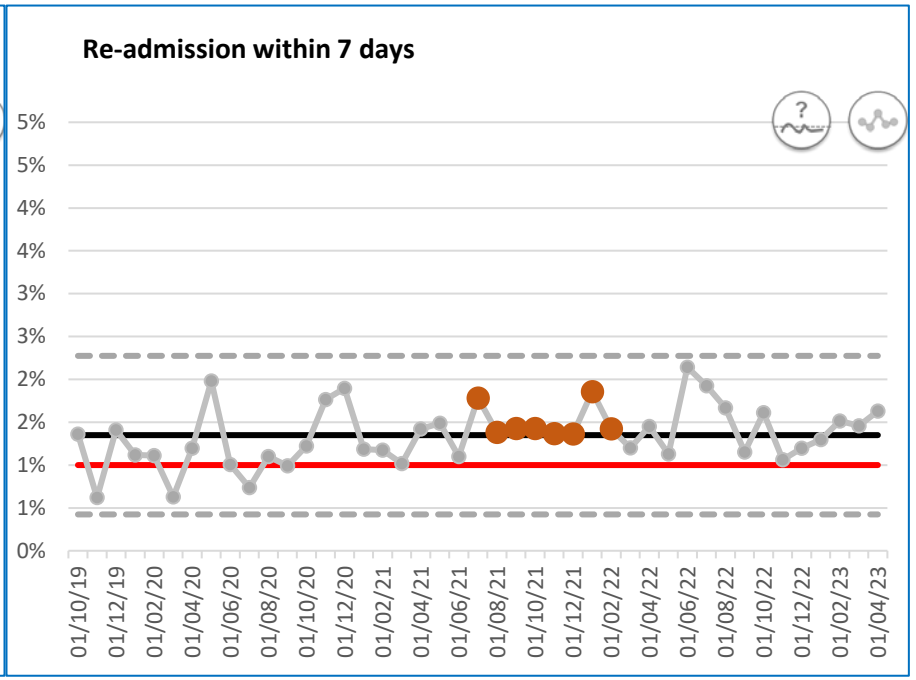




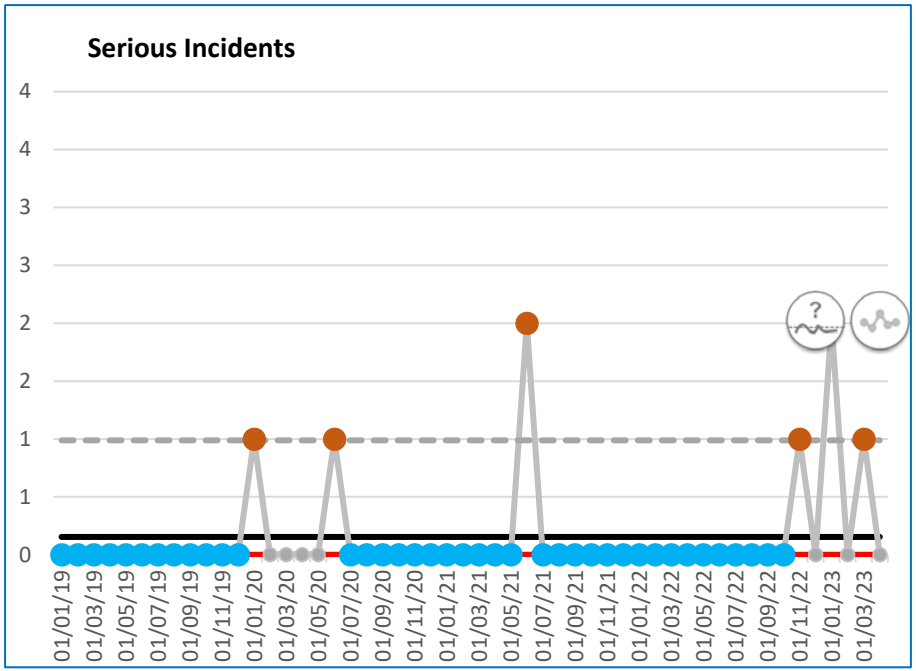
Effective Indicators (1)

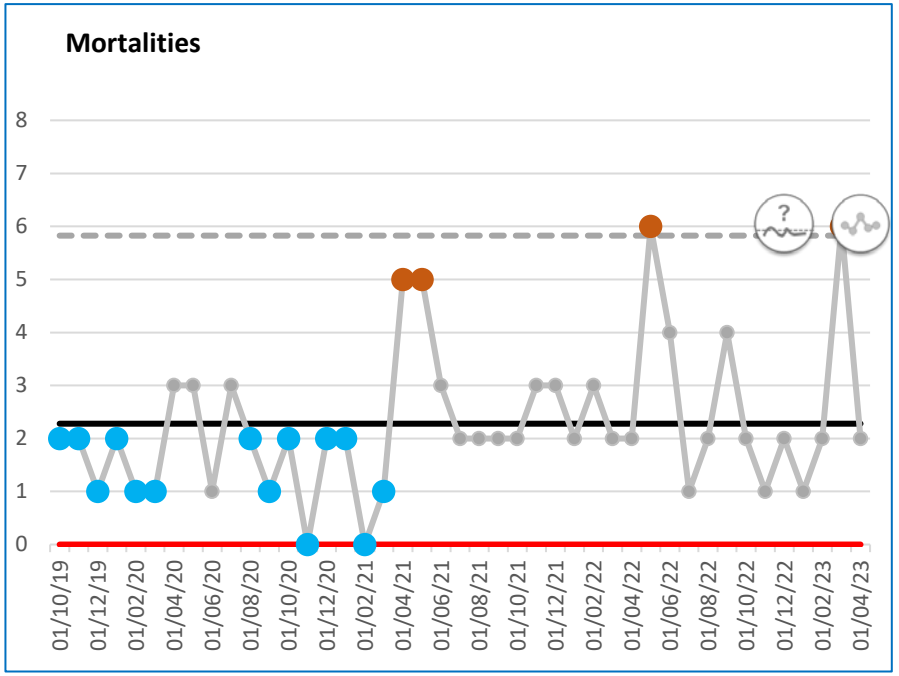
Re-admission levels remain within expected levels. Specialty governance leads review and discuss re-admissions of concern at their governance meetings.



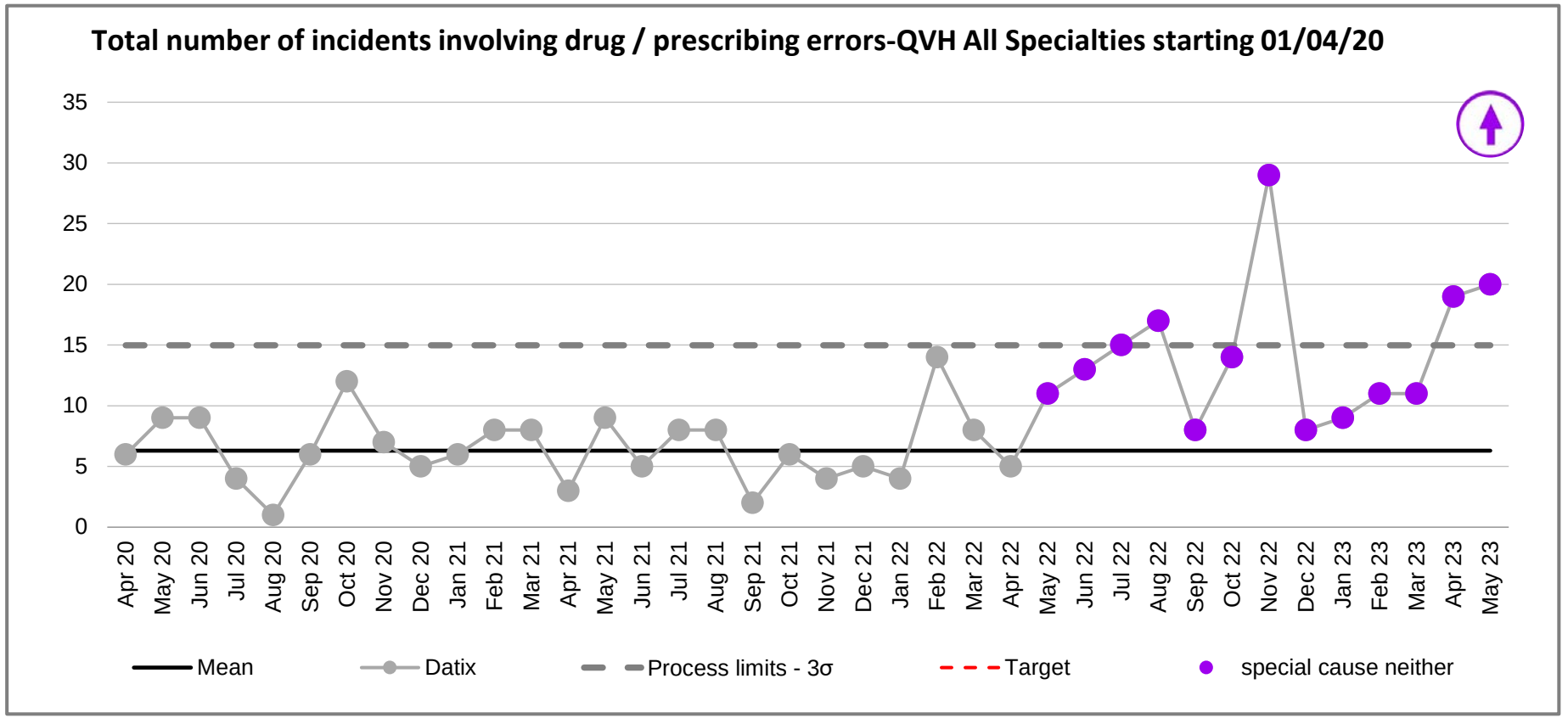


Both serious incidents and mortalities are within expected levels of variation. There are 11 mortalities awaiting preliminary reviews.





The reporting of incidents related to drug and prescribing errors has been variable but mostly within expected limits; we are currently seeing higher levels of errors, these errors are not specialty specific and are a combination wrong site mentioned, wrong patient's name, and regular medicine not prescribed or prescribed incorrectly.



Nursing Workforce - Performance Indicators

Metrics	Q1 2022/23	Q2 2022/23			Q3 2022/23			Q4 2022/23			Q1 2023/24	
Nursing Workforce	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23
Establishment WTE Including Bank & Agency	::	394	394	394	384	384	384	384	384	384	384	384
Establishment WTE excluding Bank & Agency	::	344	344	344	352	352	352	352	352	352	352	352
Staff In Post WTE	::	327	328	332	329	331	328	329	330	328	331	333
Agency Total worked in month WTE	::	3	4	3	3	3	2	3	3	5	8	6
Bank WTE Total worked in month WTE	::	37	37	34	38	35	31	35	39	47	35	33
Staff in Post Vacancy WTE	::	17	16	11	23	21	24	22	21	24	21	19
Vacancies % Including Bank & Agency Usage	::	7%	7%	6%	4%	4%	6%	5%	3%	1%	3%	3%
Staff in Post Vacancies %	::	5%	5%	3%	7%	6%	7%	6%	6%	7%	6%	5%
Qualified Nurses (NMC) Vacancies WTE	::	15	12	7	26	27	27	27	32	35	35	37
Theatre Practitioners (AHP) Vacancies	::	-1.82	-2.13	-2.39	1.75	1.75	1.75	1.75	1.75	1.75	1.75	1.75

Band 2 & 3 HCSW Vacancies WTE Clinical support to clinical staff	::	2	4	8	-2	-2	-4	-5	-6	-7	-8	-10
Band 2 & 3 HCSW Vacancies WTE Non clinical support to clinical staff	::	4	4	5	3	3	3	3	3	3	3	3
Other Unqualified Nursing/Support to Nursing/Support to Theatre Practitioners (including TNA's Nursing Associates, Students, Associate Practitioners/Nurses, Dental Nurse and Student ODP's)	::	1	0	-2	-4	-6	-2	-5	-8	-8	-9	11
Trust rolling Annual Turnover % Excluding Trainee Doctors	::	12%	11%	10%	11%	10%	9%	9%	8%	8%	8%	9%
Starters WTE In month excluding HEE doctors	::	2	4	4	1	4	2	6	1	5	3	4
Leavers WTE In month excluding HEE doctors	::	3	1	1	3	2	3	3	0	2	3	4
12 month sickness rate (all sickness)	::	5.0%	5.1%	5.1%	5.1%	5.1%	5.4%	5.2%	5.1%	5.0%	5.0%	TBC
Monthly Sickness Absence % All Sickness	::	5.0%	4.9%	4.6%	4.8%	5.4%	8.0%	5.0%	4.9%	4.7%	4.8%	TBC

		Total Hours Planned & Actual (combined reg & support)														
		RN			NA			HCA			Site Practitioner			Total		
		Planned	Actual	%	Planned	Actual	%	Planned	Actual	%	Planned	Actual	%	Planned	Actual	%
Day	Apr-23	3450	3450	100%	138	138	100%	1679	1679	100%	690	690	100%	5957	5957	100%
	May-23	5106	5049	99%	207	207	100%	2565	2565	100%	690	684	99%	8568	8505	99%
Night	Apr-23	3830	3749	98%	127	127	100%	1288	1277	99%	690	678	98%	5935	5831	98%
	May-23	3715	3708	100%	81	81	100%	1277	1277	100%	724	724	100%	5797	5790	100%

Medical Workforce - Performance Indicators

Metrics	Q1 2022/23	Q2 2022/23			Q3 2022/23			Q4 2022/23			Q1 2023/24		12 month rolling
Medical Workforce	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	
Turnover rate in month, excluding trainees	1%	1%	4%	0%	2%	0%	0%	4%	0%	1%	1%	0%	17%
Turnover in month including trainees 9%	0%	1%	16%	3%	3%	0%	0%	10%	1%	3%	6%	1%	46%
Management cases monthly	0	0	0	0	0	2	0	2	1	1	0	0	3
Sickness rate monthly on total medical/dental headcount	3%	3%	2%	2%	2%	3%	3%	1%	1%	2%	1%	nc	nc
Appraisal rate monthly (including deanery trainees)	69%	67%	71%	75%	75%	73%	74%	77%	79%	80%	82%	83%	
Mandatory training monthly	87%	87%	87%	87%	87%	86%	86%	83%	86%	88%	89%	88%	87%
Exception Reporting – Education and Training	0	0	5	3	3	0	1	3	1	3	2	0	21
Exception Reporting – Hours	7	6	4	4	2	1	3	2	2	5	0	4	40

Medical & Dental Staffing	At the April induction we welcomed 15 Plastic Surgery and OMFS trainees. Plans are in place for the August induction, usually our biggest induction of the year.
Education	In May we hosted a pensions seminar for 5 registrars which was well received, and on 19 May the Trust hosted the Pan Thames regional day for Plastic Surgery which was very well attended (40 attendees) and provided an excellent day of teaching.

Report cover-page					
References					
Meeting title:	Board of Directors				
Meeting date:	06/07/2023		Agenda reference:	55-23	
Report title:	Six monthly nursing workforce review				
Sponsor:	Nicky Reeves, Chief Nurse				
Author:	Liz Blackburn, Deputy Chief Nurse				
Appendices:	Appendix one: National Quality Board requirements and self-assessment				
Executive summary					
Purpose of report:	The workforce review comes to the board of directors for **assurance** as to the nurse staffing levels within the Trust				
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:	Board is requested to **review** the report and the **assurance** within it				
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:	NA				
Assurance route					
Previously considered by:	Quality & Governance committee				
	Date:	26/ 06/23	Decision:	Approved to go forward to Board	
Next steps:	NA				

Report to:	Board Directors
Agenda item:	55-23
Date of meeting:	6 July 2023
Report from:	Nicky Reeves, chief nurse
Report author:	Liz Blackburn, deputy chief nurse
Date of report:	26 June 2023
Appendices:	Appendix one: National quality Board requirements and self-assessment

Six monthly nursing workforce review

1. Purpose

The purpose of this paper is to provide the six monthly overview of safe nurse staffing levels including right staff, right skills, right place. These include establishment reviews, workforce planning, new and developing roles and recruitment and retention to comply with requirements set out by: NHS England/ Improvement (NHSE/I), the National Quality Board (NQB) and the Care Quality Commission (CQC). This paper covers staffing in theatres, inpatient and outpatient areas of the organisation and reviews the outcomes of a range of initiatives taken regarding recruitment and retention of the nursing and theatre practitioner workforce.

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

The 2023/24 priorities and operational planning guidance outlines the ongoing need to recover our core services and improve productivity, making progress in delivering the key NHS Long Term Plan ambitions and continuing to transform the NHS for the future. It establishes three key tasks across the NHS:

- The immediate priority is to recover core services and productivity
- As recovery progresses, focus remains upon delivering key ambitions outlined within the NHS Long Term Plan
- Transformation of the NHS for the future must continue

Having a nursing workforce in the right numbers, with the right skills and competencies working in the right places is essential to delivering against these tasks. International Recruitment has been by far the biggest driver of growth across the nursing workforce. However, work is being undertaken to reduce the reliance upon international recruitment due to the limited long-term benefits it brings to the nursing workforce.

Domestic supply has been adversely affected by significantly increased leaver rates which are particularly prevalent in the under 55s and those with less than one year's service. Retention represents a significant risk to the nursing workforce. At present,

the national leaver rate is slightly worse at 6.9% than the September 2019 position (6.7%), with no signs yet of the rate slowing down.

Workforce shortages continue to be the biggest challenge facing the NHS and adult social care in England. The on-going cost of living crisis following on from the pandemic has driven increased demand for health care, growing waiting lists and a substantial elective care backlog. This has also had a negative effect on staff wellbeing and absence. Workforce planning is crucial for recovery, particularly from a staff recruitment, retention and wellbeing perspective, but also for patient safety, experience and satisfaction.

Members of the Royal College of Nursing (RCN) in England took strike action in December 2022, January and February 2023. The government reached a pay settlement with a million health workers after a majority of unions representing NHS staff backed a deal in which staff will get a 5% pay rise plus a one-off sum of at least £1,655. At the time of writing, the Royal College of Nursing and two other unions are balloting members regarding further potential strike action.

4. Training and education

Since the roll out of the Trainee Nursing Associate and Registered Nurse Degree Apprenticeship, we have looked at varying options in our funding streams to support this. Future workforce planning is very important to grow our workforce, and budget planning within each department did not allow us to do this efficiently. Ring fencing these apprenticeships within our Professional Development budget has allowed us to plan our nursing establishments, support our staff in career development and be proactive in looking at new ways of working. The following is an outline of the training and education programmes over the past six months. It should be noted that there is an appetite to increase these numbers however, backfill costs and lack of economy of scale mean we are unable to train as many staff as we would like and this is kept under review.

Education supporting recruitment

- Supported one employee ‘return to practice’ with the Nursing and Midwifery Council (NMC).
- Canadian Wing have an excellent record for employing newly registered nurses who have had clinical placements on the ward during their training. During this period, they employed one new to register nurse.
- Continuing to support two Health Care Support Workers (HCSW) who have an overseas nurse qualification to gain their NMC registration.

Clinical Apprenticeships

- One apprentice successfully registered with the NMC as a Nursing Associate in February 2023.
- Two Apprentice Nursing Associates started their training in February 2023. The perioperative service separately funded the second position as a rotation post across the departments.
- QVH Education Lead submitted a business case to increase the Trainee Nursing Associates and Registered Degree Nurse Apprenticeship posts to support future workforce development; this has not yet been approved.

Continuous Professional Development (CPD)

- QVH delivered 35 training days and workshops attended by over 450 nurses and other health care professionals and support staff.

- The 2022/23 the clinical effectiveness quality priority for inter-professional learning successfully met the planned achievements.
- During this period 35 nurses and Allied Health Professionals attended external conferences, workshops and postgraduate modules to support their continuous professional development.

Clinical practice placements

- QVH supported 39-student and apprentice clinical placements across nursing and AHP teams and departments.
- QVH clinical placement capacity tool was completed and submitted to support clinical placements expansion across Sussex in collaborative with NHS Sussex Integrated Care System.

Health Care Support Workers (HCSW) training and development

- Twenty HCSW were awarded the care certificate.
- The HCSW trainer introduced a new 'role ready' induction and care certificate training programme for new HCSW to ensure they have the knowledge and skills needed to support patients across the organisation.

5. Recruitment and Retention

We have continued to utilise the 'new starter' premium in order to act as an incentive to apply. In October 2022 we ran a very successful 'Career and Recruitment Event' led by the Deputy Chief Nurse with over 90 attendees. A work experience event was also run at the end of March which encouraged local students to come and find out about a career in the NHS.

Below is the leaver and starter information for the nursing workforce, this includes all new starters, leavers, those who have increased or decreased their hours and those who have moved from a bank contract to a permanent one. The vacancy rate has remained stable over the past six months, and our turnover rate has fallen by nearly 3% over the past six months.

1st October 2022 to 31st March 2023 leaver and starter data for information

All Qualified and Unqualified Nursing								
Trust Workforce KPIs	Workforce KPIs 2022/23	Oct 22	Nov 22	Dec 22	Jan 23	Feb 23	Mar 23	Compared to previous month
Establishment WTE (Establishment includes 12% headroom)		384.33	384.33	384.33	384.33	384.33	**384.33**	↔
Establishment WTE excluding Bank & Agency		351.75	351.75	351.75	351.75	351.75	**351.75**	↔
Staff in post WTE		328.87	330.62	328.15	329.30	330.26	**327.99**	↓
Vacancies WTE		22.88	21.13	23.60	22.45	21.49	**23.76**	↑
Vacancies %	< 8%	6.50%	6.01%	6.71%	6.38%	6.11%	**6.75%**	↑
Trust rolling annual turnover	< 10%	10.79%	10.16%	9.24%	9.01%	8.06%	**7.98%**	↓
Starters WTE (Excluding rotational Doctors)		1.45	3.60	2.00	6.00	0.81	**5.40**	↑
Leavers WTE (excluding rotational Doctors)		2.60	1.75	3.00	2.80	0.00	**2.40**	↑
Starters and Leavers balance		-1.15	1.85	-1.00	3.20	0.81	**3.00**	↑

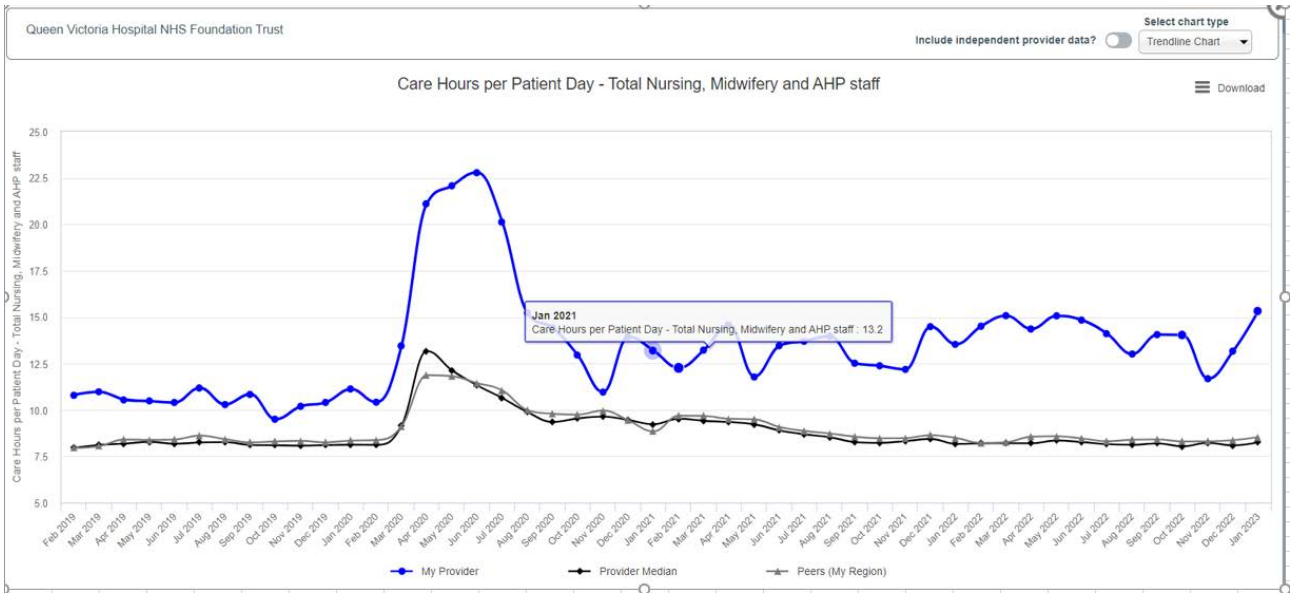
Sourced via ESR data

6. Incident Reporting

There were ten incidents reported via datix during this period in relation to staffing. The most significant of these incidents is the lack of trained staff available in both CCU and H&N ward. There continued to be high levels of long term sickness absence on CCU and H&N during this period. This has been managed as per the Trust absence policy. Industrial action was also reported although safe staffing levels were maintained due to the reduction in activity.

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. We are above the national benchmark due to the specialist nature of our work.



Model Hospital

SafeCare Live has been within the trust for a number of years but had not been utilised effectively until April 2022. A weekly meeting with an action plan between nursing staff and the e rostering staff within the trust has allowed for actions to be completed efficiently bringing SafeCare up in line with health roster. The SafeCare standard operating procedure is complete and has been approved at the Nurses Quality Forum, and is due to go to Clinical Governance Group for approval and ratification in June 2023.

Peanut have been the trailblazers in using SafeCare, they no longer print up paper copies of health roster and utilise SafeCare effectively. In order to increase the use of SafeCare there have been some changes of access for some nursing staff with regards to health roster. The SafeCare 'sunburst' is due to be available to view via the 'at a glance' monitor in the inpatient areas.

The compliance percentage for each area in using SafeCare has significantly increased since September 2022. It is hoped with continued engagement with the teams that this will increase on a month by month basis.

SafeCare Live compliance

Inpatient area	Sept 22	May 23
Burns	76%	87%
C Wing	90%	93%
CCU	66%	73%

Head and Neck	55%	83%
Peanut	70%	84%

Safe Care data

8. Establishment reviews and budget setting

Our budgets and establishments have been reviewed with the Finance team for the new financial year, this has been based on Month 8 outturn.

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. There has been an increase in vacancy in both Burns ward and CCU, this is as a result of staff leaving due to relocation. The percentages of vacancy have been RAG rated as follows:

Department	Total Recruitable (Substantive WTE inc 12% uplift)	WTE Staff in post 30th Sept 2022	WTE Staff in post 31st Mar 2023	Change in staff in post	Number of vacant posts 31st Mar 2023	% Vacant posts 31st Mar 2023
Burns Ward	25.59	18.91	15.92	↓3.00	9.68	38%
Canadian Wing	42.65	37.39	36.01	↓1.38	6.64	16%
Corneo OPD	19.00	15.07	18.17	↑3.10	0.83	4%
Critical Care	25.08	17.65	15.83	↓1.82	9.25	37%
Head & Neck	13.19	10.21	11.20	↑1.00	1.99	15%
MaxFax OPD	22.50	18.69	21.48	↑2.79	1.02	5%
MIU	8.85	6.87	8.49	↑1.62	0.36	4%
Peanut Ward	19.82	14.93	14.44	↓0.49	5.38	27%
Plastics OPD	15.66	10.93	13.09	↑2.16	2.57	16%
Peri-op (inc pre assessment)	161.03	134.11	144.72	↑10.61	16.31	10%
Site Practitioners	10.78	9.63	10.78	↑1.15	0	0%

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 narrative 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** – Advertising for Matron, band 6 and 5 staff nurses.
- **Canadian Wing** – Good staff retention.
- **Corneo Outpatients Department** – Good staff retention.
- **Critical Care** – High long term sickness absence in this area. Use of bank and agency staff to maintain safe staffing.

- **Head and Neck Ward** – Good staff retention and use of Band 4 Nursing associates.
- **Max Fax Outpatients Department** – Review of band 4 dental nurse in progress.
- **Peanut Ward** – Good staff retention.
- **Plastics Outpatients Department** – Staff member completed return to practice course.
- **Peri-op** – Workforce stabilising.
- **Minor Injuries Unit** – Stable workforce.
- **Site Practitioners** – New site member commenced in November 2022.
- **Nurse management** – Chief Nursing Information Officer started in post.

Health Education England (HEE) supported us to run a 'Star Workshop' which focussed on maximising the supply and career pipeline of the nursing workforce. Facilitated conversations took place using the five domains of the star:

- **Supply** – Create a long-term workforce plan
- **Upskilling** – Investigate opportunities to incentivise up-skilling
- **New roles** – Research what new roles are being used elsewhere
- **New ways of working** – Embed IT training into induction
- **Leadership** – Develop leadership for band 4s and above

NHS England

9. Temporary Staff usage

The use of agency and bank staff has increased over the past six months. This can be accounted for by high long-term sickness absence particularly in our critical care unit (CCU), where specialist nurses are required. Approval was sought from the executive management team (EMT) to use the 'break glass' clause and utilise off framework agency staff. Each agency staff have had their curriculum vitae reviewed to ensure adequate experience for the role. We continue to use the enhanced rate of bank pay for areas that have staffing as a corporate risk.

There has been significant estates work which has resulted in operational challenges within the Trust. The Canadian Wing flooring and refurbishment took a total of 16

weeks to complete, during this time, beds on the Head and Neck (H&N) ward were utilised in order to accommodate our elective patients. In addition, both CCU and H&N experienced significant water ingress due to the weather which resulted in the relocation of CCU to recovery. These works resulted in inefficiencies with staffing across the site.

	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23
Agency Total worked in month WTE	3.19	2.72	1.65	2.72	3.17	**5.21**
Bank WTE Total worked in month WTE	37.62	35.03	30.95	35.03	39.19	**47.45**

Sourced via ESR data

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

The Heads of Nursing attend the 08.00 handover and the 15.00 bed meeting giving further assurance that safe staffing, appropriate deployment of staff and planned staffing for the next 24 hours is achieved. Monthly review of actual staffing against planned is carried out and triangulated against incidents raised via DATIX and safer nursing metrics and complaints data.

10. Retirements

The table below indicates the numbers qualified Nurses/theatres practitioners who could retire in the next 5 years. Included is anyone aged 50 and over for any NMC registered staff and anyone 55 and over for any HCPC registered staff. This is currently 85 staff and is the equivalent of 62.39 WTE. Of note, this includes staff who have already retired and returned to work.

	Department											
	Burns	CCU	Corneo	C-Wing	H&N	MaxFax	MIU	OPD	Peanut	Site	Specialist	Theatres (inc pre-assess)
Band 5		1	2	2				3	2		1	12
Band 6	4	1	1	2	1			2	3		4	16
Band 7			2		1	1	5	1	1	5	7	
Band 8a											2	
Band 8b												1
Band 9											1	
Totals	**4**	**2**	**5**	**4**	**2**	**1**	**5**	**6**	**6**	**5**	**15**	**29**
WTE	2.97	1.4	3.6	2.92	1.92	0.68	3.57	4.11	5.07	3.38	10.51	22.26

Sourced via ESR data

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

2.96 WTE registered nurses are currently on maternity leave, data taken on 31st March 2023.

The data below demonstrate the sickness rates in the registered and unregistered nursing workforce.

	KPI	Mar-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23
12 month sickness rate (all sickness)	3%	4.66%	5.09%	5.09%	5.12%	5.36%	5.24%	5.11%	5.00%
Monthly Sickness Absence % All Sickness		6.39%	4.61%	4.77%	5.44%	8.04%	4.98%	4.91%	4.66%

Sourced via ESR data

12. Assurance

The last 12 months have seen a slight increase in the sickness rate. All sickness absence is managed as per Trust policy. The health and wellbeing of all our staff remains a key priority. The Trust continues to support staff mental and physical health through appropriate referrals, communications and well-being initiatives.

Bank and agency usage has increased in line with sickness absence and patient acuity.

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

Following the HEE Star Workshop, 32 potential projects were captured. Further development of the five domains in identifying the priorities for the next year. Continue to recruit to Burns ward Matron post, and other vacant posts.

13. Recommendations

The Board is asked to:

- note the use of HEE to help future proof our workforce
- 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

References

https://www.rcn.org.uk/news-and-events/Press-Releases/nursing-staff-vote-to-strike-in-the-majority-of-nhs-employers-across-the-uk
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)
https://www.kingsfund.org.uk/blog/2022/10/nhs-nursing-workforce#:~:text=The%20last%20year's%20data%20(June,under%2045%20years%20of%20age

Appendix 1

National Quality Board requirements and self-assessment

Recommendation	Current Position March 2023
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 four times per day in the ward areas. This information is presented at the twice daily bed meeting where senior clinical and operational staff manages the patient flow for electives and trauma. Nursing and care staff can be reallocated at the start or during a shift and local escalation process is embedded. Heads of Nursing are visible in the clinical areas. Daily oversight of planned versus actual staffing levels by 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 discussed six monthly	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.

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 on a regular basis with the ICB Chief Nurse and Quality leads. Staffing levels discussed at these meeting. The commissioners are aware of the nurse staffing levels and the actions the trust is taking to optimise recruitment and retention.

Report cover-page					
References					
Meeting title:	Board of directors				
Meeting date:	06/07/2023		**Agenda reference:**	**56-23**	
Report title:	Quality and governance committee assurance				
Sponsor:	Karen Norman, Committee Chair				
Author:	Karen Norman, Committee Chair Ellie Simpkin, governance officer				
Appendices:	None				
Executive summary					
Purpose of report:	The purpose of the report is to provide assurance on matters considered and discussed by the quality and governance committee at its meetings on 15 May 2023 and 26 June 2023.				
Summary of key issues	• The committee received the various annual reports • There have been no new serious incidents declared • The Trust received fourteen formal complaints during April and May 2023. No cases were reopened or referred by the Parliamentary and Health Service Ombudsman (PHSO) • The results of the 2022 Patient-Led Assessments of the Care Environment (PLACE) inspections have been reviewed • The committee considered a deep dive into risk 1226 adult burns - delivery of commissioned services whilst not meeting all national standards/criteria				
Recommendation:	The Board is asked to **note** the contents of the report, the assurance where given and risks 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:	KSO3- outstanding patient experience- quality and supply issues with providers, ongoing workforce challenges KSO2- World class clinical services- restricted facilities to manage more complex patients				
Corporate risk register:	The committee continues to review the patient safety risks.				
Regulation:	Health and Social Care Act 2008 CQC standards of quality and safety				
Legal:	As above				
Resources:	None				
Assurance route					
Previously considered by:	Quality and governance committee				
	Date:	15/05/23 26/06/23	Decision:		
Next steps:	N/A				

Report to:	Board Directors
Agenda item:	56-23
Date of meeting:	6 July 2023
Report from:	Karen Norman, Committee Chair
Report author:	Karen Norman, Committee Chair Ellie Simpkin, governance officer
Date of report:	27 June 2023
Appendices:	None

Quality and governance committee assurance

Introduction

This purpose of this report is to provide the Board with assurance on matters considered by the quality and governance committee at its meetings on 15 May 2023 and 26 June 2023.

15 May 2023

The committee received the following annual reports:

Quality Account 2022/23

The committee noted the importance of the report demonstrating good performance at QVH whilst ensuring the right balance of information and ensuring that the document meets statutory requirements. This year, the report contains more qualitative feedback. With regard to the patient experience quality priorities for 2023/24, the committee noted that the patient engagement strategy will consider the trends and look at triangulated data. The committee took assurance from the report, where given, noted the identified risks, and recommended the report for approval by the Trust Board at its meeting on 14 June 2023.

Infection Prevention & Control Annual Report 2022/23

The Trust has maintained compliance with Care Quality Commission (CQC) regulations relating to Infection Prevention and Control and the overall incidence of Healthcare Associated Infection remains low with zero cases of methicillin resistant staphylococcus (MRSA) bacteraemia, zero cases of methicillin Sensitive Staphylococcus (MSSA) bacteraemia, one case of Escherichia coli (E.coli) bacteraemia and four cases of Clostridium Difficile (CDI) infections. Further assurance is required on the provision of microbiologists and there is concern that contract service level agreements are not being delivered. There is a lack of ventilation authorised person which needs to be addressed.

Medicines Governance Annual Report 2022/23

The committee was assured that governance processes are in place to ensure that medication related incidents are managed appropriately and fully investigated; learning is shared and actions taken to reduce further incidents. Oversight is provided by the Medicines Management, Optimisation and Governance Group (MMOGG) and governance is in place to ensure safe handling and storage of medicines. Patient safety alerts, Medicines and Healthcare products Regulatory Agency (MHRA) drug alerts and medicines recalls are actioned appropriately and in a timely manner. The committee noted that there have been delays in the investigation of maxillofacial mediation incidents. The antimicrobial pharmacist post remains vacant despite continual advertising; a plan has been submitted for a new post which will combine the theatres and antimicrobial pharmacist roles.

Safeguarding (Adult and Children) Annual Report 2022/23
The committee received assurance on the Trust's adherence to the Sussex Safeguarding standards which identify key benchmarks, ensuring an effective auditable approach to safeguarding of all patients. The committee also noted the achievements of the safeguarding team in 2022/23 including two domestic abuse sessions run by external provider, Safelives, and a retrospective review of the multi-disciplinary team database which evaluated the patterns and types of injuries in the population of children where there had been identified safeguarding or child protection concerns. There have been changes in the appraisal system to capture the eight hours of safeguarding training and new training videos have been produced for level 2 training and for new medical staff. The team has also collaborated with the team at Sussex Partnership Foundation Trust to provide QVH staff with a guidance document to understand how to manage disclosures of non-recent abuse. The committee noted the current challenges for the team, including senior medical staff engagement with the safeguarding and Mental Capacity Act (MCA) process in a meaningful way. Non-permanent staff compliance with training has been highlighted and is reported in the monthly metrics to the Board. An audit undertaken in the summer of 2022 indicated adherence to the Mental Capacity Act appears to be poor. The safeguarding team is currently under pressure to deliver on all the required work streams and the audit programme is delayed due to workload. It was also reported that managing safeguarding concerns is made more difficult by the lack of electronic patient records.

Patient Safety Annual Report 2022/23
The report provided assurance to the committee that the Trust is meeting its duty in relation to patient safety requirements and standards. The committee noted that work has commenced on the Patient Safety Investigation Response Framework (PSIRF) and the transition from the 'National Reporting and Learning System' (NRLS) to the 'Learn from Patient Safety Events' system (LfPSE) which will result in some changes to reporting and investigations. Further work on ensuring that learning is captured and fed through governance processes to meet the new PSIRF requirements is required.

Health & Safety Annual Report 2022/23
The committee took assurance from the information provided on the achievements, noting the ongoing commitment health and safety matters. The Care First employee assistant programme highlighted the need for the triangulation of HR data relating to staff health and wellbeing.

Learning from Deaths Annual Report 2022/23
The committee were assured that all inpatient deaths at QVH and deaths occurring within 30 days of an inpatient episode or outpatient procedure have been appropriately reviewed with learning identified where appropriate. The Learning from deaths policy has been reviewed and amended to include a Trust Mortality Surveillance Panel to ensure that all inpatient deaths which occur at QVH or post transfer out are reviewed quickly so as to identify any which require formal investigation. The Trust now has a Medical Examiner to support its Learning from Deaths process.

Guardian of Safe Working Annual Report 2022/23
The report gave an overview of the gaps, vacancies and extra hours worked by junior doctors in 2022/23. Assurance was taken that no safety issues have been raised and rota gaps and vacancies have been filled by locum shifts. The committee noted the main issues for the year have been doctors being moved from their training activity to

extra ward cover and locum shifts being offered for 'training' activities. There is continued use of locum hours. The number of unclosed Exception reports has highlighted an issue with the system for responding to the reports with regards to meeting with the trainee, engagement of the Assigned Educational Supervisors and timely closing of these reports. Where payment is due, the Guardian of Safe Working (GOSW) has acted to highlight this to HR. The GOSW recommended active recruitment to prevent rota gaps, locum shifts to be offered for the service commitments and not displace trainees from training, an HR rota review of the maxillofacial registrar late cancer cases to accommodate them in usual paid hours and improving the ease of the exception reporting system.

Patient Experience Annual Report 2022/23
The committee took good assurance from the positive inpatient friends and family test (FFT) recommendation rate of 99% against the national score of 94%, a testament to staff. Action is being taken to ensure a timely response to complaints. The committee noted that there are plans to roll out and embed a patient engagement strategy and standardised patient co-design approach to help shape services.

Research & Innovation Annual Report 2022/23
The committee was pleased to note that 2022/23 was a positive year for the research and innovation team with activity in national portfolio studies having increased by 41% over the previous year. The impact that research has on services and resources beyond the research and innovation team, such as pharmacy, was noted. Discussion was had on the consideration being given to non-portfolio studies and a detailed proposal on the reinstatement of QVH sponsored research activity for submission to the Board will prepared as part of the development of the wider future strategy for QVH.

Appraisal & Revalidation Annual Report 2022/23
The report provided assurance that the statutory functions of the Responsible Officer (RO) are being appropriately and adequately discharged. The committee noted that there have been challenges with the availability of appraisers due to staff vacancies and appraisal rates for doctors undertaking short-term contracts remain lower than for other doctors post pandemic. The committee requested confirmation that all outstanding appraisals have now been completed. An e-appraisal system is being procured which will bring the Trust in line with General Medical Council (GMC) requirements for electronic forms.

The committee received the report on behalf of the Trust Board, noting that it will be shared with the South East Higher Level RO no later than 23 September 2023. The Committee, on behalf of the Trust Board, noted the Statement of Compliance item 5, Section 7 which confirms the Trust, as a Designated Body, is compliant with the regulations.

Emergency Preparedness, Resilience & Response (EPRR) Annual Report
The committee congratulated the team on the positive outcome of the 2022/23 NHS England annual assurance review which found QVH to have substantial compliance. It meets the requirements of the category one responder as evidenced in retaining substantial assurance during the external review of core standards.

Medical Devices Annual Report 2022/23
The report provided assurance that there is robust and rigorous medical devices management across the Trust, and that the developments which are planned for

2023/24 will further increase the safety and effectiveness of patient care. A programme for the replacement of equipment across the Trust is being developed.

Clinical Audit and Quality Improvement Annual Report 2022/23
The report provided a comprehensive overview and assurance on the clinical audit activities undertaken across the Trust in 2022/23. Clinical audit resources are being concentrated on the delivery of national mandated projects and key internal priorities, specifically the Trust's participation in relevant National Clinical Audit and Patient Outcomes Programme (NCAPOP) projects. There is clinical audit project activity across all specialities, including findings and recommendations for change and QVH has continued to see an increase in reporting and action plans which have led to improvements in patient care.

26 June 2023

Information governance annual report 2022/23
The committee was assured of the strong governance and reporting that enables scrutiny and oversight of information governance activities across the Trust. The Trust achieved a 'Standards met' accreditation for the Data Security and Protection Toolkit self-assessment and the committee congratulated the team on the excellent outcome of the clinical coding audit. There has been an increase in information governance incidents from the previous year, however, no incidents were considered serious. There has also been an increase in Freedom of Information requests and work is continuing to ensure a timely response to requests.

Clinical quality and patient safety
There have been no new serious incidents declared. Following investigation, a request to downgrade an incident declared in March 2023 has been agreed by the Integrated Care Board scrutiny committee.

Discussion was had on the impact of the recent industrial action and the committee noted that although there had been a loss of clinical capacity, a safe service had been maintain throughout.

Patient experience
The Trust received fourteen formal complaints during April and May 2023. The main themes are treatment, perceived delays and staff behaviour. No cases were reopened or referred by the Parliamentary and Health Service Ombudsman (PHSO) for consideration during this period. The Trust has an overall inpatient Friends and Family Test (FFT) recommendation rate of 100%.

The committee reviewed the results of the 2022 Patient-Led Assessments of the Care Environment (PLACE) inspections which provides feedback from patient assessors on the environment in which care is delivered. An action plan to address the areas for improvement is being developed and monitored by the patient experience group.

Risk
The committee considered a deep dive into risk 1226 adult burns - delivery of commissioned services whilst not meeting all national standards/criteria. It was noted that the service performed well in the peer review carried out in November 2022, demonstrating the highest level of standards-compliance in the network. The committee took good assurance on the clinical mitigations which are in place to ensure that safe patient care is being provided. Staffing remains a challenge. It will

be important for the Trust to work with commissioners to ensure the long term future of the unit.

Other

- Feedback on a visit to the Research and Innovation Group was provided.
- All quality priorities for 2022/23 have been met.
- The nursing workforce review was considered and approved for submission to the Board.
- The committee received the infection prevention and control report for quarter four 2022/23, noting the risk relating to antimicrobial prescribing issues.
- The committee is not yet fully assured on the concerns in respect to surgical patients who do not fall under the referral to treatment waiting time targets. Further information on this will be provided to the committee at its next meeting.

Recommendation

The Board is asked to **note** the contents and recommendations of the report, the assurance where given and the risks identified.

Report cover-page					
References					
Meeting title:	Board of Directors				
Meeting date:	06/07/2023		**Agenda reference:**	**57-23**	
Report title:	Financial performance report				
Sponsor:	Maria Wheeler, chief finance officer				
Author:	Jeremy Satchwell, deputy chief finance officer				
Appendices:	Appendix one: financial performance data pack				
Executive summary					
Purpose of report:	To present an overview of the Financial position of the Trust at the end of May 2023				
Summary of key issues	Month 2 Key Financial Data				
Recommendation:	Note the contents of this 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:	KS04				
Corporate risk register:	None				
Regulation:	None				
Legal:	None				
Resources:	None				
Assurance route					
Previously considered by:	Finance and performance committee				
	Date:	26/0623	Decision:		
Next steps:	NA				

Report to: Board of Directors
Agenda item: Finance Report
Date of meeting: 6 July 2023
Report from: Maria Wheeler, chief finance officer
Report author: Jeremy Satchwell, deputy chief finance officer
Date of report: 26 June 2023
Appendices: Appendix one: financial performance data pack

Finance Report - Month 2

1. Introduction

This report presents an overview of the financial position of the Trust at the end of May 2023 (Month 2).

2. Executive summary

Financial Metric	Period	Result Month
Income and Expenditure	YTD	Breakeven
	Year End Forecast	Breakeven
Cash at Bank	YTD	£13.4m
Capital spend	Plan YTD	£0.61m
	Actual YTD	£0.18m
BPPC (Combined NHS & Non NHS)	YTD Volume (%)	97.0%
	YTD Value (%)	95.8%
Efficiencies	Plan YTD	£0.91m
	Actual YTD	£0.91m
	Year End Forecast	£5.5m (5.5%)

Figure 1: Key Financial Performance Metrics

3. Background

In 2023/24, funding allocations are composed of three key elements:-

- A Block value for all ICB contracts and NHSE Specialised Commissioning.
- An Elective Recovery Fund (ERF) to deliver to 109% of 2019/20 levels and which is paid based on elective patient activity delivered
- Block values for all ICBs with activity value below £500k

4. Situation

Income and Expenditure

	In Month £'000				Year to Date £'000				Forecast Outturn £,000		
	22/23	Plan	Actual	Variance	22/23	Plan	Actual	Variance	Plan	Forecast	Variance
Income											
Patient Activity Income	7,482	7,747	7,196	(551)	13,877	15,493	15,349	(144)	92,960	92,960	0
Other Operating Income	(152)	248	324	77	491	496	638	142	2,974	2,974	0
Total Income	**7,329**	**7,994**	**7,520**	**(474)**	**14,367**	**15,989**	**15,987**	**(2)**	**95,933**	**95,933**	**0**
Pay											
Substantive	(4,281)	(4,803)	(4,521)	283	(8,691)	(9,605)	(9,033)	573	(57,630)	(55,400)	2,230
Bank	(281)	(196)	(200)	(3)	(533)	(393)	(592)	(199)	(2,355)	(3,255)	(900)
Agency	(121)	(43)	(140)	(97)	(185)	(86)	(289)	(203)	(514)	(2,259)	(1,745)
Total Pay	**(4,683)**	**(5,042)**	**(4,860)**	**182**	**(9,409)**	**(10,084)**	**(9,913)**	**171**	**(60,499)**	**(60,914)**	**(415)**
Total Non Pay	**(2,341)**	**(2,446)**	**(2,183)**	**263**	**(4,347)**	**(4,893)**	**(5,149)**	**(256)**	**(29,356)**	**(28,990)**	**366**
Total Non Operational Expenditure	**(507)**	**(506)**	**(491)**	**15**	**(1,014)**	**(1,013)**	**(976)**	**37**	**(6,077)**	**(6,034)**	**44**
Total Expenditure	**(7,531)**	**(7,994)**	**(7,535)**	**460**	**(14,770)**	**(15,989)**	**(16,038)**	**(49)**	**(95,933)**	**(95,938)**	**(5)**
	(201)	**(0)**	**(14)**	**(14)**	**(403)**	**(0)**	**(51)**	**(50)**	**0**	**(4)**	**(5)**
Surplus / (Deficit)											
Technical Adjustments			*14*	**14**		*0*	*51*	**51**			*0*
Adjusted Surplus / (Deficit)	***(201)***	***(0)***	***(0)***	**(0)**	***(403)***	***(0)***	***0***	**0**	***0***	***(0)***	***(1)***

Figure 2: Income and Expenditure Summary Month 2

4.1. Income

4.1.1. Patient Activity Income

- M1 actual is 94% against income plan, M2 actual is 106% against income plan
- Value Weighted Activity (VWA) performance vs relevant month in 2019/20 – Estimate of achievement is 108% for M1 and 122% for M2.

4.1.2. Non Patient Care Income

- This is various non-patient related income sources e.g. catering, parking and is above plan

4.2. Expenditure

- Pay costs are under plan year to date. Vacancies in substantive posts offset by increased temporary staff costs.

4.3. Forecast Outturn

- The Forecast out turn is Breakeven.

4.4. Risks and Mitigations

- There are financial risks (and mitigation plans in place) for inflation and planned elective activity/funding levels.

5.0 Treasury Management

- The Trust's cash balance was £13.4m.
- The Trust's BPPC performance is summarised in the table below, as at the end of May.

Invoices	Total Invoice(s)		Actual Paid in Time		Performance vs 95%	
	No	Value (£000)	No	Value (£000)	No (%)	Value (%)
NHS	126	614	116	590	92.1%	96.1%
Non NHS	3,036	9,649	2,950	9,238	97.2%	95.7%
Overall	**3,162**	**10,263**	**3,066**	**9,828**	**97.0%**	**95.8%**

Figure 3: BPPC Performance @ Month 2

5.1 Capital Expenditure

- Capital Expenditure is £0.18m at the close of May. Year to date plan of £0.61m.
- A 6 Facet Survey, electrical and fire surveys have been undertaken on the estate to inform Capital planning in year.

6.0 Assessment

- Month 2-Breakeven position and cash balances of £13.4m.
- The Forecast Outturn is Breakeven.
- Patient Activity levels are broadly in line with plan.
- The Efficiency savings requirement is c. 5.5% of the Trust's cost base (the requirement for all the providers in Sussex). £3.4m full year effect already found recurrently, and the remainder of the efficiencies requirement profiled into the position.

7.0 Recommendation

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

Financial Performance Report: Appendix

May 2023
Month 2

Income & Expenditure Month 2

Queen Victoria Hospital NHS Foundation Trust

Financial Performance Month 2 2024
Income and Expenditure

	In Month £'000				Year to Date £'000				Forecast Outturn £,000		
	22/23	Plan	Actual	Variance	22/23	Plan	Actual	Variance	Plan	Forecast	Variance
Income											
Patient Activity Income	7,482	7,747	7,196	(551)	13,877	15,493	15,349	(144)	92,960	92,960	0
Other Operating Income	(152)	248	324	77	491	496	638	142	2,974	2,974	0
Total Income	**7,329**	**7,994**	**7,520**	**(474)**	**14,367**	**15,989**	**15,987**	**(2)**	**95,933**	**95,933**	**0**
Pay											
Substantive	(4,281)	(4,803)	(4,521)	283	(8,691)	(9,605)	(9,033)	573	(57,630)	(55,400)	2,230
Bank	(281)	(196)	(200)	(3)	(533)	(393)	(592)	(199)	(2,355)	(3,255)	(900)
Agency	(121)	(43)	(140)	(97)	(185)	(86)	(289)	(203)	(514)	(2,259)	(1,745)
Total Pay	**(4,683)**	**(5,042)**	**(4,860)**	**182**	**(9,409)**	**(10,084)**	**(9,913)**	**171**	**(60,499)**	**(60,914)**	**(415)**
Total Non Pay	**(2,341)**	**(2,446)**	**(2,183)**	**263**	**(4,347)**	**(4,893)**	**(5,149)**	**(256)**	**(29,356)**	**(28,990)**	**366**
Total Non Operational Expenditure	**(507)**	**(506)**	**(491)**	**15**	**(1,014)**	**(1,013)**	**(976)**	**37**	**(6,077)**	**(6,034)**	**44**
Total Expenditure	**(7,531)**	**(7,994)**	**(7,535)**	**460**	**(14,770)**	**(15,989)**	**(16,038)**	**(49)**	**(95,933)**	**(95,938)**	**(5)**
	(201)	**(0)**	**(14)**	**(14)**	**(403)**	**(0)**	**(51)**	**(50)**	**0**	**(4)**	**(5)**
Surplus / (Deficit)											
TechnicalAdjustments			*14*	***14***		*0*	*51*	***51***		***4***	*4*
Adjusted Surplus / (Deficit)	***(201)***	***(0)***	***(0)***	***(0)***	***(403)***	***(0)***	***0***	***0***	***0***	***(0)***	***(1)***

Run Rate Month 2

NHS
Queen Victoria Hospital
NHS Foundation Trust

Run Rate £,000

	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May
Income													
Patient Activity Income	7,482	8,313	7,142	7,770	7,691	7,685	7,537	7,301	6,993	6,928	10,236	8,153	7,196
Other Operating Income	(152)	(232)	771	638	(418)	591	387	273	867	572	515	313	324
Total Income	***7,329***	***8,081***	***7,913***	***8,408***	***7,273***	***8,275***	***7,924***	**7,575**	**7,859**	**7,499**	**10,751**	**8,467**	**7,520**
Pay													
Substantive	(4,281)	(4,379)	(4,259)	(4,839)	(4,196)	(4,737)	(4,539)	(4,464)	(4,522)	(4,513)	(5,919)	(4,512)	(4,521)
Bank	(281)	(329)	(416)	(373)	(359)	(430)	(295)	(251)	(382)	(388)	(440)	(392)	(200)
Agency	(121)	(29)	(88)	(122)	(84)	(125)	(110)	(101)	(108)	(43)	(160)	(149)	(140)
Total Pay	***(4,683)***	***(4,737)***	***(4,763)***	***(5,335)***	***(4,639)***	***(5,292)***	***(4,944)***	***(4,816)***	***(5,012)***	***(4,944)***	***(6,520)***	***(5,053)***	***(4,860)***
Non Pay													
Clinical Services & Supplies	(948)	(1,049)	(960)	(1,309)	46	(586)	(750)	(891)	(498)	65	(548)	(485)	(473)
Clinical Services & Supplies - Med & Surg	(567)	(610)	(713)	(127)	(778)	(763)	(811)	(591)	(715)	(773)	(549)	(764)	(467)
Drugs	(117)	(126)	(122)	(128)	(118)	(127)	(120)	(115)	(110)	(98)	(250)	(148)	(137)
Establishment Expenses	(273)	(246)	(340)	(363)	(310)	(381)	(337)	(287)	(335)	(481)	(1,409)	(1,050)	(343)
Consultancy	0	0	0	0	0	0	0	0	0	0	0	0	0
Other non pay	(437)	(590)	(557)	(687)	(874)	(698)	(474)	(393)	(684)	(777)	(778)	(518)	(763)
Total Non Pay	***(2,341)***	***(2,621)***	***(2,693)***	***(2,614)***	***(2,033)***	***(2,555)***	***(2,492)***	***(2,277)***	***(2,342)***	***(2,064)***	***(3,534)***	***(2,966)***	***(2,183)***
Non Operational Expenditure	(127)	(124)	(122)	(126)	(207)	(140)	(140)	(140)	(135)	(140)	(157)	(141)	(141)
Non Operating Income	8	8	8	9	14	15	19	27	39	42	45	49	43
Depreciation and amortisation	(388)	(265)	(363)	(363)	(428)	(323)	(387)	(387)	(429)	(391)	(516)	(393)	(393)
Total Expenditure	***(7,531)***	***(7,739)***	***(7,933)***	***(8,428)***	***(7,293)***	***(8,295)***	***(7,944)***	***(7,595)***	***(7,879)***	***(7,497)***	***(10,682)***	***(8,503)***	***(7,535)***
Surplus / (Deficit)	***(201)***	***343***	***(20)***	***(20)***	***(20)***	***(20)***	***(20)***	***(20)***	***(20)***	***2***	***70***	***(36)***	***(14)***

Workforce Financial performance Month 2

Queen Victoria Hospital NHS Foundation Trust

	In Month WTE					In Month £'000					Year to Date £'000				
	22/23	Plan	Actual	Variance	Total Pay Variance	22/23	Plan	Actual	Variance	Total Pay Variance	22/23	Plan	Actual	Variance	Total Pay Variance
Substantive															
Admin & Clerical	272.44	292.88	284.95	7.93	(6.08)	(957)	(1,143)	(1,013)	130	57	(1,984)	(2,063)	(2,018)	45	(124)
Allied Health Professionals & Healthcare Scientists	158.27	175.56	161.79	13.77	11.26	(661)	(745)	(684)	61	69	(1,315)	(1,491)	(1,361)	129	100
Medical	162.47	171.45	155.42	16.03	10.43	(1,534)	(1,739)	(1,650)	89	87	(3,168)	(3,478)	(3,316)	162	83
Nursing & Healthcare Assistant	89.92	97.77	94.35	3.42	4.95	(199)	(247)	(229)	18	11	(386)	(495)	(457)	38	7
Qualified Nursing	185.72	201.71	181.51	20.20	25.38	(779)	(908)	(795)	113	90	(1,543)	(1,817)	(1,586)	231	141
Support Staff	57.95	54.27	55.93	-1.66	(2.42)	(150)	(131)	(149)	(18)	(21)	(296)	(262)	(295)	(33)	(36)
Substantive Total	**926.77**	**993.64**	**933.95**	**59.69**	**43.52**	**(4,281)**	**(4,914)**	**(4,521)**	**394**	**293**	**(8,691)**	**(9,605)**	**(9,033)**	**573**	**171**
Bank															
Admin & Clerical	24.22	11.17	25.18	-14.01		(66)	(32)	(70)	(38)		(151)	(63)	(160)	(97)	
Allied Health Professionals & Healthcare Scientists	2.89	6.30	7.96	-1.66		(20)	(16)	(37)	(21)		(33)	(33)	(84)	(52)	
Medical	4.02	2.22	6.16	-3.94		(37)	(23)	55	79		(51)	(47)	(1)	46	
Nursing & Healthcare Assistant	7.94	10.36	8.83	1.53		(33)	(26)	(33)	(7)		(59)	(52)	(84)	(31)	
Qualified Nursing	18.67	22.11	19.50	2.61		(120)	(93)	(105)	(12)		(231)	(185)	(247)	(62)	
Support Staff	1.52	2.51	3.27	-0.76		(5)	(6)	(10)	(4)		(9)	(13)	(15)	(3)	
Bank Total	**59.26**	**54.67**	**70.90**	**-16.23**		**(281)**	**(196)**	**(200)**	**(3)**		**(533)**	**(393)**	**(592)**	**(199)**	
Agency															
Admin & Clerical	3.98	1.00	1.00	0.00		(32)	(3)	(38)	(35)		(57)	(7)	(80)	(73)	
Allied Health Professionals & Healthcare Scientists	1.62	2.32	3.17	-0.85		(2)	(6)	23	29		(6)	(11)	11	22	
Medical	2.68	0.26	1.92	-1.66		(35)	(3)	(84)	(80)		(52)	(7)	(131)	(124)	
Nursing & Healthcare Assistant	0.00	0.00	0.00	0.00		0	0	0	0		0	0	0	0	
Qualified Nursing	6.08	6.90	4.33	2.57		(52)	(30)	(42)	(11)		(69)	(61)	(89)	(28)	
Support Staff	0.00	0.00	0.00	0.00		(1)	0	0	0		(0)	0	0	0	
Agency Total	**14.36**	**10.48**	**10.42**	**0.06**		**(121)**	**(43)**	**(140)**	**(97)**		**(185)**	**(86)**	**(289)**	**(203)**	
Workforce Total	**1,000.39**	**1,058.79**	**1,015.27**	**43.52**		**(4,683)**	**(5,153)**	**(4,860)**	**293**		**(9,409)**	**(10,084)**	**(9,913)**	**171**	

Efficiencies month 2

Queen Victoria Hospital NHS Foundation Trust

Efficiency Savings 2023/24 YTD	Actual 30/04/2023 Month 1 £'000	Actual 31/05/2023 Month 2 £'000	Plan 31/05/2023 YTD £'000	Actual 31/05/2023 YTD £'000	Variance 31/05/2023 YTD £'000	Plan 31/03/2024 Year ending £'000	Forecast 31/03/2024 Year ending £'000	Variance 31/03/2024 Year ending £'000
Recurrent								
Pay - Recurrent	438	438	875	875	0	5,252	5,252	0
Non-pay - Recurrent	15	15	30	30	0	201	201	0
Income - Recurrent	0	0	0		0	0		0
Total recurrent efficiencies	**453**	**453**	**905**	**905**	**0**	**5,453**	**5,453**	**0**
Total non-recurrent efficiencies	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
Total Efficiencies	**453**	**453**	**905**	**905**	**0**	**5,453**	**5,453**	**0**
Efficiency Savings - by category								
Pay Efficiencies								
Agency - price cap compliance	0	0	0	0	0	0	0	0
Agency - eliminate off framework supply	0	0	0	0	0	0	0	0
Bank - collaborative working	0	0	0		0	0		0
Bank - rate review	0	0	0		0	0		0
Establishment reviews	288	288	575	576	1	3,452	3,452	0
E-Rostering	0	0	0	0	0	0		0
Corporate services transformation - pay	0	0	0	0	0	0		0
Digital transformation	0	0	0	0	0	0		0
Service re-design - pay	0	0	300	0	(300)	1,800	1,500	(300)
Other - pay (Non-recurrent Vacancies)	162	161	0	323	323	0	323	323
Total Pay	**450**	**449**	875	**899**	**24**	5,252	5,276	24
Non-pay Efficiencies								
Medicines optimisation			0	0		0		0
Procurement (excl drugs) -non-clinical	3	3	0	6	6	0		0
Service re-design - Non-pay	0	0	30	0	(30)	201	171	(30)
Total Non-Pay	**3**	**3**	30	**6**	**(24)**	201	177	**(24)**
Total Income	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
Total Efficiencies	**453**	**452**	**905**	**905**	**0**	**5,453**	**5,453**	**0**

Cashflow Report Month 2

Queen Victoria Hospital
NHS Foundation Trust

Financial Performance Month 02 2023/24

Cashflow Report

	Actual £'000	Actual £'000	Actual £'000	Actual £'000	Actual £'000	Forecast £'000	Forecast £'000	Forecast £'000	Forecast £'000
	Jan 23	Feb 23	Mar 23	Apr 23	May 23	Jun 23	Jul 23	Aug 23	Sep 23
Opening Balance	**13,930**	**13,207**	**15,350**	**11,719**	**10,880**	**0**	**0**	**0**	**0**
Receipts									
NHS Block & System	7,101	8,951	7,267	8,334	9,566				
Receipts from other in	344	424	231	244	647				
Public Dividend Capit	0	0	0	0	0	0	0	0	0
PDC Cash Support R	0	0	0	0	0	0	0	0	0
Total Receipts	**7,445**	**9,375**	**7,498**	**8,578**	**10,213**				
Payments									
Payments to NHS Bodie	(437)	(264)	(241)	(667)	(440)				
Payments to non-NHS b	(2,664)	(2,170)	(5,055)	(3,817)	(2,460)				
Capital Payments									
Net Payroll Payment	(2,677)	(2,719)	(2,949)	(2,733)	(2,708)				
Payroll Taxes	(1,284)	(1,302)	(1,323)	(1,436)	(1,344)				
Pensions Payment	(673)	(776)	(762)	(763)	(769)				
PDC Dividends Payment		-	(799)	-	-				
Loan Interest & Repayr	(433)	-	-	-	-	-		-	
Interim Revenue Loan Interest & Re	-	-	-	-	-	-		-	
Total Payments	**(8,169)**	**(7,232)**	**(11,129)**	**(9,416)**	**(7,722)**				
Net Cash Movement	**(723)**	**2,143**	**(3,631)**	**(838)**	**2,491**	**193**	**(1,054)**	**5,676**	**(903)**
Closing Balance	**13,207**	**15,350**	**11,719**	**10,880**	**13,372**	**10,212**	**9,158**	**14,834**	**13,930**

Debtors Month 2

Queen Victoria Hospital NHS Foundation Trust

Financial Performance Month 02 2023/24

Debtors

	May 22 £'000	Jun 22 £'000	Jul 22 £'000	Aug 22 £'000	Sep 22 £'000	Oct 22 £'000	Nov 22 £'000	Dec 22 £'000	Jan 23 £'000	Feb 23 £'000	Mar 23 £'000	Apr 23 £'000	May 23 £'000	In Month Change £000
NHS Debtors														
0-30 Days Past Invoice Due Date	55	651	1,249	1,280	330	364	119	1,428	2,078	434	1,841	1,691	800	**(891)**
31-60 Days Past Invoice Due Date	266	24	13	339	1,224	4,061	219	88	15	571	31	320	50	**(270)**
61-90 Days Past Invoice Due Date	49	265	8	14	339	1,224	11	15	84	14	483	(8)	315	**323**
Over 90 Days Past Invoice Due Date	752	630	822	766	726	912	1,273	1,449	961	1,012	995	1,467	1,382	**(85)**
Total NHS Debtors	**1,122**	**1,570**	**2,091**	**2,398**	**2,619**	**6,562**	**1,623**	**2,981**	**3,138**	**2,031**	**3,349**	**3,470**	**2,546**	**(924)**
Non NHS Debtors														
0-30 Days Past Invoice Due Date	42	63	102	60	29	80	173	154	102	249	223	226	97	**(128)**
31-60 Days Past Invoice Due Date	68	6	9	1	27	0	0	51	83	0	52	103	73	**(30)**
61-90 Days Past Invoice Due Date	1	49	3	2	2	17	0	0	33	3	0	52	29	**(24)**
Over 90 Days Past Invoice Due Date	234	200	249	227	227	237	164	160	160	157	168	150	142	**(9)**
Total Non NHS Debtors	**345**	**318**	**362**	**290**	**285**	**285**	**285**	**366**	**377**	**409**	**443**	**531**	**340**	**(191)**
Total Invoiced Debtors	**1,467**	**1,887**	**2,454**	**2,688**	**2,904**	**6,847**	**1,908**	**3,347**	**3,515**	**2,440**	**3,792**	**4,002**	**2,887**	***(1,115)***
NHS : Total NHS & Non NHS ratio	*0.76*	*0.83*	*0.85*	*0.89*	*0.90*	*0.96*	*0.85*	*0.89*	*0.89*	*0.83*	*0.88*	*0.87*	*0.88*	

Creditors Month 2

Queen Victoria Hospital
NHS Foundation Trust

Financial Performance 2023/24

Trade Creditors

	May 22 £'000	Jun 22 £'000	Jul 22 £'000	Aug 22 £'000	Sep 22 £'000	Oct 22 £'000	Nov 22 £'000	Dec 22 £'000	Jan 23 £'000	Feb 23 £'000	Mar 23 £'000	Apr 23 £'000	May 23 £'000	In Month Change £'000
NHS Accounts Payable Creditors														
0-30 Days Past Invoice Due Date	86	76	50	258	392	490	382	388	334	253	799	385	303	(82)
31-60 Days Past Invoice Due Date	51	58	5	0	239	23	163	187	78	241	56	106	156	49
61-90 Days Past Invoice Due Date	11	2	58	3	(25)	232	72	96	184	17	196	99	147	48
Over 90 Days Past Invoice Due Date	273	247	239	286	213	185	399	661	734	846	855	978	1,005	28
Total NHS Accounts Payable Creditors	**421**	**383**	**352**	**547**	**819**	**929**	**1,016**	**1,331**	**1,330**	**1,357**	**1,906**	**1,568**	**1,611**	**43**
Non NHS Accounts Payable Creditors														
0-30 Days Past Invoice Due Date	1,100	837	770	799	1,303	795	1,038	912	575	789	1,741	929	1,120	191
31-60 Days Past Invoice Due Date	172	33	119	100	30	29	41	85	54	19	86	44	48	4
61-90 Days Past Invoice Due Date	36	140	26	23	48	12	11	19	70	30	18	43	17	(25)
Over 90 Days Past Invoice Due Date	35	38	179	185	1	10	23	55	64	106	146	85	86	0
Total Non NHS Accounts Payable Creditors	**1,343**	**1,048**	**1,094**	**1,106**	**1,382**	**846**	**1,112**	**1,072**	**763**	**945**	**1,991**	**1,101**	**1,271**	**170**
Total Accounts Payable Creditors	**1,765**	**1,431**	**1,446**	**1,653**	**2,200**	**1,775**	**2,128**	**2,403**	**2,093**	**2,302**	**3,897**	**2,669**	**2,882**	**213**
NHS : Non NHS ratio	***0.31***	***0.37***	***0.32***	***0.49***	***0.59***	***1.10***	***0.91***	***1.24***	***1.74***	***1.44***	***0.96***	***1.42***	***1.27***	

Report cover-page					
References					
Meeting title:	Board Directors				
Meeting date:	06/07/2023		**Agenda reference:**	**58-23**	
Report title:	Operational performance report				
Sponsor:	Shane Morrison-McCabe, Director of Operations				
Author:	Shane Morrison-McCabe, Director of Operations				
Appendices:	Appendix one: Performance data set				
Executive summary					
Purpose of report:	The report sets out the May performance for national and local targets. In addition, the report gives a summary of the outpatient and theatre transformation programmes. The report briefly sets out the June 14th -17th junior doctor industrial action.				
Summary of key issues	Cancer: 62day target was achieved. We are above trajectory for patients waiting 104 days+ for cancer treatment and plans are underway to review and treat these complex patients. Faster diagnosis was achieved for cancer patients. DMO1 remains below national target, achieving 73.8% against the 95% target and the Sleep improvement actions and capacity remain in place. Waiting lists have increased and is now 16,844. In-house validation exercise underway and system task group. Theatre transformation: 88.2% utilisation was achieved and is the highest rate for over a year. Cancellations on the day was 3.3% of elective activity and was the lowest level for over a year. Late starts averaged at 10mins, the lowest for over 7 months. Early finishes was below the trust target (30mins) at average 28mins.				
Recommendation:	The Board is asked to **note** the contents of the report.				
Action required	Approval	**Information**	Discussion	**Assurance**	Review
Link to key strategic objectives (KSOs):	KSO1:	KSO2:	KSO3:	KSO4:	KSO5:
	Outstanding patient experience	*World-class clinical services*	***Operational excellence***	***Financial sustainability***	*Organisational excellence*
Implications					
Board assurance framework:	None				
Corporate risk register:	None				
Regulation:	None				
Legal:	None				
Resources:	None				
Assurance route					
Previously considered by:	None				
	Date:		Decision:		
Next steps:					

Report to:	Board Directors
Agenda item:	58-23
Date of meeting:	6 July 2023
Report from:	Shane Morrison-McCabe, Director of Operations
Report author:	Shane Morrison-McCabe, Director of Operations
Date of report:	26 June 2023
Appendices:	Operational performance report

Operational performance report

Cancer

QVH continues to receive increasing numbers of referrals for patients on a two week suspected cancer pathway. These patients require initial consultant outpatient appointment, diagnostic tests, and review to determine whether they need to be treated within 62days or referred back to their GP. The backlog of patients on a 62day pathway was 39 which is above our threshold (35 patients) in May. We are forecast to achieve the national 62 day performance target (85%), at 86%. The number of patients waiting 104 days plus for definitive cancer treatment is 14 for May against a trajectory of 3: Plastics x 12, breast x 1, head & neck x 1.

Diagnostics

QVH has achieved the faster diagnosis standard for April = 84.1% (target = 80%). N.B. May data is not available until end June 2023 in line with standard cancer reporting. We expect to continue to achieve this target going forward.

Imaging continues to achieve the monthly diagnostic target (DMO1) at 99.5% of patients waiting less than 6 weeks for a diagnostic test. Sleep DMO1 performance in May remained relatively stable at 50**%** compared to 48% in previous month. We continue to outsource Oximetry testing and have agreed to explore other options with the supplier. A new contract for outsourced Polysomnography tests has been implemented with an initial cohort of patients sent over as a pilot. Performance has exceeded the new revised trajectory by approx. 8%. Overall, DMO1 reports an improving position at 73.8% for May, however the national target is not met; driven by challenges within sleep. Note that the national DMO1 target is currently 95%.

Waiting list and referral to treatment (RTT) waits

The RTT waiting list total is 16,844. This is for patients awaiting inpatient elective procedures, day cases, new outpatient appointment or follow-up appointments on an open RTT pathway.

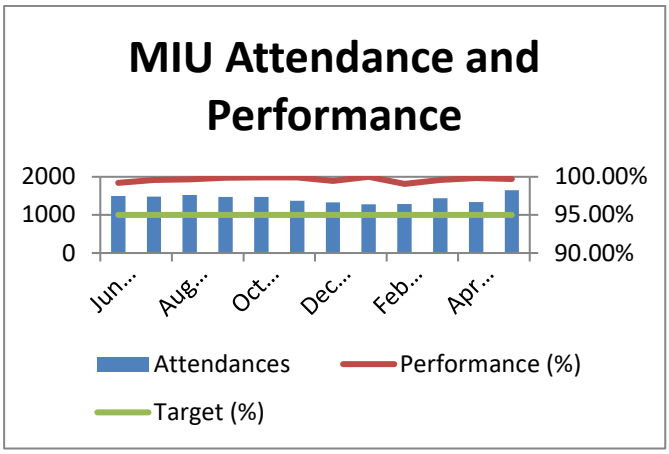
The Trust has engaged with an external company (The Source Group) to carry out validation of a significant number of non RTT open follow-up episodes to determine whether they can be closed or potentially move to a Patient Initiated Follow-up pathway. A bid for financial support through the Integrated Care Board has been submitted to support this work and we await the outcome. QVH will attend the system task and finish group.

Activity

The activity plan target for 2023/24 is to achieve 109% of the 2019/20 activity. 107.9% of 2019/20 plan was achieved for May 2023, which is ahead of the phased plan.

MIU

The service achieved 99.7% against the national 4hr standard of 95% despite attendances in May being the highest for over a year:



Outpatient Transformation
The outpatient transformation programme aims to

- Increase the number of patients placed onto Patient Initiated Follow-Up (PIFU) pathways
- Maintain and increase the number of virtual clinics
- Reduce the number of patients brought into the hospital for follow-up
- Reduce the number of patients who did not attend (DNA)
- Reduce the number of patients who cancel their appointment
- Reduce the time from referral to new patient appointment

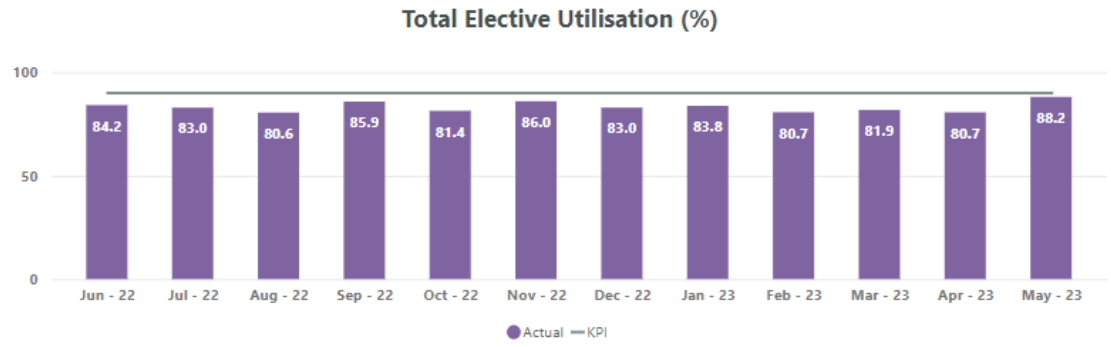
Over the first 2 months of 2023/24 the Trust has delivered a reduction of 16% of follow up outpatient attendances with a target of a 25% reduction by year end. The teledermatology clinics commence 20 June 2023 in a phased approach and this will reduce the number of patients travelling to QVH to be seen. An improvement will be seen particularly for patients referred on a 2 week cancer pathway as well as patients referred on a skin pathway. The teledermatology pilot has demonstrated the benefits to be derived.

A new speech and language therapist has been appointed to commence one stop see and treat clinics particularly for patients who may be experiencing head and neck symptoms i.e. voice issues such as hoarseness, lymph node adenopathy, acid reflux, haemorrhagic polyps which can be ameliorated through therapeutic non-invasive interventions and functional exercises. This is an improvement in patient care, new staff roles and timely patient first appointments. Initial data shows that 90% of patients are discharged with a treatment plan and do not require a further appointment.

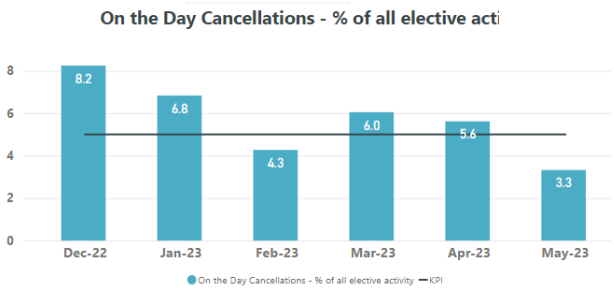
Theatre transformation
The theatre transformation work programme is in Phase 1 and focused on the following key aspects through task and finish groups:

- Reducing cancellations on the day
- Increasing the flow of patient through theatre
- Exploring the feasibility of moving local anaesthetic cases out of main theatres and backfilling with general anaesthetic cases
- Reducing ‘late starts’ and early list finishes to maximise utilisation of the theatre lists during Mon-Fri 08:30 – 17:00.

Utilisation for May was the highest for over a year at 88.2% (national target = 85%):



On the day cancellations in May were the lowest for over a year:



Look ahead
The industrial action which took place on 14-17 June led to a reduction in available capacity. Once the dates were announced, in line with our process we did not schedule further patients for elective operative procedures (including day cases) and ceased booking into routine outpatient appointment slots. This capacity is lost in real time which inevitably requires patients to be booked into future capacity (which patients on the waiting list would have been scheduled into). Every effort is made to treat Priority 1 and Priority 2 as well as cancer patients despite industrial action. There is a further junior doctor strike 13-17 July 2023 and a potential consultant strike mid-July, the impact of this is being assessed.

Bank holidays
The 3 May Bank Holidays led to a reduction in available capacity for elective procedures and outpatient appointments.

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

Operational Performance Report

Shane Morrison-McCabe, Director of Operations

June 2023

Contents

Performance Summary

Queen Victoria Hospital NHS Foundation Trust

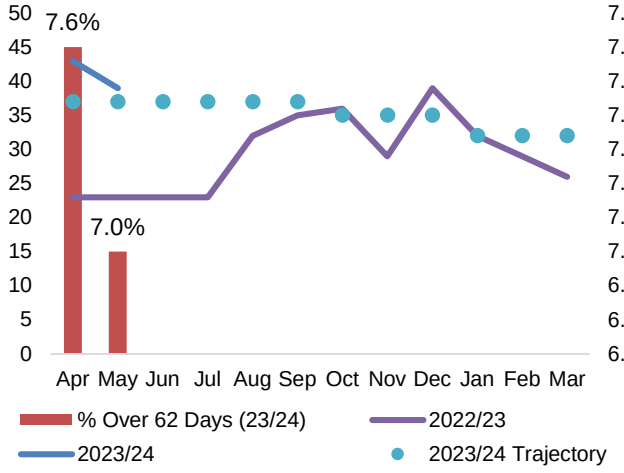
	KPI	TARGET / METRIC	SOURCE	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Change from last month
CANCER	Faster Diagnosis	75% by March '24	National	85.5%	84.5%	86.2%	84.4%	81.4%	84.0%	82.9%	82.5%	87.4%	87.2%	83.8%		↓
	Cancer 62 day+ backlog	Internal trajectory	ICS	23	23	32	35	36	29	39	32	29	26	43	39	↓
	Cancer 62 day performance	85%	National	85.1%	89.5%	91.9%	86.3%	84.0%	85.1%	86.3%	80.0%	85.5%	82.5%	83.6%		↓
DMO1	Diagnostic Activity (excl. Sleep)	Internal plan (% against plan)	Local											89%	87%	↓
	DM01 Diagnostic waits (overall)	95% <6 weeks by March '25	National	88.7%	72.1%	71.6%	75.4%	73.9%	70.1%	56.6%	52.8%	62.0%	71.0%	72.4%	73.8%	↑
	Sleep DM01	Internal trajectory	Local	30.3%	39.9%	41.2%	53.0%	57.2%	46.9%	31.8%	23.5%	35.4%	49.5%	47.7%	49.9%	↑
RTT WAITS	Total Waiting List Size	N/A	N/A	14,782	15,275	15,706	15,718	15,393	15,222	15,628	15,805	16,040	16,351	16,585	16,844	↑
	RTT78	0	National	7	6	5	3	11	9	16	7	14	0	4	5	↑
	RTT65	0 by March '24 (internal trajectory)	National	45	47	52	65	71	77	83	76	85	55	58	61	↑
	RTT52	Internal trajectory	Local	273	301	308	296	312	315	327	315	317	313	313	322	↑
ACTIVITY	Elective Recovery Increase ADMITTED	% of 23/24 Activity Plan	ICS											88%	97	↑
	Elective Recovery Increase NON-ADMITTED	% of 23/24 Activity Plan	ICS											107%	100%	↓
OUTPATIENTS	Follow up reduction against 19/20	25% reduction against 19/20	National	-4%	-12%	-16%	-14%	-9%	-6%	-15%	-3%	-15%	-10%	-17%	-15.0%	↓
	PIFU	2.8% by March '24	ICS	1.0%	1.0%	1.1%	1.5%	1.4%	1.5%	1.0%	1.1%	0.9%	0.9%	1.3%	1.0%	↓
	DNAs	4%	ICS	4.9%	4.5%	4.8%	4.7%	4.5%	4.3%	5.0%	4.5%	4.6%	4.7%	4.8%	4.9%	↑
THEA TRE	Theatre Utilisation (uncapped)	90%	Local	86.7%	83.5%	80.7%	86.5%	81.4%	86.0%	83.0%	83.8%	80.7%	81.9%	80.7%	88.2%	↑
MIU	MIU	95% discharged <4hrs	National	99.2%	99.6%	99.7%	99.9%	99.9%	99.9%	99.5%	100.0%	99.1%	99.6%	99.9%	99.7%	↓

RAG	Deteriorating position or plans / cause for concern	Improving position	Delivery of national / local standard or internal trajectory met

Cancer Performance

Queen Victoria Hospital NHS Foundation Trust

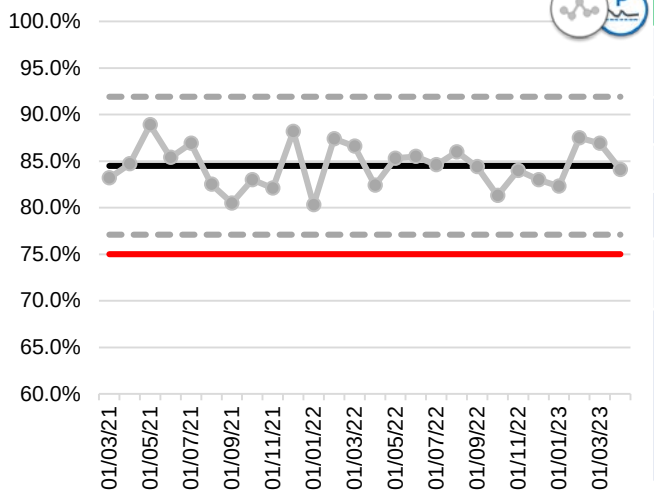
1. Trend Data - Overs



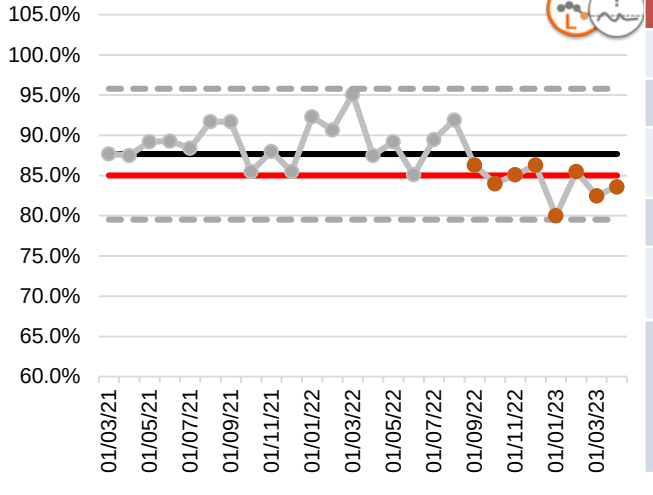
May-23
39
Trajectory
37
7.0%
PTL Target
5%
Achievement
Both targets have failed

7.7% 7.6% 7.5% 7.4% 7.3% 7.2% 7.1% 7.0% 6.9% 6.8% 6.7%

2. Trend Data - Performance



Apr-23
84.1%
National Target
75%
Target (ICB)
80%
Variance/ Assurance
No significant change. Assurance of consistently meeting the target.



Apr-23
83.6%
National Target
85%
Target (internal)
86%
Variance/ Assurance
Deteriorating variance. No assurance of meeting the target regularly.

3. Key Contributors/Forward Look

- ❑ **Late tertiary referrals** – 28% of the May backlog were late referrals, down from 40% in April.
- ❑ **Increased complex pathways** due to patient comorbidities which require MDT input internally and externally (e.g. primary care, community, safeguarding, CNS).
- ❑ Continued **delays to consultants reviewing results** – delay to benign/results letter.
- ❑ **Patients choosing to delay** at various points along the pathway – reporting 19 in April.
- ❑ **Patient cancellations** – reporting 41 in April with 3 patients cancelled twice.
- ❑ **Outpatient capacity** – reporting 43 outpatient capacity breaches, 22 in head & neck and 21 in skin.
- ❑ **Medical delays** remain a risk factor due to the complexity of patients referred to QVH.
- ❑ The **total PTL size** continues to remain high, averaging 536 over the last 3 months. Skin reporting a 25% increase in the number of patients between 44-62 days (12 patients).
- ❑ **SLNB performance** has improved and achieved the April trajectory; sharp decrease of breaches (4).
- ❑ Saved 1.5 **62 days breaches** in April – reporting 1 breach (2 pts) in skin
- ❑ **104 day** – reporting 14 in May: 7 were late referrals, 5 are complex or patient initiated delays. Of the longest waiting, the main reasons are complex medical situations with GP and safeguarding involved
- ❑ **May forward look =** TWW: passing, FDS: passing, 62 Day: passing, 31 Day: failing.
- ❑ Going forward, Trusts will be monitored weekly on % variance from Mar-24 plan with a 50% threshold; QVH Mar-24 plan is 32, reporting 21.9% over plan for May.

4. Key Assurance/Action Plans

Countermeasures	Actions	Owner	Complete
Skin Cancer Recovery	Recovery plan and speciality trajectory agreed, weekly service led backlog meeting	Plastic GM	Ongoing
Performance Pack	Weekly: overs, PTL breakdown, TWW, referral numbers.	CDIPM	Ongoing
Additional admin resource	Head & Neck Navigator started in June Skin – additional admin for cancer PTL to start in June	Head of Access	Completed
Breach reporting and analysis	Root cause analysis – individual monthly meetings, moving towards pareto charts	CDIPM	Ongoing
Skin results letters	Reviewing process to implement a quicker turnaround	GM/SC	Ongoing
Cancer tracking KPI's	Three agreed KPI's, weekly reporting, monitoring and addressing challenges	ACM	Ongoing
Pre service lead PTL	Focus on confirmed cancers, reducing overs and tip ins	GM/SM	Ongoing
Thrice weekly capacity meeting	Mon, Wed and Fri service/access meeting to identify future at risk weeks/underutilisation	Access/ GM	Ongoing

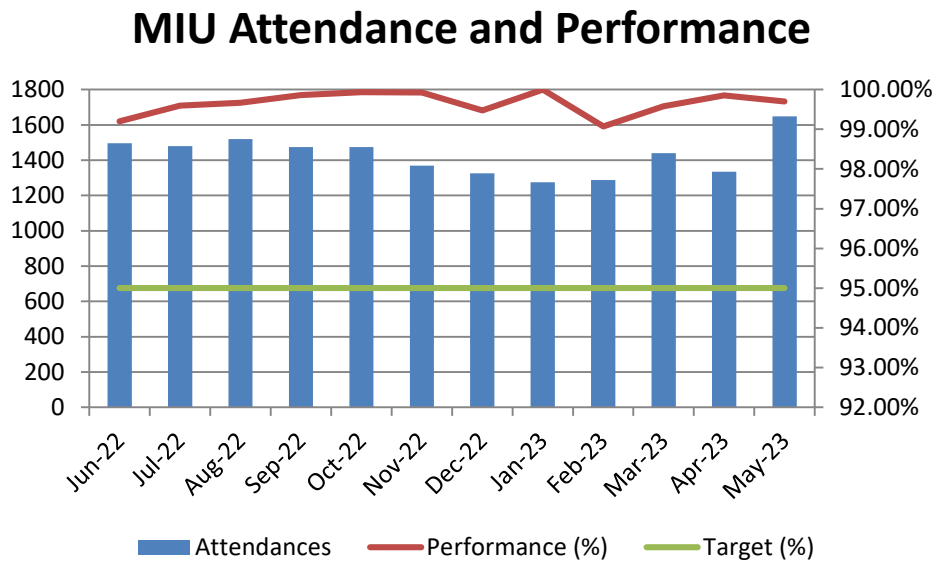
MIU

Diagnostics

DMO1 NATIONAL POSITION: *(look back – Apr 23)*	
National DMO1: 72.4%	**QVH DMO1:** 72.3%

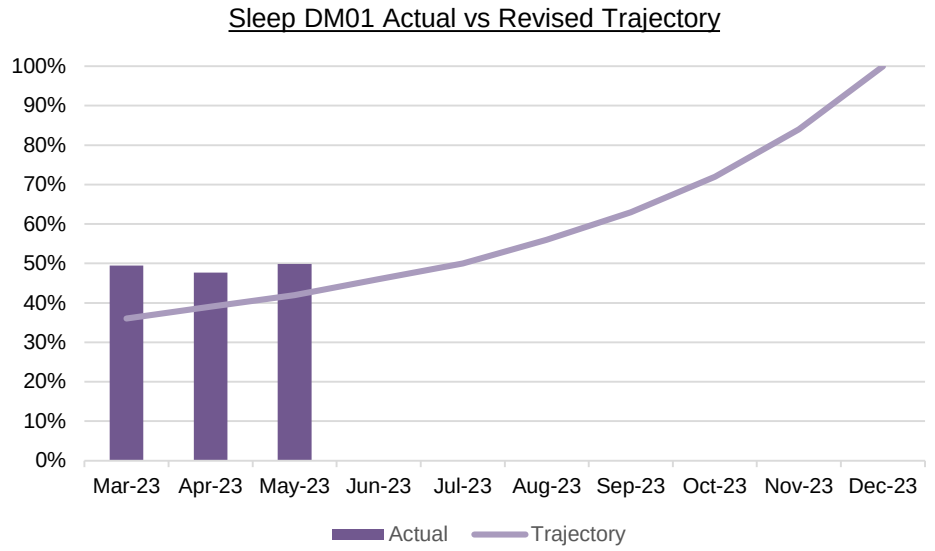
MIU

- MIU attendance has remained at a consistently high level. We continue to meet the 4 hour clinical standard, reporting 99.7% in May which exceeds the target of 95%.



DMO1:

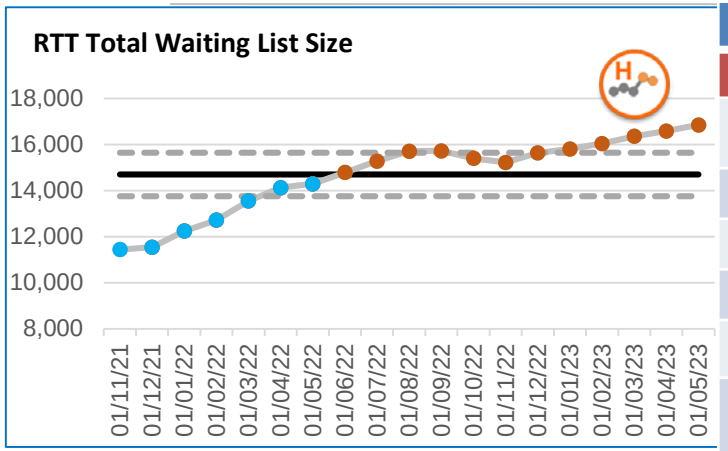
- Overall DMO1 reports an improving position at 73.8% for May, however the national target is not met; impacted by challenges within Sleep. Note that the national DMO1 target reduced from 99% to 95% as of April 2023.
- Radiology DMO1 performance 99.5% for May.
- Sleep DMO1: Performance in May remained relatively stable at 50**%** compared to 48% in previous month. Performance has exceeded the new revised trajectory by approx. 8%.



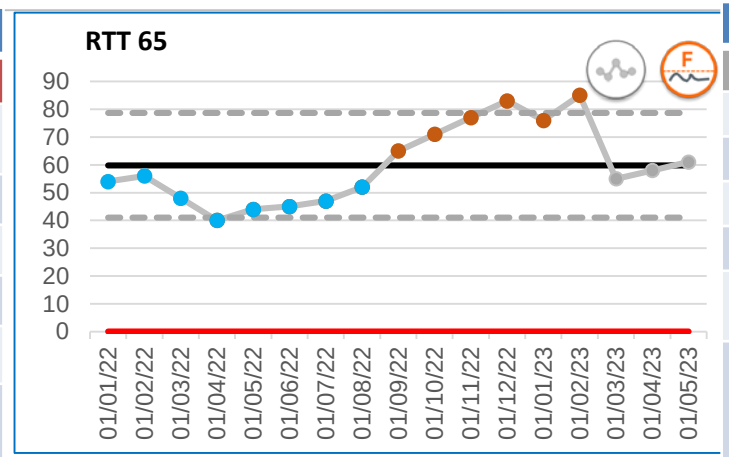
RTT Performance

RTT NATIONAL POSITION: *(look back – Apr 23)*	
National RTT18: 58.3%	**QVH RTT18:** 62.4%

52WW NATIONAL POSITION: *(look back –Apr 23)*	
National % >52WW: 5%	**QVH % >52WW:** 1.9%



May-23
16,844
National Target
n/a
Internal Target
n/a
Variance
Deteriorating variance.



May-23
61
National Target
0 by Mar-24
Internal plan - May
64
Variance/ Assurance
Common cause variance. Consistently failing target.

KPI	Latest month	Measure	End of Year Target	Variation	Assurance
RTT Total Waiting List Size	May 23	16844	-		
RTT 18	May 23	63.9%	92.0%		
RTT 52	May 23	322	359		
RTT 65	May 23	61	0		
RTT 78	May 23	5	0		

Performance Commentary

78WW failed trust trajectory. Performance has an improving special cause variation but is predicted to fail target.

Reported 5 patients in May: 3 of which have a TCI date.

65WW achieved trust trajectory. Performance is in common cause variation (no significant change from previous month) but is predicted to fail target.

Reported 61 patients in May; 54% of which have a TCI date.

52WW achieved trust trajectory. Performance has an improving special cause variation but there is no assurance of reliably hitting target.

Reported 322 patients in May, 43% of which have a TCI date. All specialties achieved their internal trajectories.

Key Actions & Mitigations

Maxfacs and Orthodontics are running waiting list initiative lists on Saturdays to increase capacity, prioritising the longest waiters.

Orthodontics are recruiting a substantive consultant to increase capacity, awaiting confirmation of start date.

Plastics greatest RTT challenges are within breast, hands & Mohs. Mitigations include:

- A focused weekly scheduling meeting; out of which the schedulers are given a target list of long waiting patients to book into current month.
- Insourcing 7 additional Mohs lists on Saturdays throughout April-July via HBSUK
- Hands patients are offered to change their care to be under consultants with shorter waiting times.
- Recruitment of 3 consultants (Mohs, skin & breast)
- Progressively devolving further management responsibility of PTLs to admin teams (schedulers and medical secretaries)

Assurance

Long waiters continue to be **monitored at service level** through weekly PTL meetings and Operational team meetings

New live PTL tool is in development which will improve proactive management of long waiters.

Theatre Improvement programme is underway with specific T&F groups for cancellations on the day, patient flow and increasing GA capacity.

Outpatient transformation programme is underway with targeted workstreams to increase utilisation and efficiency.

Waiting list deep dive is in progress to evaluate the increased waiting list size; results shared in next month's report.

Forward Look

78WW: predicting 3 in June; failing trajectory.

65WW: predicting 69 in June; failing trajectory.

52WW: predicting 358 in June; failing trajectory.

Risks to Performance

Industrial Action – negatively affecting the length of pathways and available capacity; circa 23 theatre sessions lost in June in addition to loss of clinics.

Waiting list (PTL) continues to grow.

Cancellations by patient, for medical reasons or for other unavoidable causes.

Staffing – fragility of theatre staffing and future consultant absences affecting both day case and elective delivery.

Activity Vs Plan

QVH Site / Independent Sector

Queen Victoria Hospital NHS Foundation Trust

Elective Recovery Group	POD Grouping	M2 Activity Plan	M2 23/24 Activity	% Activity Plan against 23/24 M2 Activity
Elective Recovery Increase	Day Case Total	962	943	98%
	Elective Total	270	252	93%
	First Outpatients Total	3,719	3,736	100%
	Outpatient Procedures Total	3,081	3,098	101%
Elective Recovery Increase Total		**8,033**	**8,029**	**100%**
Elective Recovery Reduction Total	Follow Up Outpatients Total	**10,493**	**8,955**	**-15%**

PERFORMANCE COMMENTARY

- Day case headcount under plan but value weighted activity suggestive of an increased case complexity. This results in a value weighted position exceeding plan.
- Elective activity marginally behind plan but early suggestions are that this will be offset by the over performance in day case value weighted delivery.
- Meeting plan for First outpatient activity. Sleep and Max Fax over performing with all other services broadly delivering plan.
- Exceeding Outpatient procedure performance driven by Ophthalmology. Slight underperformance in Max Fax and Orthodontics.

FORWARD LOOK / RISKS

- Ongoing risk due to fragility of staffing in theatres affecting both day case and elective delivery.
- CCU capacity and staffing challenges continue to be improved resulting in fewer cancellations of elective activity in Max Fax.
- Future consultant absences due to retirement, maternity leave, parental leave, special leave a potential risk to delivery across services.
- Industrial action and loss of capacity affecting ability to deliver activity plans and performance targets.

Service improvement

Theatre Utilisation May 2023

Queen Victoria Hospital NHS Foundation Trust

THEATRE KPIs	Definition	Target	Current Trust position	Model Hospital position as at 21.05.23
LIST BOOKING	• The minutes booked (estimated case length plus the ORSOS turnaround time added) over the number of minutes available (planned session start time to planned session finish time less lunch break minutes)	All specialty pre-lists booked to minimum 95%	Trust wide 101% Maxillofacial 103 % Eyes 100% Plastics 101 %	
TRUST THEATRE ELECTIVE UTILISATION	• The sum of the actual minutes used (arrival in theatre suite to leave theatre) per case over the available minutes. • Sessions available v sessions delivered in month per specialty	>90% for elective	88.2%	**Model Hospital target "good" 85%** Provider value 86% Peer median 79% Provider median 82%
LATE STARTS	• Time difference between planned start time and arrival of the first patient in the theatre suite – to include anything more than 15 minutes	Session start 08:30hrs minimum 90% starting on time using the acceptable slippage of 15 minutes - capturing Late starts as 08:45hrs	10 minutes	Provider value 40 Peer median 32 Provider median 30
EARLY FINISHES	• Time difference between last patient leaving and planned end time of theatre session – to include anything more than 30 minutes	5% Early finishes – captured as anything under 30 minutes from session end of 17:30hrs	29 minutes	Provider value 59 Peer median 67 Provider median 70
ON THE DAY CANCELLATIONS	• On the day cancellation that could have been avoided	5% or less - cancellations on the day	28 patients – 3.3% of all elective activity 3 patients 0.4% – within our control 25 patients 2.9%– not within our control	Additional capacity including 5% COTD rate Provider value 9% Peer median 15% Provider median 12%

EXCLUSION CRITERIA

TRUST THEATRE ELECTIVE UTILISATION – Excludes; External Breast DVH, SASH, WSHT, MTW, ESHT,BSUH, UHSX, BURNS and all Trauma lists

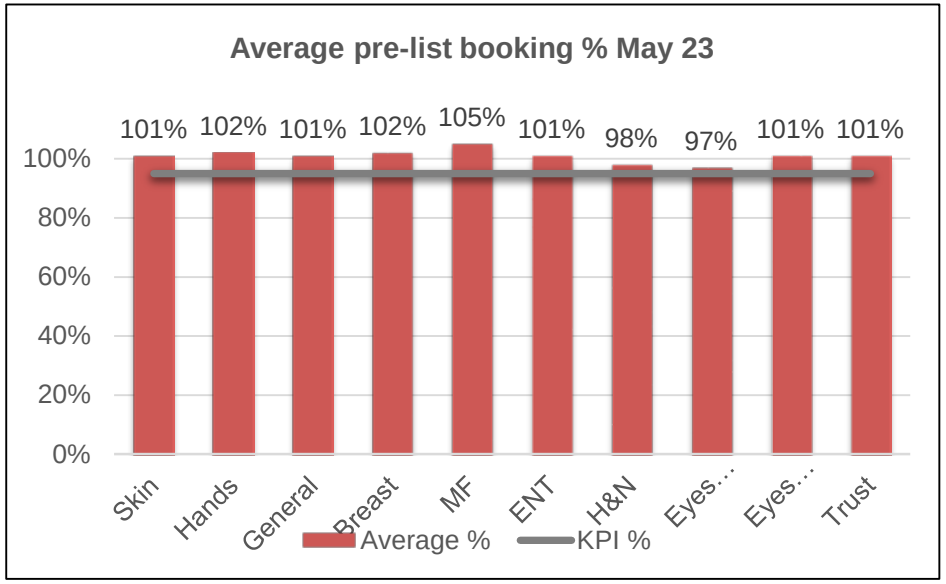
LATE STARTS – Trauma excluded for reporting purposes

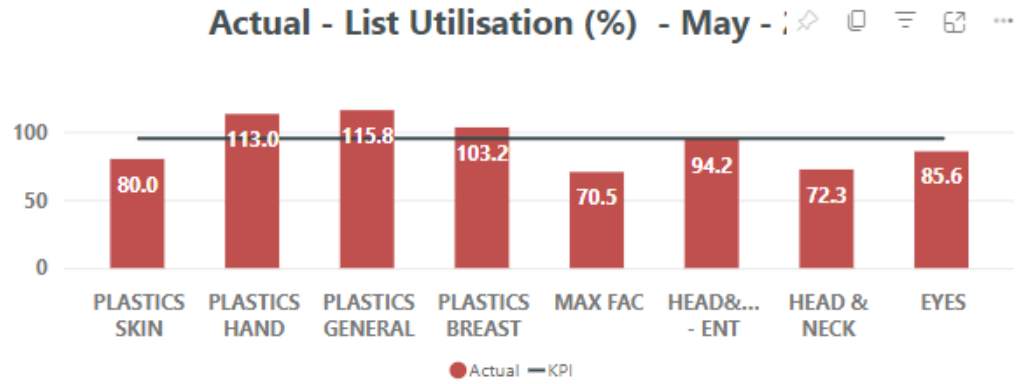
EARLY FINISHES – Trauma excluded for reporting purposes

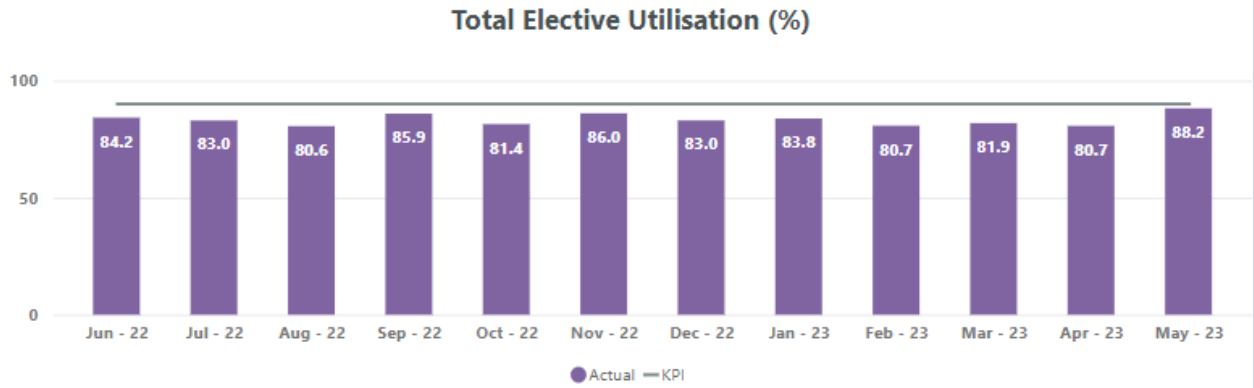
Service improvement

Theatre Utilisation – May 2023

Queen Victoria Hospital NHS Foundation Trust





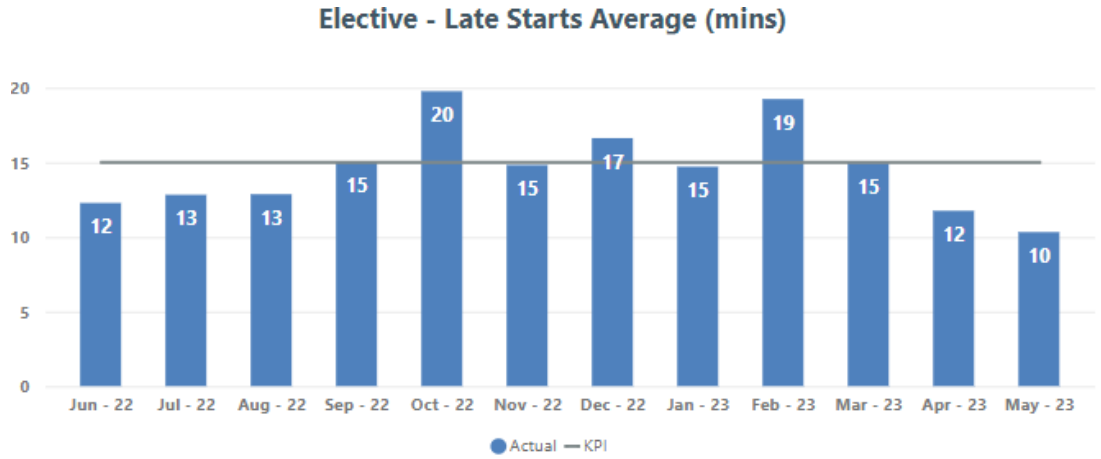


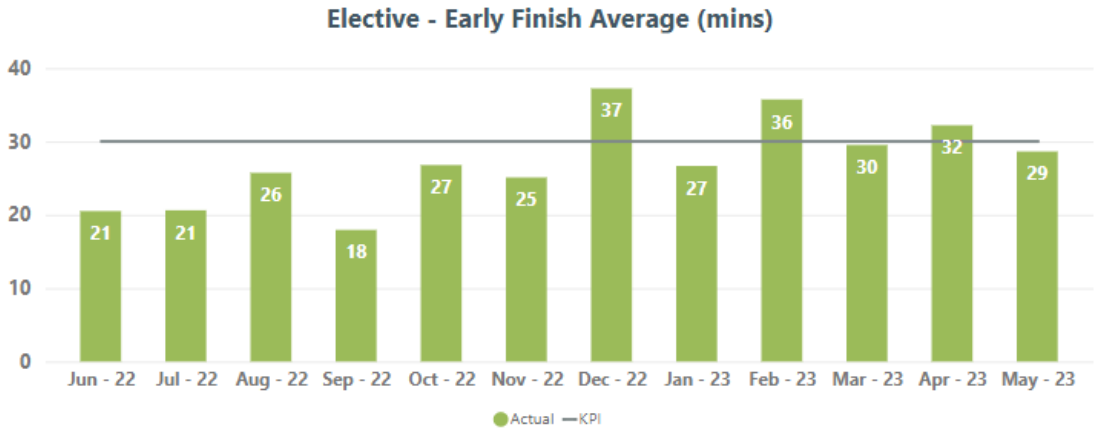
PERFORMANCE COMMENTARY	FORWARD LOOK / PERFORMANCE RISKS
• **Pre-list booking** - all specialties continue to achieve target at list locking. • **Actual list utilisation**. An improvement in performance for all Plastics sub-specialities. Work continues within Skin with a T&F group that includes clinicians to identify where gains can be made. H&N influenced by the complexity and unpredictability of the cases and max fac by estimated timings • **Total Elective utilisation** – Remains consistent and ***performing above the GIRFT national target of 85%.***	• **Actual list utilisation** – Services continue to engage through 6-4-2 / scheduling to ensure optimum use of all available sessions. • Theatre Improvement Programme underway with specific T&F groups focusing on COTD and Patient Flow feeding into the Theatre Productivity Steering group. Skin T&F Group including Theatre representation. • **Total Elective utilisation** – Expected to remain consistent

Service improvement

Theatre late starts, early finishes – May 2023

Queen Victoria Hospital NHS Foundation Trust





PERFORMANCE COMMENTARY	FORWARD LOOK / PERFORMANCE RISKS
• **Elective late starts** – An improvement in month. Continue to be challenged with sickness across all staff groups resulting in rota changes and staff/theatre moves. Steris issues continue. The consistent identified delay theme in month continues to be clinical reasons - surgeon/anaesthetist seeing patients prior to surgery. Work is ongoing with the national team to fully understand the value of the metric. • **Elective early finish** – An improvement in month impacted by a reduction in COTD and late notice cancellations. Services review their lists to ensure the maximum use of theatre. • .	• **Elective late starts** – A risk for June 2023 due to theatre staffing challenges. • **Elective early finish** – Due to on-going work within the services to identify where improvements can be made within sub-specialities it is predicted that June 2023 will perform well against KPI.

Statistical Process Control (SPC) Charts Icon Key

Queen Victoria Hospital NHS Foundation Trust

Variation/Performance Icons			
Icon	***Technical Description***	***What does this mean?***	***What should we do?***
	Common cause variation, NO SIGNIFICANT CHANGE.	This system or process is **currently not changing significantly**. It shows the level of natural variation you can expect from the process or system itself.	**Consider if the level/range of variation is acceptable**. If the process limits are far apart you may want to change something to reduce the variation in performance.
	Special cause variation of an CONCERNING nature where the measure is significantly HIGHER.	**Something's going on!** Your aim is to have low numbers but you have some high numbers – something one-off, or a continued trend or shift of high numbers.	**Investigate** to find out what is happening/ happened. Is it a one off event that you can explain? Or do you need to change something?
	Special cause variation of an CONCERNING nature where the measure is significantly LOWER.	**Something's going on!** Your aim is to have high numbers but you have some low numbers - something one-off, or a continued trend or shift of low numbers.	
	Special cause variation of an IMPROVING nature where the measure is significantly HIGHER.	**Something good is happening!** Your aim is high numbers and you have some - either something one-off, or a continued trend or shift of low numbers. Well done!	Find out what is happening/ happened. **Celebrate** the improvement or success. Is there **learning** that can be shared to other areas?
	Special cause variation of an IMPROVING nature where the measure is significantly LOWER.	**Something good is happening!** Your aim is low numbers and you have some - either something one-off, or a continued trend or shift of low numbers. Well done!	

Assurance Icons			
Icon	***Technical Description***	***What does this mean?***	***What should we do?***
	This process will not consistently HIT OR MISS the target as the target lies between the process limits.	The process limits on SPC charts indicate the normal range of numbers you can expect of your system or process. If a target lies **within** those limits then we know that the target may or may not be achieved. The closer the target line lies to the mean line the more likely it is that the target will be achieved or missed at random.	Consider whether this is acceptable and if not, you will need to change something in the system or process.
	This process is not capable and will consistently FAIL to meet the target.	The process limits on SPC charts indicate the normal range of numbers you can expect of your system or process. If a target lies **outside of those limits in the wrong direction** then you know that the target cannot be achieved.	**You need to change something in the system or process if you want to meet the target.** The natural variation in the data is telling you that you will not meet the target unless something changes.
	This process is capable and will consistently PASS the target if nothing changes.	The process limits on SPC charts indicate the normal range of numbers you can expect of your system or process. If a target lies **outside of those limits in the right direction** then you know that the target can consistently be achieved.	**Celebrate the achievement**. Understand whether this is by design (!) and consider whether the target is still appropriate; should be stretched, or whether resource can be directed elsewhere without risking the ongoing achievement of this target.

Reading/Resources
There are a number of resources to support the use of the Making Data Count methodology, including videos and presentations explaining SPC charts and the approach on the NHS Futures Platform under 'Making Data Count' https://future.nhs.uk/MDC An NHS email address is required to sign up and view.

Report cover-page					
References					
Meeting title:	**Board of Directors**				
Meeting date:	**6 July 2023**		**Agenda reference:**	**59-23**	
Report title:	**Workforce and organisational development report**				
Sponsor:	Clare Pirie, director of communications and corporate affairs				
Author:	Clare Pirie, director of communications and corporate affairs				
Appendices:	Appendix one: Workforce Data – May 2023 data				
Executive summary					
Purpose of report:	To provide an update on key issues around workforce and organisational development activity, highlighting achievements and challenges for the organisation in this domain.				
Summary of key issues	Leadership development workshops for our senior staff Recruitment quality improvement project Approach to developing WRES and WDES action plans				
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:	1291 - Overarching Corporate Risk - Keeping our staff engaged, motivated and supported during a time of great change				
Regulation:	Well Led				
Legal:	n/a				
Resources:	Pressures on workforce team noted in paper				
Assurance route					
Previously considered by:	Finance and Performance Committee				
	Date:	24/04/23	Decision:	Discussed and noted	
Next steps:	NA				

Report to:	Board of Directors
Agenda item:	59-23
Date of meeting:	6 July 2023
Report from:	Clare Pirie, director of communications and corporate affairs
Report authors:	Clare Pirie, director of communications and corporate affairs Workforce and organisational development team
Date of report:	25 June 2023
Appendices:	Appendix one: Workforce Data – May 2023 data

Workforce and organisational development report

Leadership development workshops
Twenty one of our most senior staff working below executive director level have been invited to attend one of two development workshops in July and September, which have been commissioned to help participants gain a better understanding of their own personality and preferences, how they respond in stressful and challenging situations, and how they can better collaborate and communicate. Members of the executive team have undertaken the same training and it is hoped that once a number of senior staff have completed this workshop we will have a helpful shared language and improved understanding around how we manage ourselves and how we lead others, which will be valuable for the important work we have ahead of us.

The identification of this cohort of our most senior staff could support further focussed work on leadership skills and behaviours.

Recruitment quality improvement project
The project team continues work on the full recruitment process, with a group of staff from across the Trust reviewing each stage of the process and identifying where changes could be made to reduce time to recruit. The third meeting took place on 8 June to go through actions that were previously deemed as ‘quick wins’ which could be implemented at the earliest opportunity. These include

- New starter portal - recruitment forms are now being built into system to reduce the level of admin needed around new starters in future
- Digital ID checks (national and gov.uk requirement) - costings received and paper to be drafted for executive director consideration
- A number of other small changes in processes that will make a big difference to time to recruit.

Appraisals
Work continues to ensure all staff have a timely and meaningful annual appraisal conversation with their line manager. Appraisals should support the regular feedback that every member of staff should have, with a conversation on wellbeing, career and development aspirations.

A piece of work is underway to look at how the Board can be assured that appraisals support wellbeing, career development, retention and staff satisfaction. Appraisal documents are not centrally held and the process of the updating the system to confirm an appraisal is complete is resource intensive; this project is also looking at whether this can easily be addressed.

Sickness Absence
There is continued improvement in sickness absence, as expected as we approach the summer month, with a particularly significant reduction in absence due to cough, cold or flu.

WRES and WDES action plans
External support has been commissioned to help the Trust gain insight into workforce experience and develop realistic and achievable action plans addressing the issues raised in our workforce race equality standard (WRES) and workforce disability equality standard (WDES).

This work has commenced with the development of a bespoke framework for conversations around the experience in the QVH workforce for people with a disability and people from ethnic minority groups, framed around the indicators of WRES and WDES. A series of confidential one-to-one conversations with staff have been carried out to understand individual staff experience, including identifying what is going well, where more work needs to be done, and what that improvement work might look like. This feedback will be analysed alongside the data, and used to create a set of recommended goals to tackle racial and disabled inequalities in the workforce based on both quantitative and qualitative data.

This work is being carried out with a focus on identifying actions that are achievable with the Trust's resources and which support significant movement toward the recommendations.

Workforce and organisational development team
Interviews for the Chief People Officer will be held in late July. The director of communications and corporate affairs has been managing and supporting the team since mid-February 2023. An interim chief people officer will join the Trust in July.

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

Workforce and Organisational Development Report

June 2023 (May 2023 Data)

Contents

Workforce KPI Summary

Queen Victoria Hospital NHS Foundation Trust

	KPI	May-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23
Establishment WTE Including Bank & Agency		1057.42	1057.16	1057.16	1057.16	1057.16	1057.16	1057.16	**1057.16**
Establishment WTE excluding Bank & Agency		974.96	1026.97	1026.97	1026.97	1026.97	1026.97	1026.97	**1026.97**
Staff In Post WTE		938.84	954.75	952.49	953.62	957.54	959.47	957.33	**961.58**
Agency Total worked in month WTE		8.44	8.96	8.55	10.95	10.02	14.76	12.98	**11.35**
Bank WTE Total worked in month WTE		66.24	76.91	66.17	76.53	74.26	91.30	72.37	**73.73**
Staff in Post Vacancy WTE		36.12	72.22	74.48	73.35	69.43	67.50	69.64	**65.39**
Vacancies % Including Bank & Agency Usage	8%	4.15%	**1.56%**	**2.83%**	**1.52%**	1.45%	-0.79%	1.37%	**0.99%**
Staff in Post Vacancies %	8%	3.70%	**7.03%**	**7.25%**	**7.14%**	6.76%	6.57%	6.78%	**6.37%**
Trust rolling Annual Turnover % Excluding Trainee Doctors	10%	16.34%	**13.27%**	**12.95%**	**13.24%**	13.31%	13.73%	13.28%	**12.92%**
Starters WTE In month excluding HEE doctors		10.04	9.07	8.70	13.80	8.64	14.20	14.00	**11.21**
Leavers WTE In month excluding HEE doctors		10.21	7.48	7.31	12.80	8.63	11.86	10.65	**7.43**
12 Month Rolling Stability % Remained employed for the 12 month period	85%	83.20%	**82.43%**	**86.11%**	**86.49%**	**87.74%**	**86.12%**	**87.33%**	**87.44%**
24 Month Rolling Stability % Remained employed for the 24 month period		74.56%	**74.70%**	**74.75%**	**75.20%**	**76.33%**	**75.00%**	**76.68%**	**76.09%**
12 month sickness rate (all sickness)	3%	4.04%	**4.18%**	**4.31%**	**4.25%**	**4.22%**	**4.17%**	**4.09%**	**TBC**
12 month sickness rate of which is Long Term		2.03%	1.85%	1.83%	1.79%	1.82%	1.86%	1.88%	TBC
12 month sickness rate of which is Short Term		2.01%	2.33%	2.48%	2.46%	2.39%	2.31%	2.21%	TBC
Monthly Sickness Absence % All Sickness		2.49%	4.75%	572.00%	4.06%	0.04	4.13%	3.43%	TBC

	KPI	May-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23
% staff appraisal compliant	90%	**81.69%**	80.56%	**82.55%**	**84.59%**	**83.97%**	**83.90%**	**86.18%**	**85.46%**
% staff appraisal compliant AfC only		83.78%	81.92%	84.27%	85.86%	84.91%	**84.66%**	**86.93%**	**85.85%**
% staff appraisal compliant M&D		70.48%	73.41%	73.56%	77.36%	78.95%	**79.76%**	**81.88%**	**83.33%**
Statutory & Mandatory Training	90%	90.69%	**92.16%**	**91.32%**	**91.08%**	**90.62%**	**91.75%**	**92.83%**	**93.04%**
Statutory & Mandatory Training Bank only			81.37%	81.93%	81.32%	78.67%	**81.70%**	**82.48%**	**83.15%**
Statutory & Mandatory Training AfC only		92.14%	93.70%	92.82%	92.76%	91.94%	**92.63%**	**93.80%**	**94.22%**
Statutory & Mandatory Training M&D		84.35%	85.48%	84.80%	83.12%	84.76%	**87.77%**	**88.22%**	**87.65%**

Staff Engagement (National Quarterly Pulse Survey)	2023/24 Qtr. 1 (141 responses) 7.0 out of 10	2022/23 Qtr. 2 (159 responses) 7.3 out of 10	2022/23 Q3. National Staff Survey 7.4 out of 10	2022/23 Qtr. 4 (145 responses) 7.0 out of 10

National Quarterly Pulse Survey - Treatment
Quarterly staff survey to indicate likelihood of recommending QVH to friends & family to receive care or treatment

2022-23 National Survey
Strongly Agree/Agree: Strongly disagree/disagree
557 = 92% : 10 = 1%

Recruitment Activity

Queen Victoria Hospital NHS Foundation Trust

	Stage	KPI	Dec	Jan	Feb	Mar	Apr	May	Trend Line
T19	From Advert open to ready to start	45	58.75	67.8	62.7	61	82.85	74.97	
T23	From conditional offer to ready to start	18	38.7	40.65	42.2	38.9	55.15	45.47	
T16	From authorised to ready to start	53	68.85	84.7	80.05	70.2	74.16	77	
T17	From authorised to start date	70	63.7	125.4	70.42	87.33	95.6	87.25	
T1a	Time to authorise	5	4.23	3.07	1.6	0.5	1.7	1	
T1b	From authorised to advert live	2	3.13	3.07	5.3	0.8	3.05	2.3	
T4	Time to shortlist	3	11.43	15.13	9.2	8	11.86	21.88	

Success rates of protected characteristic shortlisted candidates to offer

Gender	Applications Received	Applications Shortlisted	Conditional offers sent	% of offers from shortlisting
Male	91	119	10	8%
Female	159	137	8	6%
Ethnic Origin	**Applications Received**	**Applications Shortlisted**	**Conditional offers sent**	**% of offers from shortlisting**
WHITE - British	20	30	3	10%
WHITE - Any other white background	12	28	1	4%
BLACK or BLACK BRITISH - African	104	48	2	4%
BLACK or BLACK BRITISH - Any other black background	2	5	0	0%
I do not wish to disclose my ethnic origin	3	4	0	0%
Disability	**Applications Received**	**Applications Shortlisted**	**Conditional offers sent**	**% of offers from shortlisting**
No	242	252	6	2%
Yes	6	4	0	0%
Sexual Orientation	**Applications Received**	**Applications Shortlisted**	**Conditional offers sent**	**% of offers from shortlisting**
Heterosexual or Straight	236	241	6	2%
Gay or Lesbian	5	3	0	0%
I do not wish to disclose my sexual orientation	9	8	0	0%

Data highlights	Actions
Recruitment KPIs have improved again with conditional offer to ready to start reducing by 9.68 days in June, however average time to shortlist has increased to 21.88 days – this is attributed the volume of Medical and Dental recruitment.	Quality improvement project group ongoing, has generated some quick wins to be implemented ASAP and some longer term focussed work.
New data this month showing conversion of shortlisted applicants to offered in protected characterstics (gender, ethnic origin, disability and sexual orientation) Data shows males, white, no disability and heterosexual candidates are more likely to be appointed.	Continue to monitor protected characteristic appointed data, support creation of staff networks, work with these networks to improve protected characteristic and unconscious bias awareness in recruitment. Review reporting so provides greater insight; in month data for number of applications/shortlisting/offers does not provide picture of success rate for applicants as an individual's recruitment journey covers more than one month.
Highest volume of adverts placed for agenda for change was in Operational Nursing at 24.15 WTE (burns 8, and ITU 6.81 with other areas at 3 or below WTE). Highest in medical and dental was within MaxFax at 4.55.	Form building is ongoing but slowed down due to lack of resource for intensity of work, this is being looked at as part of the QI project group. (Trac starter portal)

Health and Wellbeing

Queen Victoria Hospital NHS Foundation Trust

Highlights
• Developing a Health & Wellbeing /Wellness plan in line with regional and national teams to implement the “we are safe and healthy” NHS People Plan – to include NHS England HWB self-diagnostic actions • May – Accessibility for All: Equality, Diversity & Human Rights Week (8th – 13th), Global Accessibility Awareness Day (18th)

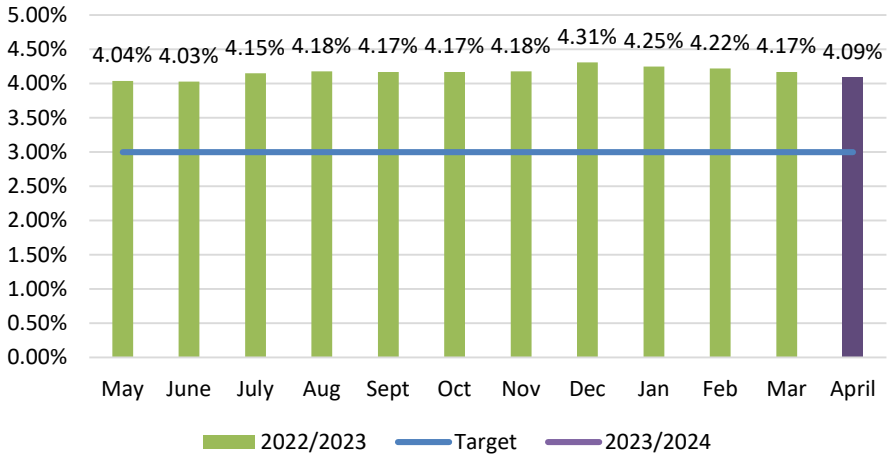
Future initiatives/Successes
Men’s Colleague and Disability Networks being scoped for interest to form – additional questions in National Quarterly Pulse Survey (NQPS) July 2023
Ethnically Diverse Staff (EDS) Network – term of Chairs ended 31 Mar 2023; work to recruit ongoing.
Work with The Hiro Collective to improve the experience of our ethnically diverse staff and those with disabilities has begun, with confidential 1:1 meetings offered to staff
July is Disability Pride Month and NHS75 (5 July)

Action Plan	Update
Implementation of the Best Place to Work Trust-wide project priorities	Key priorities agreed by EMT in Feb 2023 (inc senior leadership links into staff networks, work with staff re views on reward and recognition). Leadership development support commissioned for senior managers.
Scoping for Occupational Health new provider	Procurement of a new provider to commence in December 2023
Scoping for Employee Assistance Provider new provider	Commence specification with procurement in June 2023

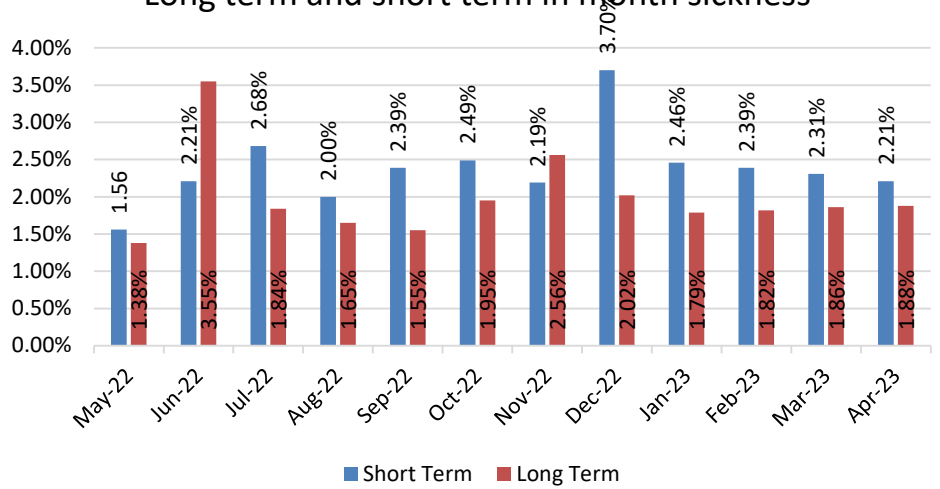
Sickness absence

Queen Victoria Hospital NHS Foundation Trust

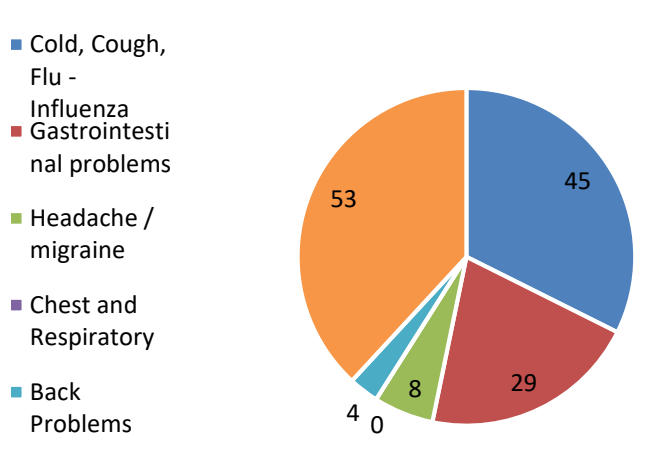
12 month rolling sickness



Long term and short term in month sickness



Short term reasons - 1 month total



Highlights	Hot Spots	Future initiatives/Successes
• 12 month rolling sickness absence has seen a downward trend since Dec 2022 which is anticipated to continue through to the summer months • Short term sickness has decreased by 40% in Apr 2023, with a 53% decrease in cough/cold/flu absences and a decrease seen across all absence reasons • Short term sickness absence due to Covid has decreased by 32% from 28 in Mar to 19 in Apr 2023	• Long term sickness due to anxiety/stress/depression has increased by 12.5% from 8 in Mar to 9 in Apr 2023 • Long term sickness saw a minor increase from 1.86% in Mar to 1.88% in month (Apr)	Targeted activities identified for Day Surgery team and Estates department to address work related stress

Action Plan	Update
Advisory team to triangulate sickness absence with health & wellbeing offerings in conversations with managers and staff in hot spot Business Units	Advisory team arranged catch up meetings with engaged managers
Review NHS England improving attendance toolkit as a benchmark to increase offerings at QVH	

Organisational development & learning and medical education

Queen Victoria Hospital NHS Foundation Trust

Compliance summary data up to 31 May 2023

Organisation	Count	MAST %	Change	PDR %	Change
All QVH (all perm)	1087	**93.04%**	**0.21%**	**85.46%**	**0.71%**
Non-perm (excl. hon & locum)	193	**83.15%**	**0.66%**	**N/A**	**N/A**
AfC (excl. bank)	919	**94.22%**	**0.43%**	**85.85%**	**1.07%**
Medical & Dental (excl. hon & locum)	168	**87.65%**	**0.57%**	**83.33%**	**1.46%**

PDR expiry up to 31 May 2023

Total PDR expired	AfC expired	M&D	Total PDR >3mnths	AfC PDR >3mths	M&D PDR >3mths
162	**131**	**31**	**76**	**59**	**17**

Future initiatives

- 5 requests for bespoke events (Recovery, Hotel Services, RTT Admin, CCU). 3 x 360 facilitation undertaken in May 2023 to support leadership development., 3 coaching requests.
- Developing a leadership framework for QVH, signposting staff to available development across ICS
- Appraisal process to be redeveloped to include heath & wellbeing and career conversations to allow meaningful appraisals with a qualitative focus supporting culture change at QVH
- Investigate ESOL/English Support for staff initiatives based on Bksb assessments received
- Further Enact training to be investigated for all staff on Dignity & respect and Diversity & Inclusion

Highlights

- 22 invited to April Corporate Induction (16 attended, 0 DNA and 4 W/D)
- Of 381 course bookings, 260 attended (68%) 34 DNA (9%) and 67 (18%) W/D
- 6 week British Sign Language course completed, feedback positive
- Promoted ESOL/English Support BSKB tool to all staff at QVH
- There were a large number of applications for the LEEP leadership training so the number of places offered were increased. The first session will take place on 16 June.
- Library staff involved in 'Nurses Day' on 12 May to promote access to a range of resources. It was nice to hear feedback on how the library has supported them.

Hot Spots

- Overdue appraisals

Action Plan	Owner	Due by	Update
Apprenticeship comms to widen participation	KB	July 2023	Connect article case study to be developed to promote inclusive and diverse Apprenticeships at QVH
Appraisal review	AB	July 2023	Work under way re quality assurance. Appraisal form redesigned and will be reviewed in quality context.
Leadership framework	AB	July 2023	Due to changes in funding across SHCP, leadership framework will need to go on hold until further clarity on SHCP initiative/funding had been agreed
Work Experience Placements	KB	Aug 2023	Working with departments to ensure work experience placements have a positive experience at QVH
Library activities	RS	Jul/Aug 2023	To bring back more activities the library such as search training for clinical staff in the lecture theatre on Monday mornings and to explore new ways to support the Trust, underpinning values in the knowledge strategy.

Report cover-page					
References					
Meeting title:	**Board of Directors**				
Meeting date:	**06/072023**		**Agenda reference:**	**60-23**	
Report title:	**Staff survey results**				
Sponsor:	Clare Pirie, director of communications and corporate affairs				
Author:	Clare Pirie, director of communications and corporate affairs				
Appendices:	Appendix one: Staff survey summary				
Executive summary					
Purpose of report:	To provide a summary of the QVH results of the 2022 National NHS Staff Survey with comparison data.				
Summary of key issues	• Headline results are very positive • Staff who declare as black or minority ethnic or disabled are less positive than other groups and there is focussed work ongoing around this				
Recommendation:	The Board is asked to review and note the report.				
Action required	Approval	**Information**	Discussion	Assurance	**Review**
Link to key strategic objectives (KSOs):	**KSO1:**	KSO2:	KSO3:	KSO4:	**KSO5:**
	Outstanding patient experience ✓	***World-class clinical services*** ✓	***Operational excellence*** ✓	*Financial sustainability*	***Organisational excellence*** ✓
Implications					
Board assurance framework:	KSO5. Trust reputation as a good employer and ensuring there are sufficient and well trained staff to deliver high quality care Engaged and motivated staff deliver better quality care (KSO1)				
Corporate risk register:	1291: Corporate Risk - keeping our staff engaged, motivated and supported during a time of great change				
Regulation:					
Legal:	NA				
Resources:					
Assurance route					
Previously considered by:	Private Board pre-publication				
	Date:	March 2023	Decision:		
Next steps:					

Report to:	Board of Directors
Agenda item:	60-23
Date of meeting:	06 July 2023
Report from:	Clare Pirie, director of communications and corporate affairs
Report author:	Clare Pirie, director of communications and corporate affairs
Date of report:	25 June 2023
Appendices:	Appendix one: QVH national benchmark report

NHS staff survey results

Background

The NHS Staff Survey is one of the world's largest workforce surveys and provides a robust benchmarking process for individual trusts. The questions in the NHS Staff Survey are aligned to the People Promise as well as two themes, staff engagement and morale. The People Promise sets out, in the words of NHS people, the things that would most improve our working experience – like health and wellbeing support, the opportunity to work flexibly, and to feel we all belong, whatever our background or our job. The QVH results were considered by the Board in private in March 2023 while under embargo.

Survey process

QVH ran a mixed mode survey, meaning most staff completed the survey online but some specific areas were targeted to receive a paper survey where it was clear that this would support return rates. We surveyed 1081 eligible staff, of these, 609 responded making a 56.4% return, a decrease from 64.5% the year before but still above peer average.

Summary of results

Overall the Trust managed to maintain largely positive survey results in comparison to the national picture in a challenging environment.

Our headline results are very positive:

- 90% of people said care is the Trust's top priority
- 92% would recommend the care the Trust provides to family or friends
- 71% would recommend the Trust as a place to work.

QVH is the highest scoring acute trust in the south of England for staff recommending the Trust as a place to work.

QVH scores are above average for six of the People Promise themes:

- We are compassionate and inclusive
- We are recognised and rewarded
- We each have a voice that counts
- We are safe and healthy
- We are always learning
- We are a team.

The QVH score for the remaining theme, we work flexibly, is average.

More detailed consideration

Looking at the results in relation to the experiences of staff with protected characteristics, shows that those staff who declare as black or minority ethnic or disabled are less positive than other groups.

The results can be broken down into 25 individual departments to give a more granular level of feedback. Each department has been asked to have a discussion on the issues that have come up through these reports to ensure that staff feel heard and that their voices matter. A minimum number of respondents is required for this in order to protect confidentiality, so the results some smaller teams are combined in this level of reporting.

Department level reporting shows some areas of the Trust where staff are less positive; this triangulates with information received through other sources of reporting such as the freedom to speak up guardian or 'Tell Nicky'.

Actions
QVH needs to focus on improving engagement with staff who are disabled and staff who are black or ethnic minority in order to improve the workplace experience. These issues are set out in more detail in our workforce race equality standard (WRES) and workforce disability equality standard (WDES) which have been previously reviewed by the Board. External support has been commissioned to help the Trust gain insight into workforce experience and develop realistic and achievable actions based on what staff tell us is required to make a difference. This work is being reviewed through the finance and performance subcommittee of the Board.

QVH has some teams where staff experience is notably out of line with the overall levels of motivation and engagement. These areas are understood by the executive team and in some cases correlate with higher levels of vacancies, staff turnover and staff raising concerns through various channels. An integrated programme of work is needed to support line managers in these areas, ensure staff know their voices have been heard, and develop specific actions to address the needs of these teams. This will be an early area of focus for the interim chief people officer working with other executive colleagues.

For all teams, the results are considered through performance review meetings, alongside feedback from the team meetings where department level reports have been shared with staff for ideas to inform improvements.

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

Queen Victoria Hospital
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NHS National Staff Survey 2022

Annette Byers, Head of Organisational Development & Learning

Top level summary…

Queen Victoria Hospital
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2022 (vs. 2021) NHS Staff Survey Summary Findings

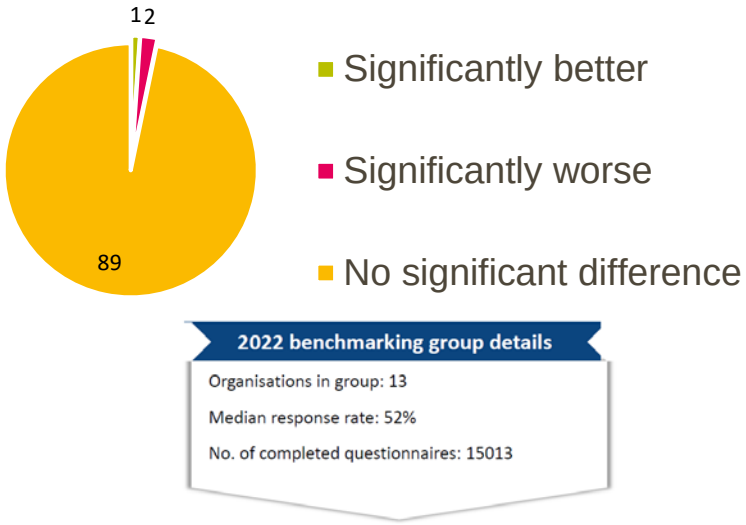
1081 (1056) Invited to complete the survey	**1081**(1053) Eligible at the end of survey	**56%** (64%) Completed the survey 609 (679)	**52%** (54%) Average response rate for similar trusts 13 (14)

A total of **117** questions were asked in the 2022 survey, of these **97** can be positively scored, with **92** of these which can be historically compared to 2021.

2022 vs. 2021: Our views…

71% / **70%**	23c. Would recommend organisation as place to work
92% / **92%**	23d. If friend/relative needed treatment would be happy with standard of care provided by organisation
90% / **88%**	23a. Care of patients/service users is organisation's top priority

Benchmarking…



Results include every question where our organisation had the minimum required 11 respondents.

Bank summary results…

Queen Victoria Hospital NHS Foundation Trust

159 (2021 - N/A) Invited to complete the survey	**22** (14%) AFC Clinical Bank	**23** (14%) AFC Non Clinical Bank	**6** (4%) Bank Medical

Summary…

- Non-clinical bank showed the greatest response rates
- In general, non-clinical bank results are more favourable than clinical bank

Top 3 People Promise themes…

1. PP1: We are compassionate and inclusive
2. PP3: We each have a voice that counts
3. PP5: We are always learning

2022 vs. 2021: Our views…

80%	N/A	27c. Would recommend organisation as place to work
92%	N/A	27d. If friend/relative needed treatment would be happy with standard of care provided by organisation
92%	N/A	27a. Care of patients/service users is organisation's top priority

2022 All QVH findings…

Queen Victoria Hospital NHS Foundation Trust

People Promise elements	All		Ethnicity		Disabled		Gender	
	2022 No=609	2021 No=679	BME No=101	White No=499	Yes No=131	No No=473	F No=462	M No=116
PP 1: We are compassionate and inclusive	7.7	7.7	7.3	7.8	↑ 7.5	7.7	7.7	7.8
PP 2: We are recognised and rewarded	6.2	6.3	↑ 5.9	6.3	↓ 5.9	6.3	↓ 6.2	6.2
PP 3: We each have a voice that counts	7.1	7.2	↑ 6.9	7.2	↓ 6.8	7.2	↓ 7.1	7.4
PP 4: We are safe and healthy	6.5	6.4	↓ 6.4	6.5	5.8	6.7	6.5	6.5
PP 5: We are always learning	5.9	5.7	↑ 6.1	5.8	↑ 5.4	5.9	↓ 5.9	5.6
PP 6: We work flexibly	6.4	6.3	↓ 6.1	6.5	6.1	6.5	6.5	6.4
PP 7: We are a team	7.0	6.9	6.6	7.0	↑ 6.8	7.0	7.0	6.9
Staff Engagement	7.4	7.4	↑ 7.6	7.4	↓ 7.0	7.5	7.4	7.6
Morale	6.2	6.1	↓ 6.2	6.2	5.8	6.3	6.2	6.1

↑ ↓ : 2022 compared to QVH21 results (data from national benchmarking results are weighted and 2021 results have been adjusted in 2022)

Red/**Green** text: Protected characteristics comparison.

Bright Green box: Most improved score out of 10. **Green box**: Best score out of 10. **Red box**: Lowest score out of 10

2022 QVH sub-score results…

RAG: 0.4% point difference compared to All QVH

Section	Q	Description	2021	2022
Element 1: We are compassionate and inclusive	PP1_1	Compassionate culture sub-score	8.0	8.0
	PP1_2	Compassionate leadership sub-score	7.3	7.3
	PP1_3	Diversity and equality sub-score	8.4	8.4
	PP1_4	Inclusion sub-score	7.0	7.2
	PP1	**We are compassionate and inclusive score**	**7.7**	**7.7**
Element 2: We are recognised and rewarded	PP2	**We are recognised and rewarded score**	**6.3**	**6.2**
Element 3: We each have a voice that counts	PP3_1	Autonomy and control sub-score	7.2	7.2
	PP3_2	Raising concerns sub-score	7.1	7.0
	PP3	**We each have a voice that counts score**	**7.2**	**7.1**
Element 4: We are safe and healthy	PP4_1	Health and safety climate sub-score	5.7	5.8
	PP4_2	Burnout sub-score	5.3	5.4
	PP4_3	Negative experiences sub-score	8.1	8.2
	PP4	**We are safe and healthy score**	**6.4**	**6.5**
Element 5: We are always learning	PP5_1	Development sub-score	6.5	6.6
	PP5_2	Appraisals sub-score	4.9	5.1
	PP5	**We are always learning score**	**5.7**	**5.9**
Element 6: We work flexibly	PP6_1	Support for work-life balance sub-score	6.4	6.5
	PP6_2	Flexible working sub-score	6.3	6.3
	PP6	**We work flexibly score**	**6.3**	**6.4**
Element 7: We are a team	PP7_1	Team working sub-score	6.8	6.8
	PP7_2	Line management sub-score	7.1	7.1
	PP7	**We are a team score**	**6.9**	**7.0**
Theme: Staff Engagement	E_1	Motivation sub-score	7.3	7.3
	E_2	Involvement sub-score	7.1	7.1
	E_3	Advocacy sub-score	7.9	8.0
	E_4	**Staff Engagement Score**	**7.4**	**7.4**
Theme: Morale	M_1	Thinking about leaving sub-score	6.3	6.4
	M_2	Work pressure sub-score	5.6	5.6
	M_3	Stressors (HSE index) sub-score	6.6	6.6
	M_4	**Morale score**	**6.1**	**6.2**

Score out of 10

2022 All QVH findings…

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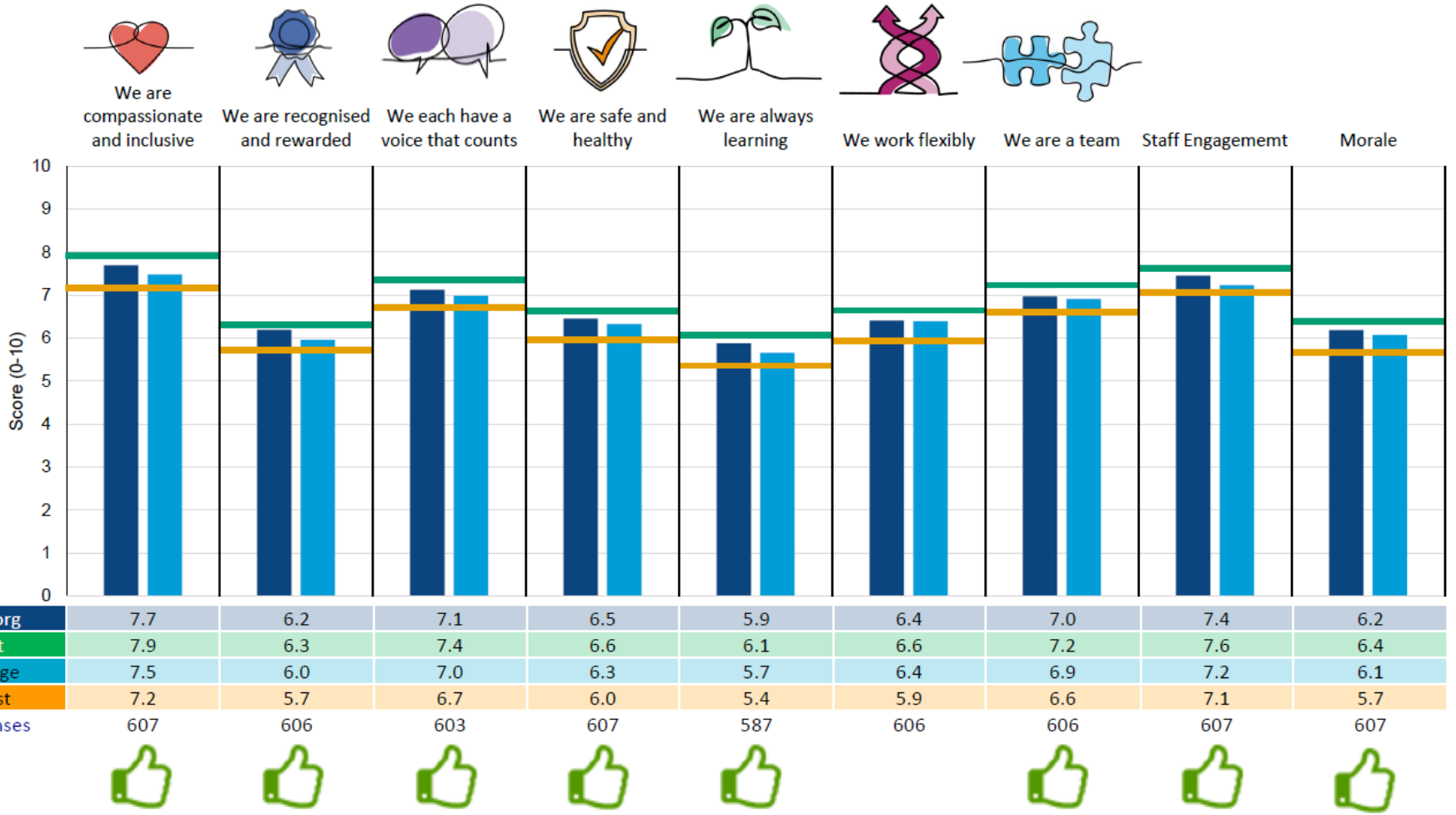

	We are compassionate and inclusive	We are recognised and rewarded	We each have a voice that counts	We are safe and healthy	We are always learning	We work flexibly	We are a team	Staff Engagememt	Morale
Your org	7.7	6.2	7.1	6.5	5.9	6.4	7.0	7.4	6.2
Best	7.9	6.3	7.4	6.6	6.1	6.6	7.2	7.6	6.4
Average	7.5	6.0	7.0	6.3	5.7	6.4	6.9	7.2	6.1
Worst	7.2	5.7	6.7	6.0	5.4	5.9	6.6	7.1	5.7
Responses	607	606	603	607	587	606	606	607	607

QVH results are above average for 6 People Promise elements/themes and average on 1 element

Most improved scores 2022	2022	2021	2020
q7b. Team members often meet to discuss the team's effectiveness	↑ **65%**	59%	56%
q14d. Last experience of harassment/bullying/abuse reported	↑ **56%**	50%	52% (13d)
q30b. Disability: organisation made reasonable adjustment(s) to enable me to carry out work	↑ **85%**	81%	82% (26b)
q3d. Able to make suggestions to improve the work of my team/department	↑ **78%**	74%	76% (4b)
q8c. Colleagues are polite and treat each other with respect	↑ **76%**	72%	70% (4j)
Most improved scores 2021	**2022**	**2021**	**2020**
q13d. Last experience of physical violence reported	↓ **68.4**	**75%**	55%
q11e. Not felt pressure from manager to come to work when not feeling well enough	↑ 79.6	**78%**	71%
q9b. Immediate manager gives clear feedback on my work	↑ 68.7	**66%**	62%

In the last three years we have seen improvements in team effectiveness and respect, people appear to be able to report harassment, bullying and abuse. Staff are involved in making suggestions to improve the work they do. Managers give clear feedback and do not pressure people to attend work when not well enough. Unfortunately, those reporting physical violence has decreased since 2021, but is still higher than 2020

The bold results indicates the year of comparison

Most declined scores 2022	2022	2021	2020
q13d. Last experience of physical violence reported	↓ **68.4**	**75%**	55%
q4c. Satisfied with level of pay	↓ **27%**	33%	34% (5g)
q2c. Time often/always passes quickly when I am working	↓ **75%**	80%	76%
q10b. Don't work any additional paid hours per week for this organisation, over and above contracted hours	↓ **61%**	65%	64%
q11d. In last 3 months, have not come to work when not feeling well enough to perform duties	↓ **51%**	56%	60%
Most declined scores 2021	**2022**	**2021**	**2020**
q3i. Enough staff at organisation to do my job properly	↓ 34%	**35%**	45%
q22b. I am unlikely to look for a job at a new organisation in the next 12 months	↑ 55% (24b)	**53%**	59%
q22a. I don't often think about leaving this organisation	↑ 48% (24a)	**46%**	52%
q4a. Satisfied with recognition for good work	↑ 60%	**59%**	64%
q4d. Satisfied with opportunities for flexible working patterns	↑ 60%	**56%**	60%

Staff are not satisfied with the level of pay, feel there are not enough staff to do their jobs properly and more staff are working additional paid hours over their contracted hours. More staff are working when unwell. However it is positive that more staff want to remain in QVH, with recognition for good work and flexible working

The bold results indicates the year of comparison

*Top 3 biggest changes

All QVH changes over 3%…

Queen Victoria Hospital NHS Foundation Trust

PP	Q	Description	2021	2022	Increase
3	q3a	Always know what work responsibilities are	86.3%	89.5%	3.1%
3	q3d	Able to make suggestions to improve the work of my team/dept	73.6%	77.6%	4.0%
3	q3f	Able to make improvements happen in my area of work	55.5%	58.8%	3.4%
M	q5a	Have realistic time pressures	27.4%	30.6%	3.2%
6	q6b	Organisation is committed to helping balance work and home life	50.2%	53.4%	3.2%
6	q6c	Achieve a good balance between work and home life	57.0%	60.0%	3.0%
7	**q7b**	**Team members often meet to discuss the team's effectiveness**	59.3%	65.3%	6.0%
7/M	q7c	Receive the respect I deserve from my colleagues at work	69.9%	72.8%	3.0%
1	q7h	Feel valued by my team	70.4%	74.1%	3.7%
1	q8b	Colleagues are understanding and kind to one another	70.5%	73.6%	3.1%
1	q8c	Colleagues are polite and treat each other with respect	72.4%	76.2%	3.9%
7	q9b	Immediate manager gives clear feedback on my work	65.6%	68.7%	3.1%
7	q9d	Immediate manager takes a positive interest in my health & well-being	71.4%	75.0%	3.6%
2	q9e	Immediate manager values my work	73.4%	76.6%	3.2%
1	q9h	Immediate manager cares about my concerns	70.7%	74.5%	3.8%
4	q11b	In last 12mths, not experienced musculoskeletal (MSK) problems as a result of work activities	68.4%	72.1%	3.6%
4	q12e	Never/rarely worn out at the end of work	20.6%	23.9%	3.3%
N/A	**q14d**	**Last experience of harassment/bullying/abuse reported**	50.0%	55.8%	5.8%
N/A	**30b**	**Disability: organisation made reasonable adjustment(s) to enable me to carry out work**	80.7%	84.8%	4.1%

PP	Q	Description	2021	2022	Decrease
M	**q2c**	**Time often/always passes quickly when I am working**	79.8%	74.8%	-5.1%
4	**q4c**	**Satisfied with level of pay**	32.9%	27.1%	-5.9%
N/A	q10b	Don't work any additional paid hours per week for this organisation, over and above contracted hours	65.4%	61.0%	-4.4%
4	q11d	In last 3 months, have not come to work when not feeling well enough to perform duties	55.7%	51.4%	-4.3%
N/A	**q13d**	**Last experience of physical violence reported**	75.0%	68.4%	-6.6%

WRES/WDES indicators…

Queen Victoria Hospital NHS Foundation Trust

Ind	Q	2022 WRES indicators: description	Trust n=609	White n=499	W21 n=525	BME n=101	BME21 n=91
5	14a	In the last 12 months how many times have you personally experienced harassment, bullying or abuse at work **from…Patients / service users, their relatives or other members of the public**	**20.5%**	↓ **19.2%**	**20.0%**	↑ **28.0%**	15.4%
6	14b_14c	Percentage of staff experiencing harassment, bullying or abuse **from staff** in last 12 months	**20%**	↓ **18%**	**19.6%**	↓ **30%**	36.0%
7	15	Does your organisation act fairly with regard to career progression / promotion, regardless of ethnic background, gender, religion, sexual orientation, disability or age?	**56.7%**	↓ **59.1%**	**60.8%**	↓ **47.0%**	48.9%
8	16b	In the last 12 months have you personally experienced discrimination at work from any of the following? **Manager / team leader or other colleagues**	**8.3%**	↑ **5.5%**	**5.3%**	↑ **21.8%**	18.3%

Ind	Q	2022 WDES indicators: description	Trust n=609	No n=473	No 21 n=496	Yes n=134	Yes 21 n=135
4a	q14a_q14b_q14c	Percentage of disabled staff compared to non-disabled staff experiencing harassment, bullying or abuse from Patients, Managers or Colleagues	**32.0%**	↑ **28.1%**	**13.5%**	↑ **45.4%**	30.1%
4b	q14d	In the last 12 months how many times have you personally experienced harassment, bullying or abuse at work from…The last time you experienced harassment, bullying or abuse at work, did you or a colleague report it?	**55.8%**	↑ **59.5%**	**47.3%**	↓ **46.3%**	55.8%
5	q15	Does your organisation act fairly with regard to career progression / promotion, regardless of ethnic background, gender, religion, sexual orientation, disability or age?	**56.7%**	↓ **57.4%**	**58.9%**	↓ **55.4%**	57.8%
6	q11e	Have you felt pressure from your manager to come to work?	**20.4%**	↓ **20.0%**	**17.7%**	↓ **22.0%**	31.8%
7	q4b	The extent to which my organisation values my work.	**51.3%**	↑ **54.1%**	**51.8%**	↑ **42.0%**	40.7%
8	q30b	Has your employer made adequate adjustment(s) to enable you to carry out your work?	**84.8%**	**N/A**	**N/A**	↑ **84.8%**	80.7%
9a	E_4	Staff Engagement Score	**7.4**	↑ **7.5**	**7.4**	↓ **7.0**	7.1

↑↓ : 2022 compared to QVH 2021 results

Red/Green text: Protected characteristics comparison RAG

Retention and Covid…

Queen Victoria Hospital NHS Foundation Trust

Staff were asked if they were looking for another job, the table below shows our comparator group results against QVH results for 2020, 2021 and 2022:

Q22d If you are considering leaving your current job, what would be your most likely destination?											
I would want to move to another job within this organisation.		I would want to move to a job in a different NHS Trust /organisation.		I would want to move to a job in healthcare, but outside the NHS.		I would want to move to a job outside healthcare.		I would retire or take a career break.		I am not considering leaving my current job.	
Avg.	QVH	Avg.	QVH	Avg.	QVH	Avg.	QVH	Avg.	QVH	Avg.	QVH
11.2%	8.8%	19.9%	15.3%	5.4%	5.6%	9.0%	9.0%	7.2%	10.6%	48.6%	50.8%
10.9%	7.9%	20.8%	18%	4.9%	5.1%	7.7%	9.1%	7.1%	10.4%	49%	49.5%
11.3%	7.4%	20.5%	17.3%	2.9%	2.8%	5.9%	5.0%	6.7%	9.0%	53%	58.4%

In the 2022 survey, staff were asked three classification questions relating to their experience during the Covid-19 pandemic:

a. In the past 12 months, have you worked on a Covid-19 specific ward or area at any time? 1 ☐ Yes 2 ☐ No

b. In the past 12 months, have you been redeployed due to the Covid-19 pandemic at any time? 1 ☐ Yes 2 ☐ No

c. In the past 12 months, have you been required to work remotely/from home due to the Covid-19 pandemic? 1 ☐ Yes 2 ☐ No

At QVH there are no significant disparities on staff experience results related to Covid-19 experience, (QVH had no Covid-19 wards).

Free text comments…

Queen Victoria Hospital NHS Foundation Trust

We analysed the **111** free text comments and grouped them into People Promise sub-score headlines. This allows us to triangulate comments with the results:

Areas we do well…

Areas to improve…

Other comments…

On what grounds have you experienced discrimination? - Other, please specify:

2 x Skills/knowledge/experience
3 x Pay/Banding/Career
3 x Health & Wellbeing
4 x Personal reasons

2022 – Our top 3 priorities…

Queen Victoria Hospital NHS Foundation Trust

Linking results to the People Promise, in-depth data tells us we need to focus on:

1. **PP1: We are compassionate and inclusive (Diversity & Equality)**
   Although QVH's highest score, we need to look at the experience of staff with protected characteristics (WRES/WDES), in particular:
   - Discrimination from patients/service users
   - Discrimination from manager/team leader or other colleagues
   - Acts fairly towards career progression

2. **PP3: We each have a voice that counts**
   Although some areas improved, we can declined results are around freedom to act and raising concerns, in particular:
   - Choice in how to do their work
   - Feel secure raising concerns about unsafe clinical practice and confidence that QVH would address them

3. **PP5: We are always learning**
   Appraisal sub-score was QVH's biggest improvement in 2022, but our lowest score:
   - Increase in staff feeling valued and giving them clear objectives
   - Decrease in 'Appraisal helped me to do my job'

These align closely with what the bank staff are telling us (PP1, PP3, PP5)

Report cover-page					
References					
Meeting title:	Board of Directors				
Meeting date:	6/7/2023		**Agenda reference:**	**61-23**	
Report title:	Financial, operational and workforce performance assurance				
Sponsor:	Paul Dillon-Robinson, Non-executive director, Chair of Finance & Performance Committee				
Author:	Paul Dillon-Robinson, Non-executive director, Chair of Finance & Performance Committee)				
Appendices:	N/A				
Executive summary					
Purpose of report:	Assurance on financial, operational and workforce performance as discussed at the latest Finance & Performance Committee (26 June 2023)				
Summary of key issues	Operational performance; Good progress on developments within theatre utilisation and outpatients noted. Discussions also held on impact of industrial action Workforce; Work on WRES/WDES action plan noted, as well as commitment on appraisals Finance; Break-even reported year-to-date and forecast, but income from elective activity is key risk Other: Various surveys on estates require capital prioritisation				
Recommendation:	The board is asked to note the matters discussed and seek further clarification.				
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:	KSO3, KSO4 and KS05 are relevant to this area. No BAFs were reviewed, given the work being done to revise them				
Corporate risk register:	Corporate risks allocated for oversight by the committee were reported upon and deep dives undertaken on two				
Regulation:	Some KPIs link into the oversight framework of reporting to NHSE and CQC. Issues within Estates have regulatory impacts				
Legal:	No specific legal implications				
Resources:	Resources are fundamental to the delivery of performance				
Assurance route					
Previously considered by:	Finance and performance committee				
	Date:	26/06/23	Decision:		
Next steps:	NA				

Report to:	Board of Directors
Agenda item:	Financial, operational and workforce performance assurance
Date of meeting:	6 July 2023
Report from:	Paul Dillon-Robinson, Non- executive Director and Committee Chair
Report author:	Paul Dillon-Robinson, Non- executive Director and Committee Chair
Date of report:	26 June 2023
Appendices:	None

Financial, operational and workforce performance assurance report

Introduction
This report covers the matters discussed at the Finance & Performance Committee meeting on Monday 26 June 2023.

The committee has moved to a new format of papers, where there is a summary paper from each of the leads; on operations, workforce and finance (2/3 pages) that highlights the main issues / assurances. A separate data pack is available as an appendix. In principle, it was agreed, that this data pack should contain management information that is already generated for management purposes.

Executive summary
Operational performance: The committee noted the key performance indicators on cancer and progress against the target to achieve zero 65ww (and 78ww).

Good progress is being made on developments to improve performance in both theatre utilisation (e.g. on the day cancellations, late starts) and outpatient transformation, with the need to embed these so that productivity is increased as a key cornerstone of the trust's future sustainability.

Discussion was held on the link between achieving activity (to plan, by value weighted activity) and the generation of income (particularly the elective recovery fund). The loss of activity due to industrial action was noted, as well as the efforts to reschedule patients as effectively as possible.

The Trust's total waiting list size continues to grow, and a validation exercise is underway to substantiate this.

Workforce: The development of an action plan to address issues arising from the most recent WRES and WDES reports was welcomed, ensuring that it also addressed related staff themes.

Progress against the requirement for annual appraisals was noted, along with the clear focus from senior management on this matter.

Finance: The Trust continues to report a break-even position both year-to-date and forecast to the year-end. The main risk to this is around income, linked to activity (see above).

There was a separate agenda item on patient level information costing systems and the committee was keen to see this information being used to inform reviews of service lines.

Estates update: The committee received an update on the results of recent surveys of the estate, as well as on fire safety and electrical services. These were to be discussed at EMT and plans for capital prioritisation would be brought to the next committee meeting.

Risk deep dives: The committee reviewed a risk deep dive into recruitment and retention within perioperative services and received assurances that, although difficult and complex, there were sufficient staff for the full theatre suite. It sought further assurance on the frequency of staff forgoing training / management time to cover theatres.

The committee also agreed with the new wording for the financial sustainability risk.

Recommendation
The Board is asked to **note** the matters above and discuss any issues.

Report cover-page					
References					
Meeting title:	Board of directors				
Meeting date:	06/07/2023		**Agenda reference:**	**62-23**	
Report title:	Digital committee assurance				
Sponsor:	Kevin Gould, Committee Chair				
Author:	Ellie Simpkin, Governance officer				
Appendices:	None				
Executive summary					
Purpose of report:	The purpose of the report is to provide assurance on matters considered and discussed by the digital committee at its meeting on 19 June 2023.				
Summary of key issues	• The committee supports aligning the final approval of the digital strategy with other Trust-wide strategies being developed in parallel. • Phase 1 of the IT infrastructure programme was on scheduled to be completed in June 2023. There is a risk associated with the delivery of phase 2b due to the delay in the finalisation of the capital programme. • Work continues on the EPR benefits development, ensuring that national requirements will be met. • The committee received an update on the funding positon for the EPR programme and reviewed the programme specific risks.				
Recommendation:	The Board is asked to **note** the contents of the report.				
Action required	Approval	Information	Discussion	**Assurance**	Review
Link to key strategic objectives (KSOs):	**KSO1:**	**KSO2:**	**KSO3:**	**KSO4:**	**KSO5:**
	Outstanding patient experience	***World-class clinical services***	***Operational excellence***	***Financial sustainability***	***Organisational excellence***
Implications					
Board assurance framework:	Corporate risks related to digital				
Corporate risk register:	Digital corporate risks to be reviewed by the committee going forwards.				
Regulation:	None				
Legal:	None				
Resources:	None				
Assurance route					
Previously considered by:	Digital committee				
	Date:	19/06/23	Decision:		
Next steps:	N/A				

Report to:	Board Directors
Agenda item:	62-23
Date of meeting:	6 July 2023
Report from:	Kevin Gould, committee Chair
Report author:	Ellie Simpkin, governance officer
Date of report:	22 June 2023
Appendices:	None

Digital committee assurance

Introduction

This purpose of this report is to provide the Board with assurance on matters considered by the digital committee at its meeting on 19 June 2023.

Digital strategy

The committee received assurance on the development of a digital strategy. The draft outline strategy was being discussed at a session with key stakeholders before wider engagement. The committee supported the suggestion that the timeline for final approval should be aligned with other Trust-wide strategies which are being developed in parallel.

Digital programmes

The committee received updates on the IT infrastructure and electronic patient record (EPR) programmes.

The committee received assurance that phase 1 of the IT infrastructure programme was on scheduled to be completed in June 2023. There is a risk associated with the delivery of phase 2b due to the delay in the finalisation of the capital programme allocation for 2023/24.

With regard to EPR, work is continuing on the benefits development, ensuring that national requirements will be met. The committee was pleased to note that the chief nursing information officer is now in post and having a positive impact on clinical engagement.

EPR

The committee received reports on the following EPR related matters:

Update on Frontline Digitisation funding

Work continues with the QVH EPR programme team and NHS England central team on the funding allocations, the profile of spend and the timelines for EPR procurement. It is anticipated that a revised profile for QVH Frontline Digitisation funding will be provided in July.

Shared procurement approach

The committee considered the opportunities for much closer alignment and collaborative working with the ICS acute partners for procurement of an EPR. It was agreed that alignment would be of benefit, being mindful of the deadlines and funding constraints. Exploration and discovery work will commence, ensuring that any risks are clearly defined and mitigated as necessary.

Risk

Programme specific risks related to the EPR programme include a lack of engagement with end users, the releasing internal resources to support the project, delays in the procurement process, insufficient clinical engagement and the risk to costs and funding.

Recommendation

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