Bundle Public Board 2 May 2024

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Assurance
11-24 Audit and risk committee assurance

12.24 Financial, workforce and operational performance assurance
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Assurance
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Assurance
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14.24 Workforce performance report
Helen Edmunds, Chief People Officer
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16.24 Quality and safety assurance
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17.24 Annual review of learning from patient stories
Nicky Reeves, Chief Nursing Officer
Assurance
17-24 Learning from patient stories

18.24 Quality and safety report
Nicky Reeves, Chief Nursing Officer
Tania Cubison, Chief Medical Officer
Assurance
18-24 Quality and safety report

19.24 Any other business (by application to the Chair)
Jackie Smith, Trust Chair
Discussion

20.24 Questions from members of the public
We welcome relevant, written questions on any agenda item from our staff, our members or the public. To ensure that we can give a considered and comprehensive response, written questions must be submitted in advance of the meeting (at least three clear working days). Please forward questions to Leonora.may1@nhs.net clearly marked "Questions for the board of directors". Members of the public may not take part in the Board discussion. Where appropriate, the response to written questions will be published with the minutes of the meeting.
Jackie Smith, Trust Chair

Queen Victoria Hospital
NHS Foundation Trust

Business Meeting of the Board of Directors

Thursday 2 May 2024

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

MEMBERSHIP
BOARD OF DIRECTORS
May 2024

Members (voting):

Trust Chair	-	Jackie Smith
Senior Independent Director	-	Karen Norman
Non-Executive Directors	-	Paul Dillon-Robinson
	-	Peter O'Donnell
	-	Shaun O'Leary
	-	Russell Hobby
Chief Executive Officer	-	James Lowell
Chief Medical Officer	-	Tania Cubison
Chief Nursing Officer	-	Nicky Reeves
Chief Finance Officer	-	Maria Wheeler

In full attendance (non-voting):

Chief Strategy Officer	-	Abigail Jago
Chief People Officer	-	Helen Edmunds
Chief Operating Officer	-	Kirsten Timmins
Company Secretary	-	Leonora May

Annual declarations by directors 2024/25

Declarations of interests

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

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

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

Register of declarations of interests

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

Karen Norman Non-Executive Director	Visiting Professor, School of Nursing, Allied and Public Health, Faculty of Science, Social Care and Education, Kingston University Visiting Professor, Doctorate in Management Programme, Complexity and Management Group, Business School, University of Hertfordshire	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 Chief Medical Officer	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 Nursing Officer	Nil	Nil	Nil	Trustee of McIndoe Burns Support Group	Nil	Nil	Nil	Nil
Other members of the board (non-voting)								

Abigail Jago Chief Strategy Officer	Nil	Nil	Nil	Nil	Nil	Nil	Nil	Nil
Helen Edmunds Chief People Officer	Nil	Nil	Nil	Nil	Nil	Nil	Nil	Nil
Kirsten Timmins Chief Operating Officer	Nil	Nil	Nil	Nil	Nil	Nil	Nil	Nil

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
James Lowell Chief Executive Officer	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Paul Dillon-Robinson Non-Executive Director	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Karen Norman Non-Executive Director	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Peter O'Donnell Non-Executive Director	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Shaun O'Leary Non-Executive Director	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Russell Hobby Non-Executive Director	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Tania Cubison Chief Medical Officer	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 Nursing Officer	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Other members of the board (non-voting)							
Abigail Jago Chief Strategy Officer	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Helen Edmunds Chief People Officer	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Kirsten Timmins Chief Operating Officer	N/A	N/A	N/A	N/A	N/A	N/A	N/A

Queen Victoria Hospital
NHS Foundation Trust

Business meeting of the Board of Directors
Thursday 2 May 2024
10.00-12.00

Agenda: session held in public		
WELCOME		
1-24	**Welcome, apologies and declarations of interest** *Jackie Smith, Trust Chair*	
STANDING ITEMS		**Purpose**
2-24	**Patient story**	*Assurance*
3-24	**Draft minutes of the public meeting held on 7 March 2024** *Jackie Smith, Trust Chair*	*Approval*
4-24	**Matters arising and actions pending from previous meetings** *Jackie Smith, Trust Chair*	*Review*
5-24	**Chair's report** *Jackie Smith, Trust Chair*	*Assurance*
6-24	**Chief Executive's report** *James Lowell, Chief Executive Officer*	*Assurance*
GOVERNANCE, STRATEGY AND RISK		
7-24	**Guardian of Safe Working report** *Jennifer O'Neill, Guardian of Safe working*	*Assurance*
8-24	**Company Secretary's report** *Leonora May, Company Secretary*	*Assurance/ approval*
9-24	**NHS Sussex Committee in Common Terms of reference** *James Lowell, Chief Executive Officer* *Leonora May, Company Secretary*	*Approval*
10-24	**Board assurance framework and corporate risk register** *Leonora May, Company Secretary* *Nicky Reeves, Chief Nursing Officer*	*Assurance*
11-24	**Audit and risk committee assurance** *Paul Dillon-Robinson, Non-Executive Director and committee Chair*	*Assurance*
Key strategic objective 3: operational excellence		
12-24	**Financial, workforce and operational performance assurance** *Peter O'Donnell, Non-Executive Director and committee Chair*	*Assurance*

13-24	**Operational performance report** *Kirsten Timmins, Chief Operating Officer*	*Assurance*
Key strategic objective 5: organisational excellence		
14-24	**Workforce performance report** *Helen Edmunds, Chief People Officer*	*Assurance*
Key strategic objective 4: financial sustainability		
15-24	**Financial performance report** *Maria Wheeler, Chief Finance Officer*	*Assurance*
Key strategic objectives 1 and 2: outstanding patient experience and world class clinical services		
16-24	**Quality and safety committee assurance** *Shaun O'Leary, Non-Executive Director and committee Chair*	*Assurance*
17-24	**Annual review of learning from patient stories** *Nicky Reeves, Chief Nursing Officer*	*Assurance*
18-24	**Quality and safety report** *Nicky Reeves, Chief Nursing Officer* *Tania Cubison, Chief Medical Officer*	*Assurance*
Meeting closure		
19-24	**Any other business (by application to the Chair)** *Jackie Smith, Trust Chair*	*Discussion*
Members of public		
20-24	**Questions from members of the public** *We welcome relevant, written questions on any agenda item from our staff, our members or the public. To ensure that we can give a considered and comprehensive response, written questions must be submitted in advance of the meeting (at least three clear working days). Please forward questions to Leonora.may1@nhs.net clearly marked "Questions for the board of directors". Members of the public may not take part in the Board discussion. Where appropriate, the response to written questions will be published with the minutes of the meeting.* *Jackie Smith, Trust Chair*	
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 7 March 2024** **Education centre, QVH**	
Present:	Jackie Smith	Trust Chair (voting) (Chair)
	Paul Dillon-Robinson (PDR)	Senior independent director (voting)
	Shaun O'Leary (SOL)	Non-executive director (voting)
	Russell Hobby (RH)	Non-executive director (voting)
	Peter O'Donnell (POD)	Non-executive director (voting)
	James Lowell (JL)	Chief executive officer (voting)
	Maria Wheeler (MW)	Chief finance officer (voting)
	Nicky Reeves (NR)	Chief nurse (voting)
	Tania Cubison (TC)	Medical director (voting)
	Robert Stevens (RS)	Interim chief people officer (non-voting)
	Kathy Brasier (KB)	Interim Director of operations (for Chief operating officer)
In attendance:	Leonora May (LM)	Company secretary (minutes)
Apologies:	Karen Norman (KN)	Non-executive director (voting)
	Clare Pirie (CP)	Director of communications and corporate affairs (non-voting)
	Kirsten Timmins (KT)	Chief operating officer (voting)
	Abigail Jago (AJ)	Chief strategy officer (non-voting)
Members of the public:	Eight governors and four members of staff (one for the staff story)	

155-24 **Welcome, apologies and declarations of interest**

The Chair opened the meeting welcoming members of the Board, and those observing the meeting including eight governors and four members of staff.

The Chair reminded those observing the meeting that they were not invited to participate in discussions and that there will be an opportunity for governors to ask questions at the end of the meeting.

Apologies were received from KN, AJ, CP and KT and the meeting was declared as being quorate. KB was in attendance on behalf of KT.

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

156-24 **Staff story**

The Chair welcomed one of the Trust's nurses who joined the meeting to talk about her experience as a member of staff at QVH including the apprenticeship she has undertaken.

The member of staff explained that she started her nursing associate apprenticeship just after the national training opportunity was created, and she has gone on to complete her full nursing degree whilst working at QVH. She spoke about how she has embraced opportunities to learn as part of her training, including volunteering in Eastbourne District Hospital during Covid, the only nursing associate in the intensive care unit. She is now supporting her own students with their studies. She shared the view that QVH is a great place to work and she has been well supported throughout her training.

The Board thanked the member of staff for sharing their experience of working at QVH and consideration was given to whether there is an opportunity to improve and increase the take up of apprenticeships at QVH. The member of staff confirmed that there is appetite for that amongst clinical staff members, however funding is needed to make is accessible. NR confirmed that consideration is being given to opening up the opportunity to more members of staff.

157-24	**Draft minutes of the public meeting held on 11 January 2024** The Board **agreed** that the minutes of the public Board meeting held on 11 January 2024 are a true and accurate record of that meeting and **approved** them on that basis.
158-24	**Matters arising and actions pending from previous meetings** 80-23 (performance dashboard) JL updated that the revised performance dashboard will be available at the May Board meeting. The action will be updated.
159-24	**Chair's report** JS presented her Chair's report to the Board, reporting that she had enjoyed recent service visits with governors, and that she and JL had an interesting discussion with Kent ICB colleagues. In response to a question, JS confirmed that Kent ICB are supportive of the Trust's strategic direction. The Board **noted** the contents of the report.
160-24	**Chief Executive's report** JL presented the report to the Board, highlighting the following: - QVH is excelling in waiting times for sleep services and improvements have been made regarding waiting time for head and neck cancer patients. The Trust remains focussed on clearing the cancer backlog - The Trust is currently undertaking a process to validate patients on waiting lists per best practice - Work regarding redefining the organisation following the recommendations from the well led review conducted by Deloitte is ongoing, including raising the profile of clinical leadership. Triumvirate working, the development of an integrated assurance framework and a revised corporate governance structure are key areas of focus - JL was pleased to welcome KT and HE to the team, and extended thanks to KB and RS for their work including helping the Trust to deliver on a number of key objectives during their time in post - To support the delivery of the improving lives together strategy, leaders across Sussex have agreed to established Sussex Provider Collaboratives and a Committee in Common The Board considered and discussed the updates as follows: - The Board welcomed KT and HE to the team - A Board member asked about the benefits of the Committee in Common for QVH. In response, JL explained that the Committee in Common structure enables QVH to have an equal voice in system discussions and for QVH to support system transformation work; a key consideration will be how we deliver clinical services. The first meeting will be held during Q1 of 2024/25 and the Board will be asked to approve the terms of reference at its next meeting - A Board member thanked JL and the team for the work on waiting list validation, and emphasised the importance of transparency and visibility in order to address any issues arising from the work - Discussion was had regarding the fire safety enforcement notice and the Board raised concern about issues being brought to attention by external bodies which the Trust should have known about. The Board agreed that the completion of actions before 3 June 2024 is critical. MW reassured the Board that good progress is being made against the action plan, with fortnightly meetings with the fire service to review progress. The Trust has appointed an authorised fire engineer that is independent and the Finance and performance committee will receive regular compliance reports going forwards The Board **noted** the contents of the report.

161-24	**Developing the future of QVH- clinical service review and defining our local population** JL presented the report to the Board which focussed on the clinical service strategy development and the definition of the local population. He explained that since the last Board meeting, a review of the frontline clinical services has been completed and the outcome of the initial assessment with recommendations for opportunities for consideration are set out within the report as well as the proposed approached for defining the local population. He highlighted engagement as a continued focus for the Trust in the development of the strategy and acknowledged the need for the Trust to increase focus on research and development which is key to the Trust being a centre of excellence. The Board considered and discussed the contents of the report as follows: - The Board agreed that continued clinical engagement is critical - A Board member requested that the resilience of the clinical services is considered further including key person dependencies with assurance regarding meeting supply and demand requirements - Consideration was given to investment, and the Board acknowledged an opportunity to invest in and to improve technology across the organisation, specifically within radiology. The Board noted that further consideration regarding strategic investments will be required within the next phase - A Board member asked is the population definition might overlap with other providers and potentially create conflict. In response, JL acknowledged that the boundaries are blurred but confirmed that providers are collaborating to work well together in the space - The Board raised concern about the perception that the Trust is continuing with all clinical services and the absence of any difficult decisions which may appear at a later date. JL confirmed that none of the services are currently making a financial loss and that the Trust's service benchmark well against others. He highlighted an opportunity to explore all services for the benefits of patients instead of being financially driven. He explained that the difficult decision making will be inherent within the next phase with discussions about which services will be commissioned - The Board sought assurance regarding consideration given to the breadth of future opportunities and potentially changing commissioning and partnership landscape. JL QVH is part of a strategic commissioning steering group for the system and that the Trust is also working with specialist commissioners. The Committee in Common for NHS Sussex will be a key driver for discussions - A Board member highlighted the importance of clearly defining what the innovative neighbourhood hub is and how it will add value, including consideration of commercial opportunities. JL confirmed that the minor injuries unit and community diagnostic centre will be key enablers and that the Trust is working closely with primary care partners to ensure that the hub meets the needs of the population The Board expressed thanks to AJ and the executive team for the extensive work and the quality of the report. The Board: - **Approved** the proposed direction of travel for Trust services - **Approved** the proposed approach for the identification of the 'local population' for the purposes of further strategy development
162-24	**Electronic patient record (EPR) business case** MW presented the EPR business case to the Board, reporting that this is a digital transformation for QVH, from using paper records to digitalising them and integrating services. This business case is central to the digital strategy and a key enabler for the Trust's Strategy. The business case amounts to £12.4m in capital investment which has

	been funded centrally by NHS England. She highlighted that this is a big transformation for the Trust and it does come with some risk of disruption but that the team are working to mitigate this. JL confirmed that clinical engagement is key to the EPR being implemented at the Trust and that the Trust has taken on board the learnings from other organisations who have already implemented the way of working. The implementation of EPR will be a key objective for the triumvirate leadership team in the coming year. The Board acknowledged the importance of mitigating the risks associated with the delivery of this transformational piece of work. The Board acknowledged extensive discussions held at Finance and performance committee and private Board meetings with assurance sought and received regarding the development of this business case. The Board **ratified** the EPR business case.
163-24	**Key strategic objectives 2024/25** JL presented the report to the Board, reporting that the integrated assurance framework will be a key enabler in ensuring that the Trust meets its key strategic objectives for 2024/25. He described the approach, stating that there are five major projects to deliver during the year and that caution has been taken to ensure that these are achievable. The report also sets out what will not be a priority during the year. The key strategic objectives will be updated with the publication of the Trust's strategy in September 2024. JL confirmed that the projects and goals will be embedded throughout the business units and directorates to ensure delivery and alignment across the organisation. A key enabler for health inequalities id understanding the ethnicity of the Trust's service users. A Board member noted the annual goal of 95% ethnic coding and asked what the percentage currently is. KB confirmed that this is variable across the organisation but noted the importance of having a baseline and agreed to report back regarding the exact number outside of the meeting. A Board member sought assurance that the Trust has the capacity and capability to deliver the key projects. In response, JL confirmed that the team is building capability for the organisation and that some areas of the business are changing, for example with the introduction of a project management office function. Resource will be allocated to the delivery of the projects and staff will be released from unnecessary bureaucracy The Board noted that the appropriate sub-committees will have regular updates regarding progress against the key projects. The Board welcomed and supported the clear list of strategic projects for the year.
164-24	**Board assurance framework (BAF) and corporate risk register (CRR)** LM presented the report to the Board, reporting that the key updates to the BAF documents since the last presentation to the Board are set out within the BAF summary document at appendix one. The scores for BAFs 4, 5 and 8 have reduced as key actions have been completed. The detail of those is included within the executive summaries. LM confirmed that all BAF documents have been reviewed in detail by the Board sub-committees during February 2024 and that there has been some debate about the risk scores.

	The Board agreed that the BAF reporting has improved and that the executive summaries within the report are helpful, but that there is further refinement required. The Board gave the following feedback: - one Board member suggested that none of the BAF risks should have a target consequence of 5 (severe), because the controls and mitigating actions should reduce this. Discussion was had on this point and the Board noted that the risk assessment matrix describes a 5 rating for consequence as a death which means that where there is still a risk of death, this will remain 5. The descriptors on the assessment matrix will be revisited once the risk appetite work concludes - the executive summaries should surface any key concerns to bring to the sub-committees and Board's attention and the Board agreed the importance of having strategic discussions about the Trust's risk profile The Board: - **confirmed** that the BAF is appropriately focussed on and accurately describes the key risks that may impact on the Trust's ability to deliver its strategic objectives - **noted** the revised corporate risk register.
165-24	**Board effectiveness review** LM presented the report to the Board. She explained that the annual review of Board effectiveness is good practice and recommended by the Code of governance for NHS provider trusts. This is the first part of the Board effectiveness review, and the annual survey will follow. LM reported that the Board's composition is in line with the requirements within the Trust's Constitution, including with the addition of the Chief operating officer being a voting member of the Board and that succession planning is in progress and will be completed by November 2024. The Board: - **Agreed** the contents of the evaluation, noting that it will be referenced in the annual report and accounts 2023/24 - **Approved** the Chief operating officer being a voting member of the Board - **Approved** the revised terms of reference for the Nomination and remuneration, Finance and performance and Quality and safety committee.
166-24	**Annual report on use of Trust seal** LM presented the report and confirmed that the Trust seal has been used once during the year, the details of which are included in the report. The seal was attested by the Trust Chair's and Chief executive officer's signatures as required by the Trust's Standing orders. The Board **noted** the contents of the report.
167-24	**Audit and risk committee assurance** PDR presented the report to Board, reporting that good progress has been made with the procurement for the Trust's internal audit and counter fraud support. PDR confirmed that he had updated the Lead governor and deputy Lead governor by email following the meeting, as there is not yet a governor working group in place for this committee. The Board **noted** the updates.
168-24	**Quality and safety committee assurance** SOL presented the report to the Board, reporting that the interaction between the committee and the governor working group has become more streamlined and that discussions had with governors have been useful.

	SOL highlighted that the main concern for the committee is ongoing issues with microbiological prescribing at QVH. There has been some improvement in recent months including with increased engagement and the recruitment of an antimicrobial pharmacist. The Board noted that the committee will now meet formally bi-monthly and hold seminars in the month's in-between. The Board **noted** the updates.
169-24	**Quality and safety report** NR presented the report to the Board, highlighting that the Trust is recruiting an anti-microbial pharmacist which will be invaluable in addressing antimicrobial prescribing issues. NR reflected on the recent PLACE inspection results, the final report for which was received after the Quality and safety Board report was written. She expressed disappointment with the results of the inspection which saw a reduction in scores for six of the eight domains assessed. Significantly reduced scores were seen within the dementia, disability and food service domains. NR recognises the results and explained that this is not where the Trust wants to be. She explained that estates maintenance work has not always been completed at the standard required and that going forward this will be an area of focus. There were also issues with oversight of the previous PLACE inspection action plan meaning that actions remained outstanding. This will be addressed through the corporate governance review and the executive leadership team will have oversight of the action plan. NR explained that some immediate actions have been completed which include a PLACE task and finish group meeting weekly and the oversight of the action plan by the executive leadership team. Protected meal times have been reinstated and mini PLACE inspections will be restarted involving governors and Board members. The Board **noted** the updates.
170-24	**Financial, workforce and operational performance assurance** POD presented the report to the Board, highlighting the following: - The committee remains concerned about waiting list management issues including clinical harm and validation. The committee awaits an update regarding learning from issues found and actions to be completed in order to be assured in this area - The committee is assured that the Trust is in a good place with performance related to workforce - The committee is pleased with the Trust's breakeven position for year-end but raised concern regarding the capital plan and spend - The committee received a detailed update regarding the action plan to address fire safety concerns Discussion was had regarding the electronic patient records (EPR) business case. POD confirmed that the committee had held three additional meetings to consider the business case and the costs versus benefits. He confirmed that the committee had been assured that clinicians have played a key role in the development of the case. The committee recognise that the delivery of the business case will be challenging given the complexity of the work, and POD confirmed that the committee will have oversight of the delivery plan which should be developed with those challenges in mind. The Board **noted** the updates.
171-24	**Financial performance report**

	MW presented the report to the Board, stating that the Trust is on track to breakeven at financial year end. She explained the capital programme has been a challenge, but work to ensure this is met will start much earlier in 2024/25. The Board noted that business planning for 2024/25 is underway and that the Board will be asked to approve the final business plan ahead of submission. The planning guidance is expected to be published next week. Discussion was had regarding the capital plan. The Board agreed the importance of maintaining quality and effectiveness of capital spend close to the financial year end, noting that the Trust was in the same position this time last year. The Board challenged this position and asked what will make the difference next year. In response, MW confirmed that the team continue to focus on ensuring value for money is obtained and that areas of spend agreed for the next financial year have been brought forward to ensure that it has been utilised. She shared the view that the delivery of the plan had not started early enough this year and in previous years. This is set to change and the incoming associate director of estates and facilities will focus on addressing backlog maintenance from April 2024. The Board **noted** the contents of the report.
172-24	**Workforce performance report** RS presented to the report to the Board and highlighted the positive staff survey results for QVH. The Board commended the introduction of the progress pride lanyards and badges for staff, noting that almost one third of staff have signed the pledge. The Board **noted** the contents of the report.
173-24	**Eliminating sexual misconduct** TC presented the report to the Board which sought support to sign up to the Charter on sexual safety in healthcare. TC confirmed that although there has been no issues found relating to sexual safety at QVH, the Trust remain focussed on considering why this may be the case including development of the freedom to speak up framework and active bystander training. Discussion was had regarding meeting the Charter requirements as follows: - TC confirmed that active bystander training will be rolled out across the whole organisation and will include four options with what to do if something does not feel right; there is no do nothing option. She acknowledged the importance of staff knowing what to do with the information as well as the person receiving the information - In response to a question regarding what the barriers are relating to speaking up about sexual safety, TC thought that this may be partly due to normalisation of certain behaviours and that the active bystander training will help staff to recognise this and call it out, thinking about it in a different way. The women's network is a key focus area but the education will be shared with male staff too - In response to a request from a Board member, NR agreed to undertake an exit interview with the current freedom to speak up guardian with reflections about what the barriers are. The outcome of this will be reported to the Quality and safety committee. **ACTION NR** - RS reiterated the importance and relevance of this Charter to QVH as a surgical centre and acknowledged the powerful impact of breaking the silence The Board **agreed and signed the Charter** for sexual safety in healthcare and **agreed** to the implementation of all of the actions.

174-24	**Operational performance report** KB presented the report to the Board and reported that cancer performance has been a challenge for the Trust during the period but that following an extensive amount of work, the number of patients waiting 62 days has reduced from 55 to 29. She highlighted that there is a small cohort of patients waiting more than 104 weeks currently but that she hopes this will be none at the end of the financial year. The Board were pleased to note the opening of the Local anaesthetic unit which will increase capacity for planned care in the Trust's theatres. KB expressed thanks to the theatre manager and her team for all of their work to make this happen. The Board **noted** the contents of the report.
175-24	**Any other business (by application to the Chair)** The Board acknowledged that this will be KB and RS's last Board meeting as interim Director of operations and interim Chief people officer. JS extended thanks to KB on behalf of the Board for her support and her work during the time in post which has been instrumental in providing the Board with assurance on important operational matters. JS extended thanks to RS on behalf of the Board for his hard work, commitment and dedication to the role which she described as driving positive change for the organisation. The Board acknowledged that CP, Director of communication and corporate affairs, will leave the Trust at the beginning of April for a career break after having been working for QVH for seven years. JS thanked CP for all of her work on behalf of the Board, commenting that she had been dedicated and loyal to QVH and wished her al the best for the future. The Lead governor extended thanks to CP for all of her help in her role as Company secretary. There was no further business and the meeting closed.
176-24	**Questions from members of the public and governors** No questions were received from members of public ahead of the meeting. The Chair invited the lead governor to ask questions regarding any of the items discussed during the meeting on behalf of the governors. The following questions were asked and responses given. Question Are there opportunities for QVH to provide commercial services to generate further income to benefit patient care? Response JL confirmed that there is ambition to consider commercial opportunities for the Trust and this will be included within the Trust's financial strategy Question How can the Council of Governors be assured that the management team are sighted on all issues, given that recently the Council of Governors have been made aware of issues including fire safety and the land sale which they were not previously aware of? Response JL confirmed that management are conducting a review of outstanding issues and missed opportunities and will bring these to the Board's attention as they come to light. Consideration is also being given to why these issues might now be coming to light, and

	what is being done about them as a priority. The sub-committees have oversight of the management of such issues. Question Is the Board content that the EPR business case is robust, given that clinical safety and relation to spoke sites are not mentioned in the report? Why has this report appeared suddenly? Response JS confirmed that Board discussions regarding EPR have been ongoing for a number of years, but that the central funding came through late, hence the submission of the business case. She confirmed that the finance and performance committee have held four meetings to discuss the business case and are content that the risks are well understood with mitigations in place and critical clinical involvement. The Chair thanked governors for observing the meeting and for their questions. There was no further business and the meeting closed.

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	September 2023	80-23	Performance dashboard	Review performance dashboard and present a revised version to the Board	**JL**	~~**11/01/2024**~~ ~~**April 2024**~~ **July 2024**	October 2023: Ongoing work to review the Trust's performance framework Janaury 2024: The operational performance report has been refreshed and the new reporting dashboard is due to be completed in April 2024 April 2024: The Integrated assurance framework will be presented to the Board at its meeting in July 2024	**Not yet due**
2	November 2023	118-23	Gender pay gap report	Provide gender pay gap benchmarking data from other NHS organisations and specialist trusts to the Board	~~**RS**~~ **HE**	~~**April 2024**~~ **July 2024**	January 2024: Deep dive being completed into gender pay gap and will be presented to the finance and performance committee April 2024: the Finance and performance committee received an update during April 2024. Other Trusts will be included in the annual report presented to the Board in July 2024.	**Not yet due**
3	March 2024	173-24	Freedom to speak up	Exit interview to be undertaken with previous freedom to speak up guardian with reflections about issues. The outcome to be reported to the Quality and safety committee.	**NR**	**1 July 2024**	April 2024: Exit interview completed with feedback to the Quality and safety committee Chair. Key learning was related to the time available to carry out the role.	**Closed**

Report cover-page					
References					
Meeting title:	Board of Directors				
Meeting date:	02/05/2024	**Agenda reference:**	**5-24**		
Report title:	Chair's report				
Sponsor:	Jackie Smith, Trust Chair				
Author:	Jackie Smith, Trust Chair				
Appendices:	None				
Executive summary					
Purpose of report:	To update the Board of Directors on Chair, non-executive director and governor activities since the last meeting, as well as provide an update regarding the business of the strategic development committee for assurance				
Summary of key issues	• Governors invited to join Non-executive directors on service visits • The Board and Council of Governors were pleased to welcome Cedi Frederick, Chair of NHS Kent and Medway ICB to the Council of Governors meeting on 22 April 2024 to talk about the system's strategic focus • Public governor election with new governors in post from 5 August 2024 • The strategic development committee had extensive discussion about the development of the clinical strategy, and the critical importance of continued extensive clinical engagement as this work progresses. Cultural change will be critical to the delivery and implementation of the strategy				
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:	NA				
	Date:		Decision:		
Next steps:	NA				

Report to:	Board Directors
Agenda item:	5-24
Date of meeting:	2 May 2024
Report from:	Jackie Smith, Trust Chair
Report author:	Jackie Smith, Trust Chair
Date of report:	24 April 2024
Appendices:	None

Chair's report

Service visits

Since the last Board meeting the non-executive directors have visited the clinical audit and pre-assessment teams. I have continued visiting services with the lead and deputy lead governor. I have visited the sleep and radiology services and enjoyed a visit to theatres with James.

These visits have been completed as part of our ongoing work to connect Board members throughout the organisation, getting to know staff from across the Trust and collecting soft intelligence. Specific issues raised by staff are followed up with executives or escalated through other routes as appropriate. I am pleased to say that governors have been invited to join the Non-executive directors on service visits to get to know more about the Trust and its services and to help in their role of holding the Non-executive directors to account for the performance of the Board.

Other activities

At its seminar on 4 April 2024, the Board continued its effectiveness review with a focus on Board development and understanding relationships and the roles that make up the unitary Board. The Board also considered its role in leadership and setting a positive and inclusive culture and its role in setting an ambitious yet achievable strategy, vision and purpose.

The Board completed cyber security training during April and held the first of two Board risk appetite workshops.

During April, a series of governor working groups were held with the Finance and Performance, Quality and safety and Strategic development committee Chairs, executive leads and governors.

The Board and Council of Governors were pleased to welcome Cedi Frederick, Chair for NHS Kent and Medway ICB to the Council of Governors meeting on 22 April 2024 who talked openly about the system's strategic focus and ensuring the best quality care for patients across Kent and Medway.

I continue to meet regularly with our lead governor and deputy lead governor to discuss key issues. Other meetings include my regular catch ups with the Sussex ICB Chair and my other fellow Chairs within the region. With the Committee in Common about to start, continued close engagement is vital.

Governors

We held our first informal meeting of the Council of Governors during April which was an opportunity for governors to get to know each other and the Board better and to raise questions or concerns that they have. These meetings will continue and are an important part of relationship building and supporting governors in their role. During May we will hold a governor development day for all governors.

At its meeting on 22 April 2024, the Council of Governors approved an election to fill some of our ten public governor vacancies, with public governors starting in post from 5 August 2024. I am looking forward to meeting prospective governors in the near future, and I would encourage people from all backgrounds and experiences to put themselves forward, as it is important to us that our Council of Governors is representative of the diverse populations that we serve.

Strategic development committee

Key agenda items

- Clinical strategy
- Health inequalities strategy

Alert

- Extensive discussion was had regarding the development of the clinical strategy, and the critical importance of continued extensive clinical engagement as this work progresses. Cultural change will be critical to the delivery and implementation of the strategy

Assure

- The committee were assured that extensive engagement has been undertaken in developing the Trust's vision and values
- Work is progressing on the nine enabling strategies which are on track. Research and innovation is a key focus area with input from clinicians
- The committee had early sight of the health inequalities strategy which is in development and supported the direction of travel. The committee will receive a further update in June. The committee recognised that some nuances for QVH and its specialist services as opposed to other acute hospitals
- Work to appoint a partner to support with the implementation of a quality improvement programme is progressing

Advise

- The committee conducted the annual review of its terms of reference and agreed to recommend them to the Board for approval. The quality and safety committee will have oversight of the quality improvement programme development

Risks discussed and new risks identified

The committee discussed an ongoing risk regarding engagement with external stakeholders and commissioners and the importance of ensuring value for money for services. This will be added to the corporate risk register.

The BAFs for key strategic risks 04 and 08 were reviewed and the committee were assured that that good progress is being made against the actions.

Recommendation

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

Report cover-page					
References					
Meeting title:	Board of Directors				
Meeting date:	02/05/2024		**Agenda reference:**	**6-24**	
Report title:	Chief Executive's report				
Sponsor:	James Lowell, Chief Executive Officer				
Author:	Michelle Baillie, acting Associate Director of Communications and Engagement				
Appendices:	Appendix one: media update				
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	This report includes: • Operational performance • Acute Provider Collaborative • NHS Sexual Safety Charter				
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: ***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:					
	Date:		Decision:		
Next steps:					

Report to:	Board Directors
Agenda item:	6-24
Date of meeting:	2 May 2024
Report from:	James Lowell, Chief Executive Officer
Report author:	Michelle Baillie, acting Associate Director of Communications and Engagement
Date of report:	21 April 2024

Chief Executive's report

Operational performance

QVH is excelling in some of our performance domains including the DMO1 diagnostic waiting time where we achieved 94% in February compared to a national average of 74%. From a cancer perspective the Trust is delivering the Faster Diagnosis Standard and achieved 75% vs a 62% national average for 62 day performance in February 2024. The Trust is focussed on reducing long waiting patients in order to ensure no patient waits in excess of 65 weeks by September 2024.

As is best practice, we are continuing to validate patients on our waiting lists.

Strategy development journey

As part of our strategy development work, we have taken the opportunity to review our vision and values which have been in place for over a decade. We want something that represents a modern QVH, reflecting our strategic direction where we will build on our specialist and regional services and also be an active local partner with an innovative neighbourhood offering. We are working with a company called Kaleidoscope Health and Care who have run a series of workshops and an online questionnaire for our staff to share their thoughts on what our new vision and values should look like. We look forward to seeing the final outcomes.

We have also run a series of workshops to help us define our clinical strategy. This will combine with patient focus groups we are hosting to help us make sure the patient voice is central to our clinical strategy considerations.

I would like to thank everyone who has taken the time to get involved – this is a very exciting time for us as an organisation.

Redefining our organisation

As mentioned in previous reports, one of the areas highlighted in the well led review of leadership and governance carried out by Deloitte in 2022/23 was around 'raising the profile of the directorates'. In response to this, we are introducing triumvirate working across our clinical directorates and business units. Each directorate will be led by a clinical director, general manager and head of nursing, with clinical leads and service or ward managers leading the day to day operations of business units.

We have held a number of sessions for staff, particularly those who may be moving directorate, as well as anyone who wanted to know more, as well as a consultation which has now concluded. We will begin introducing this new structure in April/May, recognising it will take time and support to implement fully.

Acute Provider Collaborative

NHS Trusts and Foundation Trusts are bound via the Health and Care Act 2022 to a new duty to collaborate with local partners and a shared duty to promote the Triple Aim.

In Sussex, as part of the system-wide commitment to the delivery of Improving Lives Together, provider organisations have agreed to come together to work as part of two Provider Collaboratives (Community, Mental Health, and Primary Care and Acute).

The aim of the Provider Collaboratives is to look at ways to reduce variation in outcomes and access to services; reduce health inequalities; and ensure originations work together to provide great resilience across the health system, for example through mutual aid.

Last month the Acute Provider Collaborative held its inaugural Elective Co-ordination Centre meeting here at QVH. This partnership initiative is an opportunity for us to work with University Hospitals Sussex NHS Trust, East Sussex Healthcare NHS Trust and Surrey and Sussex Healthcare NHS Trust to look at ways we can really make a difference to people in Sussex needing to access healthcare.

NHS Sexual Safety Charter
I want all colleagues to feel safe and enjoy coming to work. As part of our organisational commitment to this, our Board has signed the NHS Sexual Safety Charter. I want us to be able to actively eradicate sexual harassment and abuse – at work or anywhere else – and for colleagues to know they can speak up and we will do all we can to support them. I encourage colleagues to help us make sure that sexual harassment has no place in our organisation.

Electronic Patient Record (EPR)
After the business case was approved at our last public Board meeting to implement our first Electronic Patient Record (EPR) system, we have been able to secure a significant amount of national funding for the project. The system we have chosen to help us enhance patient care will be Altera's Sunrise EPR which is used by other local trusts. We will be formally kicking off this multi-year programme of work in May.

Team Brief
It is important that colleagues know who our executive leadership team are and have the opportunity to hear directly from them about news and updates about *our* organisation. Our monthly Team Brief session, open to all staff, is a chance to do just that and for colleagues to have the chance to join in the conversation and share their views.

Over the last few months we have been joined by a growing number of colleagues and I was delighted that our April session saw more than 100 join us - our most so far. I realise that not everyone can come to these sessions, including many of our clinical colleagues who are caring for our patients, so are now recording it. I would like to encourage those who missed it to please watch it back as well as asking managers to go through the topics covered in their team meetings and huddles. I hope to see more colleagues at our next brief in May.

Introducing Schwartz Rounds at QVH
Having been involved and benefitted from attending Schwartz Rounds in previous roles, I was pleased to hear that we are introducing them here at QVH. Schwartz Rounds provide a forum where all staff, clinical and non-clinical, can have an open and honest conversation about their work life, led by facilitators and speakers (known as storytellers), with a different topic each time. Importantly, whatever is said in the room stays in the room.

The first QVH Schwartz Round took place on 17 April and it was a privilege to join

the session and hear colleagues share their experiences. Thank you to everyone who has helped bring Schwartz Rounds to QVH, and to our QVH Charity for kindly supporting this.

Facial Palsy awareness week
Here at QVH we have the UK's first and largest expert facial palsy service, treating people with palsy and paralysis from across the country. Feedback from our patients shows how highly regarded the knowledge and skills of our team are, but also how many have struggled with the correct diagnosis before being referred to us.

For facial palsy awareness week in March, ITV Meridian helped us highlight how important it is for clinicians and the public to know what facial palsy is and why an early and correct diagnosis can make a real difference. Thank you to our patient Carol who shared her experience of facial palsy, encouraging those who think they have symptoms to seek help, and Ruben Kannan, Consultant Plastic Surgeon, and Catriona Neville, Extended Scope Practitioner in Facial Palsy, for their involvement in this vital piece.

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

Report to:	Board Directors
Agenda item:	6-24.1
Date of meeting:	2 May 2024
Report author:	Michelle Baillie, acting Associate Director of Communications and Engagement
Date of report:	25 April 2024

QVH media update –February and March 2024

Highlights of the key media coverage QVH received in *February*:

Celebrating apprenticeship week
The theme of National Apprenticeship Week (5-11 February) was 'skills for life' and the journey of one apprentice at Queen Victoria Hospital from cabin crew to CCU, caught the attention of a range of media outlets who helped raise the profile of apprenticeship opportunities at the hospital.

A chance medical emergency in the middle of a flight inspired Lisa Desbruslais to follow her dream of becoming a nurse, and having completed her Nursing Associate apprenticeship, she is now on her second at the hospital, which will enable her to become a qualified nurse.

Lisa was interviewed by BBC South East Today during apprenticeship week, alongside James Lowell, Chief Executive Officer, a former apprentice himself, and Nicky Reeves, Chief Nursing Officer, who explained the range of clinical and non-clinical opportunities. The piece aired on the evening and late news bulletins.

Lisa was also mentioned on the BBC website, NHS England website, Sussex World, More Radio, and the Mid Sussex Times print newspaper

Chemical attacks
Following a chemical attack in Clapham in February, Baljit Dheansa, Consultant Plastic Surgeon, was interviewed by BBC London about the types of injuries that could be sustained from chemical and acid burns. The interview featured on the BBC London evening news on Friday 2 February.

Using services wisely
A power failure at East Surrey Hospital generated a number of media mentions for Queen Victoria Hospital's minor injuries unit, with the public encouraged to use alternatives to A&E to relieve pressure on the hospital. The BBC website and Get Surrey were amongst those to carry the piece.

To coincide with the industrial action that took place at the end of the month, NHS Sussex issued a reminder to the public about using services wisely. The piece featured a video of Nicky Reeves, Chief Nursing Officer at Queen Victoria Hospital, explaining the role of minor injuries units like the one at the hospital.

Highlights of the key media coverage QVH received in *March*:

Raising awareness of facial palsy
For facial palsy awareness week (1-7 March) ITV Meridian featured a piece specifically about the facial palsy service at Queen Victoria Hospital. The theme of the awareness week was 'recognising facial palsy' and the item highlighted the importance of clinicians and the public to know what the condition is and why an early and correct diagnosis can make a real difference. It featured Carol one of the hospital's patients, Ruben Kannan, Consultant Plastic Surgeon, and Catriona Neville, Extended Scope Practitioner in Facial Palsy. It was also on the ITV X website.

Giving children the chance to be themselves
RH Uncovered magazine ran a full page article in its March edition for the East Grinstead area about the Challenging Recreational Experience Weekend (CREW) camp that is funded for by QVH Charity for children who have been a patient at Queen Victoria Hospital. The article explained how one child, Thomas, benefitted from attending the camp last year for the first time and hopes to go again.

On the back of the article, a donor visited the hospital to give a £1,000 donation to help fund CREW camp.

Showcasing Healthcare Scientists
The visit by Victoria Chalker, Deputy Chief Scientific Officer for NHS England, to Queen Victoria Hospital was mentioned by Sussex World. A Clinical Scientist by background, she met some of the hospital's own Healthcare Scientists who provide a range of integral services which make a life-changing difference to the life of patients.

PLACE inspection
Queen Victoria Hospital was mentioned by HSJ (behind the paywall) in an article about Patient-Led Assessments of the Care Environment (PLACE) data. The hospital was mentioned in a list of acute trusts with the worst score for patient food (77%). The article included a quote explaining the score was disappointing and how work is already underway. The Argus also ran an article about the results.

Inspirational women
For International Women's Day (8 March), Royal Star & Garter celebrated the dedication and hard work of some of its female residents throughout their lives. This included Janet, now aged 101, worked with Sir Archibald McIndoe at Queen Victoria Hospital after qualifying as a nurse.

Using services wisely
An unexpected power interruption at East Surrey Hospital again generated a number of media mentions for Queen Victoria Hospital's minor injuries unit. This included GB News, Get Surrey, and MSN News.

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

Report cover-page					
References					
Meeting title:	Board of Directors				
Meeting date:	02/05/2024		**Agenda reference:**	7-24	
Report title:	Guardian of safe working (GOSW) hours report				
Sponsor:	Tania Cubison,Chief medical officer				
Author:	Jennifer O'Neill, Guardian of safe working				
Appendices:	Appendix one: GoSW report Q3 2023/24				
Executive summary					
Purpose of report:	Assurance about Junior Doctor Rotas and working conditions				
Summary of key issues	- Rotas are safe and being monitored, exception reporting and feedback from Junior Doctor Forum are both studied and monitored by GOSW - Out of hours food - this will be resolved with the Trust out of hours frozen food initiative to be implemented shortly - GOSW attended recent Inductions and we are holding a Wellbeing event in April which will be a good welcome to new starters - Quality of Accommodation - continues to be monitored, a need is for QVH wifi to be available for juniors at Meridian Way to check results and emails (the IT department are looking into how best to arrange this) - Consultant level supervision for plastic surgery junior doctors on theatre lists and in clinics is being monitored by the Surgical Tutor and at Deanery level.				
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:	GMC survey, Deanery, BMA				
Legal:	None				
Resources:	None				
Assurance route					
Previously considered by:	N/A				
	Date:		Decision:		
Next steps:	N/A				

Report to:	Board of Directors
Agenda item:	7-24
Date of meeting:	2 May 2024
Report from:	Tania Cubison,Chief medical officer
Report author:	Jennifer O'Neill, Guardian of safe working
Date of report:	03/04/2024
Appendices:	Appendix one: GoSW report Q3 2023/24

Guardian of safe working hours

Introduction
Rotas are safe and wellbeing activity is happening for the junior doctors.

Executive summary
The Guardian of Safe Working has been actively monitoring the rotas and gathering information via exception reports and the Junior Doctor Forum meetings.

Situation
The junior doctor rotas have been safe and any arising issues have been investigated, discussed and now solved. Guardian fines have been levied where applicable.

With regard to working conditions:
1) Food out of hours - this will be resolved with the Trust out of hours frozen food initiative to be implemented shortly. The Guardian fine fund will be used to pay for microwaveable meals used by junior doctors at night.
2) Accommodation - QVH do not own this but feedback and monitor the quality. Currently we are trying to gain Wi-Fi access to the QVH systems for doctors in on call rooms.

A wellbeing event is taking place in April for Junior Doctors and SAS doctors and this will be a good way to welcome the new cohort to QVH. The Guardian fine money continues to be used to fund wellbeing for junior doctors, including welcome packs and fleeces at induction which are very well received.

Consultant level supervision for plastic surgery junior doctors on theatre lists and in clinics has been raised as an urgent issue and is currently being monitored by the Plastic Surgery Surgical Tutor, Director of Medical Education and at Deanery level too. The Trust has a deadline to resolve the issue by end June 2024, otherwise the Deanery will take action.
The next junior doctors forum will take place in June, where there will be another round of junior doctors awards.

Background
GOSW has joined the Equality and Diversity network and taken part in Visions and Values workshop to consider and promote the junior doctor issues and part in the workings of the trust. Also the Guardian notes the Sexual Safety charter and how that will apply to junior doctors who could be vulnerable.

Recommendation
The Board is asked to **note** the above and be assured that there have been no immediate recent Rota safety concerns and the situation is being monitored.

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

Quarter 3 – 1 October to 31 December 2023

Executive summary

Introduction

This report is made jointly by the Guardian of Safe Working (GOSW) Miss Jennifer O'Neill and the specialist work force data provided by Kathleen Ally, Medical Workforce Assistant

High level data for QVH

Number of doctors / dentists in training (total):	70
Number of doctors / dentists in training on 2016 contract (total):	44
Amount of time available in job plan for guardian to do the role:	0.75 PAs / 3 hours per week
Admin support provided to the guardian (if any):	Ad hoc
Amount of job-planned time for educational supervisors:	0.25 PAs per trainee

a) Exception reports (with regard to working hours)

Exception reports by department				
Specialty	No. exceptions carried over from last report	No. exceptions raised	No. exceptions closed	No. exceptions outstanding
Anaesthetics	0	0	0	0
Maxillofacial	0	6	6	0
Orthodontic	0	0	0	0
Plastics	0	9	9	0
Radiology	0	0	0	0
Total	0	15	15	0

Exception Reports for Hours breached or work pattern this Q only

Specialty	No. exceptions raised	No. exceptions outstanding
Anaesthetics	0	0
Maxillofacial	6	0
Orthodontic	0	0
Plastics	8	0
Radiology	0	0
Total	14	0

Exception reports for missed Education and Training this Q only

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

Exception reports by grade				
Specialty	No. exceptions carried over from last report	No. exceptions raised	No. exceptions closed	No. exceptions outstanding
ST3 +	0	12	12	0
CT1-2 / ST1-2	0	3	3	0
Total	0	15	15	0

Exception reports (response time)					
	Addressed within 48 hours	Addressed within 7 days	Addressed 8 to 30 days	Addressed over 30 days	Still open
All grades	3	1	5	6	0

b) Work schedule reviews

We have had no work schedule reviews in this quarter

c) Locum bookings

i) Bank

Locum bookings (bank) by department					
Specialty	Number of shifts requested	Number of shifts worked	Number of shifts given to agency	Number of hours requested	Number of hours worked
Anaesthetics	21.00	21.00	0.00	202.00	202.00
Maxillofacial	42.0	42.00	0.00	417.00	417.00
Orthodontics	0.00	0.00	0.00	0.00	0.00
Plastics	145.00	145.00	0.00	1311.00	1311.00
Total	208.00	208.00	0.00	1930.00	1930.00

ii)

Locum bookings (bank) by grade					
Specialty	Number of shifts requested	Number of shifts worked	Number of shifts given to agency	Number of hours requested	Number of hours worked
CT1-2*	61.00	61.00	0.00	580.50	580.50
ST3 +*	147.00	147.00	0.00	1349.50	1349.50
Total	208.00	208.00	0.00	1930.00	1930.00

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

Locum bookings (bank) by reason*					
Specialty	Number of shifts requested	Number of shifts worked	Number of shifts given to agency	Number of hours requested	Number of hours worked
Vacancy	14.0	14.0	0.00	188.5	188.5
Sickness	38.0	38.0	0.00	414.5	414.5
Increase in workload*	80.0	80.0	0.00	572.0	572.0
Other**	34.0	34.0	0.00	337.5	337.5
Total	166.00	166.00	0.00	1512.50	1512.50

** Increase in workload includes: Additional Clinics/Lists, WLI*

*** Other includes: Annual Leave, On Call, Special Leave, Study leave, Maternity*

Locum bookings (bank) by department and reason					
Specialty	Vacancy	Sickness	Increased Workload*	Other **	Number of shifts
Anaesthetics	0.0	0.0	20.0	1.0	21.0
Maxillofacial	9.0	0.0	2.00	14.0	25.0
Orthodontics	0.0	0.0	0.0	0.0	0.0
Plastics	5.0	38.0	58.0	19.0	120.0
Total	14.0	38.0	80.0	34.0	166.0

** Increase in workload includes: Additional Clinics/Lists, WLI*

*** Other includes: Annual Leave, On Call, Special Leave, Study leave, Maternity*

ii) Agency

Locum bookings (agency) by department				
Specialty	Number of shifts requested	Number of shifts worked	Number of hours requested	Number of hours worked

Anaesthetics	0.0	0.0	0.0	0.0
Maxillofacial	0.0	0.0	0.0	0.0
Orthodontic	0.0	0.0	0.0	0.0
Plastics	0.0	0.0	0.0	0.0
Radiology	0.0	0.0	0.0	0.0
Total	0.0	0.0	0.0	0.0

iii)

Locum bookings (agency) by grade				
Specialty	Number of shifts requested	Number of shifts worked	Number of hours requested	Number of hours worked
CT1-2	0.0	0.0	0.0	0.0
ST3-8	0.0	0.0	0.0	0.0
Total	0.0	0.0	0.0	0.0

Locum bookings (agency) by reason				
Specialty	Number of shifts requested	Number of shifts worked	Number of hours requested	Number of hours worked
Vacancy	0.0	0.0	0.0	0.0
Sickness	0.0	0.0	0.0	0.0
Total	0.0	0.0	0.0	0.0

Locum work carried out by trainees

d) Vacancies

Vacancies by month						
Specialty	Grade	Month 1	Month 2	Month 3	Total gaps (average)	Number of shifts uncovered*
Anaesthetics	ST3+	0.0	0.0	0.0	0.0	
Maxillofacial Core	CT1-2	0.0	0.0	0.0	0.0	
Maxillofacial higher	ST3+	1.0	1.0	1.0	1.0	

Plastic surgery core	CT1-2	0.0	0.0	0.0	0.0	
Plastic surgery higher	ST3+	1.0	0.0	0.0	0.3	
Orthodontics	ST3+	0.0	0.0	0.0	0.0	
Total		2.0	1.0	1.0	1.3	

**Currently non reportable*

e) Fines

Fines by department		
Department	Number of fines levied	Value of fines levied
OMFS	2	£802.91

Fines (cumulative) (See note)			
Total fines levied, as of end of last quarter - since 4/2/21	Fines this quarter	Total disbursements, including this quarter	Fine balance at the end of this quarter
£13567.51	£802.91	£8450.93	£5116.58

Note that the figures and headings in the above table have been revised following a review of the guidance relating to the information that should be provided.

Qualitative information:

The one educational exception report was movement from a training surgical list to cover service provision.

There were two Maxfax pattern exception reports and these referred to staff vacancy shifts that were being covered - by agreement - internally with bank rates being paid. This was discussed at the LFG and resolved.

The Junior Doctor Forum was held on the 23rd October 2023.

Issues arising:

At the Junior Doctor Forum, the on call facilities were discussed with regards to bedding and heating. QVH does not own the on call rooms - although housekeeping changes the bedding - so this has been a negotiation and whilst some improvements have been made, this needs to be monitored.

Supervision of trainees in theatre (in Plastic Surgery there are PlasX lists run independently by trainees) and clinics was discussed and concerns had been raised about clinics where there was no consultant - in plastics - readily available for advice. This has been raised at the Plastic Surgery LFG too.

Induction of the core dental trainees was discussed as there had been some confusion about the hours that they were expected to work and that was clarified.

Summary:

There were no immediate safety concerns. There are not many exception reports this quarter - whether this is due to the rotas working well or a reluctance to fill in exception reports will be monitored and explored by the GOSW going forward.

Report cover-page					
References					
Meeting title:	Board of Directors				
Meeting date:	02/05/2024		**Agenda reference:**	**8-24**	
Report title:	Company secretary's report				
Sponsor:	Leonora May, Company secretary				
Author:	Leonora May, Company secretary				
Appendices:	Appendix one: Scheme of delegation and Standing financial instructions Appendix two: Audit and risk committee Terms of reference Appendix three: Strategic development committee Terms of reference				
Executive summary					
Purpose of report:	This report confirms compliance with the Trust's standard and additional licence conditions for 2023/24, sets out areas on non-compliance with the Code of governance for NHS provider trusts for 2023/24 and seeks approval for changes to the Scheme of delegation and Standing financial instructions and the Audit and risk and Strategic development committee terms of reference.				
Summary of key issues	- The Trust has complied with its standard and additional licence conditions during 2023/24 - Areas of non-compliance with the Code of governance for NHS foundation trusts are set out within the report and include the Senior independent director being Chair of the Audit and risk committee during the year, succession planning, policy for removal of a governor and Chair and NED pay - Changes to the Scheme of delegation and standing financial instructions include: 1. Removal of requirement for spend of more than £250,000 to be recommended to the CFO and CEO by the Finance and Performance committee and Hospital Leadership team 2. Capital/ revenue expenditure limit to require one written quote has been increased to £10,000, and £10,000-£50,000 for three written quotes (the Standing Financial instructions have also been amended) 3. Expenditure limit for responsible directors has increased from £50,000 to £100,000 4. Expenditure limit for charitable funds for the Charity committee has increased from £20,000 to £30,000 5. The limits for leases and credit finance and income credit notes have been updated in line with expenditure limits				
Recommendation:	The Board is asked to**:** - **approve** the changes to the Scheme of delegation and reservation of power and the Standing financial instructions - **note** that the Trust has complied with its standard and additional Licence conditions during 2023/24 - **note** the areas of non-compliance with the Code of governance for NHS provider trusts as set out above - **approve** the Audit and risk committee and strategic development committee terms of reference				
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:	BAF5- compliance
Corporate risk register:	None
Regulation:	Code of governance for NHS provider trusts Standard and additional licence conditions
Legal:	None
Resources:	None
Assurance route	
Previously considered by:	Audit and risk committee 20 March 2024 Strategic development committee 23 April 2024
Next steps:	Annual report and accounts 2023/24

Report to: Board Directors
Agenda item: 8-24
Date of meeting: 2 May 2024
Report from: Leonora May, Company secretary
Report author: Leonora May, Company secretary
Date of report: 19 April 2024
Appendices: Appendix one: Scheme of delegation and Standing financial instructions
Appendix two: Audit and risk committee Terms of reference
Appendix three: Strategic development committee Terms of reference

Company secretary's report

Introduction

This report confirms compliance with the Trust's standard and additional licence conditions for 2023/24, sets out areas on non-compliance with the Code of governance for NHS provider trusts for 2023/24 and seeks approval for changes to the Scheme of delegation and Standing financial instructions and the Audit and risk and Strategic development committee terms of reference.

Scheme of delegation and Standing financial instructions

The Scheme of delegation and reservation of powers and Standing financial instructions have been reviewed to ensure that financial limits are appropriate and that delegation for decision making is appropriate and in line with good governance and best practice.

The proposed changes to these documents were reviewed by the Audit and risk committee at its meeting on 20 March 2024. The Audit and risk committee agreed to recommend the proposed changes to the Board for approval.

A summary of the proposed changes is set out below:

- Removal of requirement for spend of more than £250,000 to be recommended to the CFO and CEO by the Finance and Performance committee and Hospital Leadership team
- Capital/ revenue expenditure limit to require one written quote has been increased to £10,000, and £10,000-£50,000 for three written quotes (the Standing Financial instructions have also been amended)
- Expenditure limit for responsible directors has increased from £50,000 to £100,000
- Expenditure limit for charitable funds for the Charity committee has increased from £20,000 to £30,000
- The limits for leases and credit finance and income credit notes have been updated in line with expenditure limits

The Board is asked to **approve** the changes to the Scheme of delegation and reservation of power and the Standing financial instructions.

Annual review of compliance with Licence conditions 2023/24
The Audit and risk committee received evidence and assurance that the Trust has complied with its standard and additional Licence conditions for 2023/24 at its meeting on 20 March 2024.

The new provider licence took effect from 1 April 2023, and there is no requirement for the Trust to publish a self-certification for 2023/24 in the same way as previous years. It is now up to individual trusts how they report compliance against their licence conditions. Compliance will be reported throughout the Annual report and accounts 2023/24.

The standard NHS licence conditions can be found here. These cover essential requirements such as cooperation, registration with the Care Quality Commission, financial reporting and good governance processes.

On 20 October 2021, following a referral made by the Trust, QVH received a notice of imposition of additional licence conditions from NHS Improvement under section 111 of the Health and Social Care Act 2012. These related to the need for the Council of Governors to implement arrangements to work effectively with the Board and to ensure that the Trust has sufficient and effective Board leadership, capacity and capability.

NHS Improvement identified a risk that the Trust would fail to comply with one or more of the conditions of its Licence, in particular conditions, CoS3, FT4.3 and FT4.5(a), (d), (f) and (g) and FT4.6(a).

The Trust Chair wrote to NHSE during the year reporting progress on compliance with the additional licence conditions. The Governor code of conduct is being updated for approval by the Council of governors during Q1 of 2024/25.

The Board is asked to **note** that the Trust has complied with its standard and additional Licence conditions during 2023/24.

Annual review of compliance with Code of governance for NHS provider trusts 2023/24
The Audit and risk committee received a report regarding compliance with the Code of governance for NHS provider trusts at its meeting on 20 March 2024.

The Code of governance for NHS provider trusts (the Code of governance) was published in October 2022 and has been applicable since 1 April 2023. It replaces the previous NHS foundation trust code of governance issued by Monitor. The Trust must comply with each of the provisions of the code or, where appropriate, explain in each case why it has departed from the code in its Annual report and accounts.

Work to date completed to ensure compliance with the new Code includes:

- The ongoing development of a clear vision and values for the Trust
- A clear statement detailing the roles and responsibilities of the Council of Governors and description of how disagreements between the Board and Council will be resolved has been added to the Scheme of Delegation
- The ongoing development of a succession plan, taking into account future challenges, risks and opportunities facing the Trust, and the skills and expertise required to meet them
- The Council of Governors completed a self-assessment of its effectiveness during Q4 of 2023/24
- The Nomination and remuneration committee has agreed the level and structure of remuneration for executive directors

The Company secretary has undertaken a detailed analysis of each provision of the Code against the Trust's governance framework. Areas in which the Trust has departed from the Code during 2023/24 and will therefore report non-compliance in its Annual report and accounts 2023/24 are set out below:

Code provision	Non-compliance
B.2.5/ D.2.1 The Chair should not sit on the Audit Committee. The Chair of Audit Committee, ideally, should not be the Vice chair or Senior Independent Director.	For a period during 2023/24, the Senior independent director was also Chair of the Audit and risk committee. This was agreed by the Board of Directors and Council of Governors due to new NEDs being in post and the skillset required to undertake both roles. Since then, the roles have been separated. The Trust will explain non-compliance with this provision in its Annual report and accounts 2023/24.
C.2.1 The Nominations Committee(s) should give full consideration to succession planning, taking into account the future challenges, risks and opportunities facing the Trust, and the skills and expertise required within the Board of Directors to meet them.	The Trust's succession plan is in development, however due to changes and pressures within the executive team, the plan will not be implemented until November 2024. The Trust will explain partial non-compliance with this provision in its Annual report and accounts 2023/24.
C.4.9 The Council of Governors should agree and adopt a clear policy and a fair process for the removal of any Governor who consistently and unjustifiably fails to attend its meetings or has an actual or potential conflict of interest that prevents	The Trust's Constitution stipulates that a governor can be removed if they fail to attend three meetings, of they have a material conflict of interest, however the process for removal is not clear within the Constitution or the Governor Code of Conduct. Both of these documents ae currently being reviewed in line with the

the proper exercise of their duties. This should be shared with the Governors.	recommendations from the independent review and the process for removal of a governor will be clearly set out. The Trust will explain partial non-compliance with this provision in its Annual report and accounts 2023/24.
E.2.2 Levels of remuneration for the Chair and other Non-Executive Directors should reflect the ***Chair and Non-Executive Director remuneration structure*** (published by NHS England Dec 2019).	The CoG appointments committee is responsible for setting the Chair and Non-Executive Directors' remuneration. All Non-Executive Directors receive the same remuneration – QVH NED and Chair remuneration at QVH is slightly above NHS England's recommended remuneration. The Trust will explain why the governor led Appointments committee has agreed that the Chair and NEDs at QVH are paid more than currently recommended within the national document within its Annual report and accounts 2023/24

The Board is asked to **note** the areas of non-compliance with the Code of governance for NHS provider trusts as set out above.

Annual review of committee Terms of reference

Audit and risk committee

The Audit and Risk committee reviewed the changes to its terms of reference at its meeting on 20 March 2024 and agreed to recommend them to the Board for approval. The terms of reference will be reviewed further in 2024/25 following publication of revised HM Treasury Audit and risk assurance committee (ARAC) and Healthcare Financial Management Association (HFMA) audit committee handbook best practice guidance.

A summary of the proposed changes is set out below:

- Job titles have been updated
- Chief Executive Officer moved from 'ex-officio' into 'in attendance', meaning that they are routinely invited to attend meetings when required but not expected to attend every meeting

Strategic development committee

The strategic development committee reviewed the changes to its terms of reference at its meeting on 23 April 2024 and agreed to recommend them to the Board for approval.

A summary of the proposed changes is set out below:

- Job titles have been updated
- Removal of specific matters related to finance, work force, digital and the green plan as this is duplication with the Finance and performance committee
- Update of quoracy to two NEDs and one executive

Oversight of the implementation and development of the Trust's Quality improvement methodology will be undertaken by the Quality and safety committee.

The Board is asked to **approve** the Audit and risk committee and strategic development committee terms of reference.

Recommendation
The Board is asked to**:**

- **approve** the changes to the Scheme of delegation and reservation of power and the Standing financial instructions
- **note** that the Trust has complied with its standard and additional Licence conditions during 2023/24
- **note** the areas of non-compliance with the Code of governance for NHS provider trusts as set out above
- **approve** the Audit and risk committee and strategic development committee terms of reference

Queen Victoria Hospital
NHS Foundation Trust

Queen Victoria Hospital NHS Foundation Trust

Reservation of powers and scheme of delegation

Effective from 7 ~~September 2023~~May 2024

1. Introduction

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

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

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

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

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

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, Chief Finance Officer and, Medical Director and 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 on financial performance against budget and the annual business plan.
		2.5.5	All monitoring returns required by the Department of Health and the Charity Commission shall be reported, at least in summary, to the Board.
2.6	**Audit arrangements**	2.6.1	Receive reports of Audit and Risk Committee meetings and take appropriate action.
		2.6.2	Receive the annual management letter from the external auditor and agree action on the recommendations where appropriate of the Audit and Risk Committee.
		2.6.3	Receipt of a recommendation of the Audit and Risk Committee in respect of the appointment of Internal Auditors (note: the recommendation in respect of External Auditors is made by the Audit and Risk Committee to the Council of Governors),
2.7	**Policy determination**	2.7.1	Approve management policies including personnel policies incorporating the arrangements for the appointment, removal and remuneration of Officers.

3. Committee delegation

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

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

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

	Committee	Delegated items	Related documents
3.1	**Audit and Risk committee**	3.1.1 The Committee is authorised by the Board of Directors to: 3.1.1.1 investigate any activity within its terms of reference; 3.1.1.2 commission appropriate independent review and studies;	SFIs 3.2, SO 5.6

		3.1.1.3 seek relevant information from within the Trust and from all Officers; 3.1.1.4 Obtain relevant legal or other independent advice and to invite professional with relevant experience and expertise to attend meetings of the Audit and Risk Committee. 3.1.1.5 Approve specific policies and procedures relevant to the committee's remit; 3.1.2 The purpose of the Committee is the scrutiny of the organisation and maintenance of an Effective system of governance, risk management and internal control. This should include Financial, clinical, operational and compliance controls and risk management systems. 3.1.3 The Committee is responsible for maintaining an appropriate relationship with the Trust's internal and external auditors.	
3.2	**Nomination and remuneration committee**	3.2.1 The Committee is authorised by the Board of Directors to: 3.2.1.1 Appoint or remove the chief executive, and set the remuneration and allowances and other terms and conditions of office of the chief executive 3.2.1.2 Appoint or remove the other executive directors and set the remuneration and allowances and other terms and conditions of office of the executive directors, in collaboration with the chief executive. 3.2.1.3 consider any activity within its terms of reference; 3.2.1.4 seek relevant information from within the Trust; 3.2.1.5 instruct independent consultants in respect of Executive Director remuneration; 3.2.1.6 Request the services and attendance of any other individuals and authorities within relevant experience and expertise if it considers this necessary to exercise its functions.	SFI 10.1, SO 5.6

		3.2.2 On behalf of the Board of Directors, the Committee has the following responsibilities: 3.2.2.1 to identify and appoint candidates to fill posts within its remit as and when they arise; 3.2.2.2 to be sensitive to other pay and employment conditions in the Trust; 3.2.2.3 to keep leadership needs of the Trust under review at executive level to ensure the continued ability of the Trust to operate effectively in the health economy; 3.2.2.4 to give full consideration to and make plans for succession planning for the Chief Executive and other Executive Directors; 3.2.2.5 to sponsor the Trust's leadership development and talent management programmes;	
3.3	**Charity committee**	3.3.1 The Committee will: 3.3.2 Ensure Funds Held on Trust (charitable funds) are managed in accordance with the Trust's SOs and SFIs, as approved by the Board of Directors. 3.3.3 Receive regular reports from the Chief Finance Officer covering: 3.3.3.1 Number and value of funds 3.3.3.2 Purpose of funds 3.3.3.3 Income and expenditure analysis 3.3.4 Approve specific policies and procedures relevant to the committee's remit, and review the Annual Accounts prior to submission to the Corporate Trustee for formal approval 3.3.5 Ensure that the requirements of the Charities Acts and the Charities Commission are met and approve submissions required by regulators and auditors	

3.4	**Quality and Safety committee**	3.4.1 The Board of Directors has delegated authority to the Committee to take the following actions on its behalf: 3.4.1.1 approve specific policies and procedures relevant to the Committee's purpose, responsibilities and duties; 3.4.1.2 engage with the Trust's auditors in cooperation with the Audit and Risk Committee; 3.4.1.3 Seek any information it requires from within the Trust and to commission independent reviews and studies if it considers these necessary. 3.4.2 On behalf of the Board of Directors, the Committee will be responsible for the oversight and scrutiny of : 3.4.2.1 the Trust's performance against the three domains of quality, safety, effectiveness and patient experience; 3.4.2.2 compliance with essential regulatory and professional standards, established good practice and mandatory guidance; 3.4.2.3 Delivery of national, regional, local and specialist care quality (CQUIN) targets.	
3.5	**Finance and performance committee**	3.5.1 The Board of Directors has delegated authority to the Committee to take the following actions on its behalf: 3.5.1.1 Approve specific policies and procedures relevant to the committee's remit; 3.5.1.2 Review, by way of the finance report, the submission of monthly monitoring reports to the regulator; 3.5.1.3 Approve other exception or ad-hoc reports required by the regulator;	

		3.5.1.4 Recommend to the Board the submission of the Trust's annual plan to the regulator; and 3.5.1.5 Seek any information it requires from within the Trust and to commission independent reviews and studies if it considers these necessary. 3.5.2 On behalf of the Board of Directors, the Committee will be responsible for the oversight and scrutiny of the Trust's: 3.5.2.1 monthly financial and operational performance; 3.5.3 The Committee will make recommendations to the Board of Directors in relation to: 3.5.3.1 capital and other investment programmes; 3.5.3.2 cost improvement plans; and 3.5.3.3 Business development opportunities and business cases except for digital business cases.	
3.6	**Strategic Development Committee**	3.6.1 On behalf of the Board of directors, the committee will be responsible for providing strategic oversight and direction regarding the planning and development of the Trust wide organisational strategy including work related to clinical and enabling strategies and strategic projects and programmes. The committee will: • 3.6.1.1 Provide oversight and support to ensure appropriate resourcing and alignment of the strategy development • 3.6.1.2 Provide detailed oversight of the development of enabling strategies which might include but are not limited to digital, estates and facilities and the green plan, making recommendations related to these to the Board	

		• 3.6.1.3 Provide oversight of the implementation and delivery of the Trust strategy and enabling strategies once approved by the Board • 3.6.1.4 Ensure and provide assurance to the Board that the Trust's strategy and enabling strategies align with the strategic ambitions of the NHS locally and nationally • 3.6.1.5 Identify and make recommendations to the Board in relation to strategic communications and engagement • 3.6.1.6 Ensure appropriate consideration of OD and culture requirements in regard to the development and implementation of the strategy • 3.6.1.7 Identify and monitor key strategic risks, issues and mitigations and escalate to the Board • 3.6.1.8 Identify, review and recommend strategic opportunities to the Board 3.6.2 The committee will make recommendations to the Board in relation to strategy, business development opportunities and business cases that are within the scope 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.	

4. Board member delegation

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

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

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

5. Scheme of delegation of powers from standing orders

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

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

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

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

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

6. Scheme of delegation of powers from standing financial instructions

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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
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 (~~recommended by EMT)~~
	£250,001 to £1,000,000	Chief Finance Officer AND Chief Executive Officer ~~(recommended by Hospital Management Team & Finance and Performance Committee OR~~

	Over £1,000,000	~~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 ~~(recommended by EMT)~~ Chief Finance Officer AND Chief Executive Officer ~~(recommended by Hospital Management Team & Finance and Performance Committee OR 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**	**Minimum requirements**
	Up to £105,000	1 Written quote (Authorised by Budget Manager)
	£105,001 to £50,000	3 Written quotes (Authorised by Budget Manager)
	£50,001 to WTO GPA Threshold (contact procurement department for current value)	Competitive Tender Exercise (Level 2 Manager AND Chief Finance Officer)
	Over WTO GPA threshold (see note below – threshold is different for works and non-works)	WTO GPA Directive Requirements (Relevant Director AND Chief Finance Officer)

	~~**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 £50~~25~~,000 but greater than £10~~5~~,000 (less than £10~~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, (when Chief Finance Officer is unavailable, Chief Executive Officer), or Chief Executive (when Chief Finance Officer has commissioned the item or where there is a conflict)

Commented [ML1]: Included in SFIs

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

3.3	**Opening tenders** Electronic tenders received through on line e-Tendering tool.	Head of Procurement or Chief Finance Officer (in absence of Head of Procurement)
4 committing expenditure		

4.1	**Revenue and non-capital works expenditure within approved financial plans or business** plans	
	Up to £5,000	Budget Manager
	Up to £10,000	Level 2 Manager (Officer)
	Up to £1~~5~~00,000	Responsible Director
	Up to £250,000	Chief Finance Officer
	Up to £1,000,000	Chief Finance Officer AND Chief Executive Officer
	Over £1,000,000	Board of Directors
4.2	**Approval of purchase invoices for revenue and capital**	
	Up to £5,000	Budget Manager
	Up to £10,000	Level 2 Manager (Officer)
	Up to £10~~5~~0,000	Responsible Director
	Up to £250,000	Chief Finance Officer
	Up to £1,000,000	Chief Finance Officer AND Chief Executive Officer
	~~Unlimited~~Over £1,000,000	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 £250,000 Leases/ arrangements £250,000 to £1,000,000 Leases/ arrangements over £1,000,000 ~~£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)~~	 Chief Finance Officer Chief Finance Officer AND Chief Executive Officer ~~Deputy Chief Finance Officer~~ Board of Directors ~~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) Up to £250,000 £250,000 to £1,000,000 and signing of Landlord and Tenant Act notices relating to the acquisition or granting of leases Over £1,000,000 ~~Where annual charge does not exceed £10,000 and term does not exceed five years~~ ~~Where annual charge exceeds £10,000 or term exceeds 5 years~~ ~~Signing of Landlord and Tenant Act notices relating to the acquisition or granting of leases~~	 Chief Finance Officer Chief Finance Officer AND Chief Executive Officer Board of Directors~~Associate Director of Estates~~ ~~Associate Director of Estates~~ ~~Chief Finance Officer~~

		~~Associate Director of Estates & Chief Finance Officer~~
4.5	**Condemning and disposal** Items obsolete, obsolescent, redundant, irreparable or unable to be repaired cost effectively Up to £5,000 (carrying value) Over £5,000 (carrying value) Transfer or sale of assets to another organisation	 Responsible Director Chief Finance Officer (may be delegated in specific cases in writing, but no lower than to a level 2 manager) Chief Finance Officer ~~Chief Finance Officer~~

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

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 Chief Executive Officer and Chief Finance Officer Board of Directors
4.6.5	Reimbursement of patients monies	Financial Services Manager
4.6.6	Removal expenses, excess rent and house purchase expenses	Chief People Officer
4.6.7	Contractual and non-contractual severance payments and all non-contractual payments, excluding Directors. Up to £20,000 Over £20,000 ~~**Note:** All special payments require Treasury approval and shall be submitted via the Chief Finance Officer to the Regulator for Treasury approval.~~	 Chief People Officer Chief Executive Officer
4.7	**Expenditure from charitable funds** Up to £2,000 Up to £320,000	 ~~Two from relevant fund holder or Chief Finance Officer,~~ Executive director QVH Charity Committee

	Over £320,000	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 Officer (unless the Board has specifically given the necessary authority to another individual for the purposes of such proceedings)
5.3	Signature of the following property documents when part of day to day business and within approved business plans and financial envelopes: • Notices to activate rent reviews and lease expiries • Notices requiring signature on the granting of leases and licences • Licences permitting alterations or minor works by us in third party property or by others in our properties.	Associate Director of Estates

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

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
6.3	Authorisation of income credit notes Up to £10,000~~£500~~ ~~£5,000~~ Up to £50,000 Up to £100,000~~£50,000~~ Up to £250,000 ~~£500,000~~Up to £1,000,000 Over £1~~5~~5000,000	 Budget managers Level 2 managers, Financial Services Manager and Associate Director Business Development Responsible Director ~~Associate Director of Business Development~~ Chief Finance Officer Chief Finance Officer AND Chief Executive Officer 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 Chief Finance Officer and Chief Executive Officer 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

Queen Victoria Hospital
NHS Foundation Trust

Queen Victoria Hospital NHS Foundation Trust

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

Approved by the Board of Directors ~~6 July 2023~~ May 2024

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 Chief Finance Officer, Deputy Chief Finance Officer 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 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), 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 Chief Finance Officer

2.5.1 The 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 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 Chief Finance Officer's role in audit

3.3.1 In relation to audit, the 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 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 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 Chief Finance Officer. The reporting system for internal audit shall be agreed between the 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 Officershall 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 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 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 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 Officerand shall work with NHS Counter Fraud Authority.

3.6.7 The local counter fraud specialist and the Chief Finance Officer 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 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 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 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 or the local counter fraud specialist, who will then inform the Chief Finance Officer and/or Chief Executive. Where a criminal offence is suspected, the Chief Finance Officer 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 must immediately notify:

(a) the Board of Directors; and

(b) the auditor.

3.7 Staff expenses

3.7.1 The Chief Finance Officer shall be responsible for establishing procedures for the management of expense claims submitted by Officers on forms approved by the Chief Finance Officer. The Chief Finance Officer 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.

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 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 will prepare and submit to the Finance and Performance Committee, the Board of Directors and the regulator.

4.1.3 The Chief Finance Officer 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 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.

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 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 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 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.

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

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 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 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.

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

6.6 The Chief Finance Officer 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**'s role in financial systems and transaction processing**

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

7.3 The Chief Finance Officer 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 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 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.

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 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.

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. 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.

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.

8 CONTRACTS FOR PROVISION OF SERVICES TO CUSTOMERS

8.1 The Chief Finance Officer, supported by other Officers (nominated by the Chief Finance Officer), 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 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 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 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 £105,000	Best value, supported by 1 written quote
	£105,001 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.

9.4 Formal competitive tendering

9.4.1 The Chief Finance Officer 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.

9.6.16 Where only one tender is sought and/or received the Chief Executive and Chief Finance Officer 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 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.

9.7 Financial standing and technical competence of contractors

9.7.1 The Chief Finance Officer 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;

(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 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 and Head of Procurement;

(j) where payment is to another NHS body and the Chief Finance Officer 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 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 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.

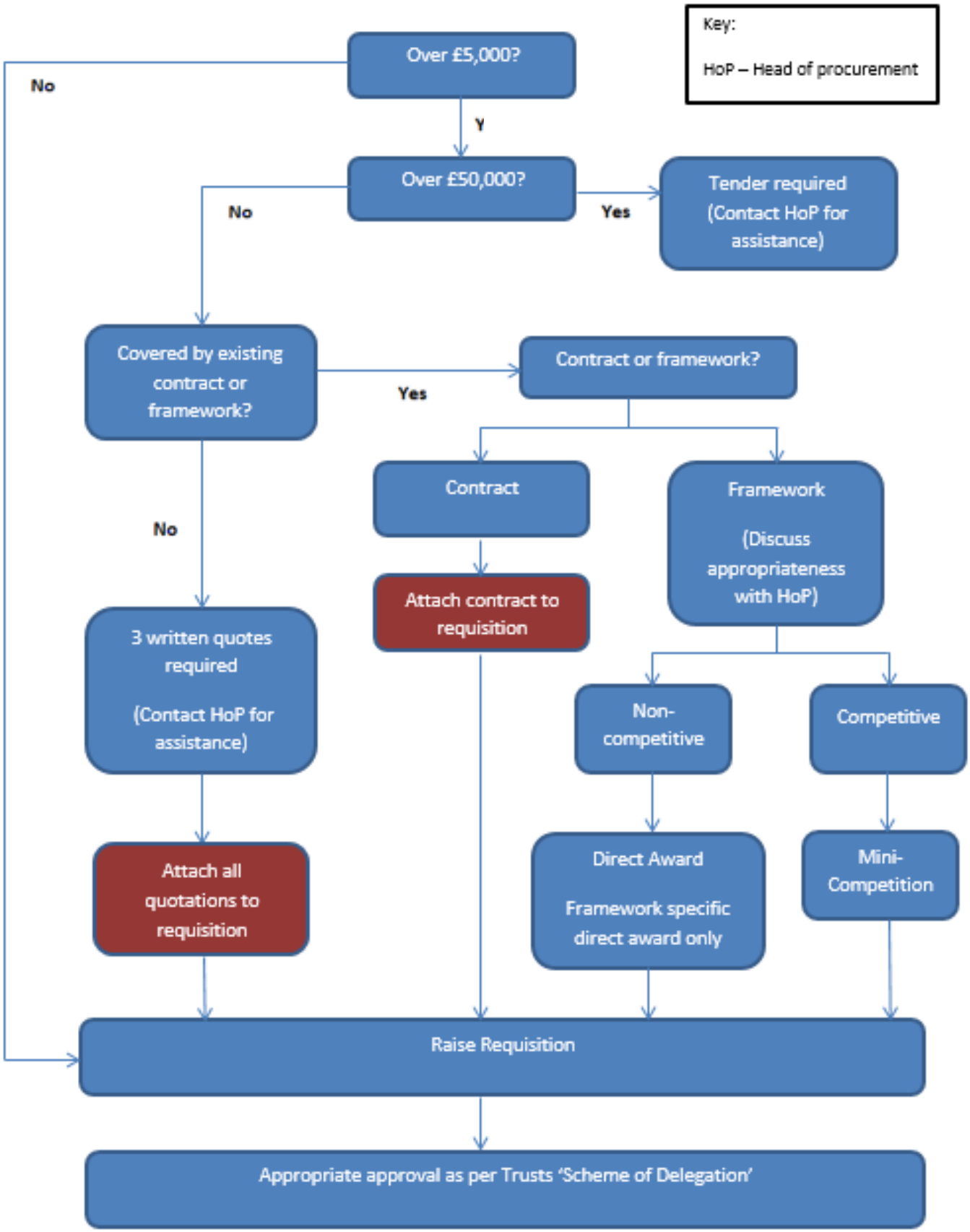
9.15 In-house services

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

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

11.3.1 The Chief Finance Officer 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 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 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, 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;

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

(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, which specifically addresses the risk of the supplier being unable to meet its commitments;

(c) the Chief Finance Officer 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 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;

(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 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 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 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's responsibilities for advising the Board of Directors concerning the performance of investments held.

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

12.2.3 The Chief Finance Officer 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.

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

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

13.2.5 The Chief Finance Officer, 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 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.

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 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 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.

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 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 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;

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

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

15.3 Losses and special payments

15.3.1 The Chief Finance Officer 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. 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 must immediately inform the police if theft or arson is involved.

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

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

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

16.3 Risk Assessments

16.3.1 The Chief Finance Officer 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 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 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 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 controls within the annual report and annual accounts.

19.4 The Chief Finance Officer 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 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 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.

Terms of reference

Name of governance body

Audit and Risk committee

Constitution

The Audit and Risk Committee ("the committee") is a statutory, non-executive committee of the Board of Directors.

Accountability

The Committee is accountable to the Board of Directors for its performance and effectiveness in accordance with these terms of reference.

Authority

The Committee is authorised by the Board of Directors to:

- investigate any activity within its terms of reference, and commission appropriate independent reviews and studies
- seek relevant information from within the Trust and from any employee (all departments and employees are required to co-operate with requests from the committee).
- obtain relevant legal or other independent advice and to invite professionals with relevant experience and expertise to attend meetings of the committee. For legal advice, the director of communications and corporate affairs or deputy company secretary shall be consulted prior to procurement of external advice

Purpose

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. The Committee is also responsible for maintaining an appropriate relationship with the Trust's internal and external auditors.

Duties and responsibilities

On behalf of the Board of Directors, the Committee will be responsible for the oversight and scrutiny of the Trust's:

- **Integrated governance, risk management and internal control**

The Committee shall review the establishment and maintenance of an effective system of integrated governance, risk management and internal control, across the whole of the organisation's activities (clinical and non-clinical), that supports the achievement of the organisation's objectives.

In particular, the Committee will review the adequacy and effectiveness of:

- All risk and control related disclosure statements (in particular the annual governance statement), together with any accompanying head of internal audit opinion, external audit opinion or other appropriate independent assurances, prior to submission to the board of directors.
- The underlying assurance processes, including the board assurance framework, that indicate the degree of achievement of the Trust's objectives, the effectiveness of the management of principal risks and the appropriateness

Reviewed by Audit & risk committee in March ~~October~~ 2024~~3~~
Approved by the Board of Directors at its meeting on ~~7~~2 May ~~September~~ 2024~~3~~

of the above disclosure statements (this may be carried out in conjunction with other board committees which scrutinise and oversee the management of relevant strategic risks).
- The Board of Directors sub-committees, including terms of reference, workplans and span of reporting on an annual basis.
- The effectiveness of assurance arrangements over the Trust's role within the Integrated Care Board (ICB) and other partnership arrangements.
- The policies for ensuring compliance with relevant regulatory, legal and code of conduct requirements and any related reporting and self-certifications.
- The policies and procedures for all work related to counter fraud and security as required by the NHS Counter Fraud Authority.

In carrying out this work, the Committee will primarily utilise the work of internal audit, external audit and other assurance functions, but will not be limited to these sources. It will also seek reports and assurances from directors and managers as appropriate, concentrating on the over-arching systems of integrated governance, risk management and internal control, together with indicators of their effectiveness. This will be evidenced through the Committee's use of an effective assurance framework to guide its work and the audit and assurance functions that report to it.

As part of its integrated approach, the Committee will have effective relationships with other key governance bodies of the Trust (for example, the Quality and Safety Committee) to support the committee's oversight role relating to the effectiveness of clinical systems of internal control.

- **Financial reporting**

The Committee shall monitor the integrity of the financial statements of the organisation and any formal announcements relating to its financial performance.

The Committee should ensure that the systems for financial reporting to the Board of Directors including those of budgetary control are subject to review as to the completeness and accuracy of the information provided.

The Committee shall review the annual report and financial statements before submissions to the Board of Directors focusing particularly on:
- Reviewing the annual governance declaration statement and other disclosures relevant to the terms of reference of the Committee.
- Changes in, and compliance with, accounting policies, practices and estimation techniques
- Unadjusted mis-statement in the financial statements
- Significant judgements in preparation of the financial statements
- Significant adjustments resulting from the audit
- Adequacy of management response to issues identified by audit activity
- Letters of representation
- Explanations for significant variances

The committee should review schedules of losses and compensations, making recommendations to the Board of Directors.

The Committee should review the Trust's standing financial instructions, standing orders and the scheme of delegation on an annual basis and make recommendations for change to the Board of Directors.

The committee will receive assurance on compliance with the Trust's standing orders and standing financial instructions.

The committee will review the waiver register.

Internal audit

The Committee shall ensure that there is an effective internal audit function that meets the Public Sector Internal Audit Standards 2017 and provides appropriate independent assurance to the Committee, Chief Executive Officer (as accounting officer) and Board of Directors. This will be achieved by:

- Considering the provision of the internal audit service and the costs involved, making recommendations to the Board of Directors regarding the appointment of the internal auditors.
- Reviewing and approving the annual internal audit plan and more detailed programme of work, ensuring that this is consistent with the audit needs of the organisation as identified in the assurance framework.
- Considering the major findings of internal audit work (and management's response), and ensuring co-ordination between the internal and external auditors to optimise the use of audit resources.
- Ensuring that the internal audit function is adequately resourced and has appropriate standing within the organisation.
- Monitoring the effectiveness of internal audit and carrying out an annual review.

Meeting with the Head of Internal Audit at least once a year, without management being present, to discuss their remit and any issues arising from the internal audits carried out.

External audit

The Committee shall review and monitor the external auditors' independence and objectivity and the effectiveness of the audit process. In particular, the Committee will review the work and findings of the external auditors and consider the implications and management's responses to their work. This will be achieved by:

- Considering the appointment and performance of the external auditors, as far as the rules governing the appointment allow (and making recommendations to the council of governors when appropriate).
- Ensuring that the work of the external auditor meets the requirements of the regulator and other regulatory bodies.
- Discussing and agreeing with the external auditors, before the audit commences, the nature and scope of the audit as set out in the annual audit plan.
- Discussing with the external auditors their evaluation of audit risks and assessment of the organisation.
- Reviewing all external audit reports and any work undertaken outside the annual audit plan, together with the appropriateness of management responses.

Speaking up (whistle blowing)

The Committee shall review the effectiveness of the arrangements in place for allowing staff to raise (in confidence) concerns about possible improprieties in financial, clinical or safety matters and ensure that any such concerns raised were investigated proportionately and independently.

Counter fraud
The Committee shall satisfy itself that the organisation has adequate arrangements in place for counter fraud and security that meet the NHS Counter Fraud Authority's ~~standards~~ requirements and shall review the outcomes of work in these areas.

Management
The Committee shall request and review reports, evidence and assurances from directors and managers on the overall arrangements for governance, risk management and internal control.

The Committee may also request specific reports from individual functions within the organisation (for example, clinical audit).

Other assurance functions
The Committee shall review the findings of other significant assurance functions, both internal and external to the organisation, and consider the implications for the governance of the organisation.

These will include, but will not be limited to, any reviews by Department of Health arm's length bodies or regulators/inspectors (for example, the Care Quality Commission and the NHS Litigation Authority) and professional bodies with responsibility for the performance of staff or functions (for example, Royal Colleges and accreditation bodies).

In addition, the Committee will review the work of other Committees within the organisation whose work can provide relevant assurance to the Committee's own areas of responsibility. In particular, this will include any financial and operational performance, clinical governance, risk management or quality committees that are established.

In reviewing the work of the Quality and Safety Committee, and issues around clinical risk management, the Committee will wish to receive assurance relating to the effectiveness of systems and processes of clinical governance including the clinical audit function.

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 at least four (4) times a year. The timing of Committee meetings should be planned to coincide with the important events in the year, thereby ensuring that the Committee is able to exercise its power to influence events.

At least once a year, the Committee should meet privately with representatives of the external and internal auditors.

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.

Any member of the Committee can ask for a meeting to be convened in person, by video- conference or by telephone, or for a matter to be considered in correspondence.

The Board of Directors, Chief Executive Officer (as accounting officer), representative of the external auditor and head of internal audit may request additional meetings if they consider it necessary.

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

Conflicts of Interest

All members and attendees of the Committee must declare any relevant potential interests at the commencement of any meeting. The Chair of the Committee will determine if there is a conflict of interest such that the member and/or attendee will be required not to participate in a discussion.

Where the Committee considers an item of its business may give rise to a potential conflict by meeting in common, the Committee may refer that business to the Board.

Chairing

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

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

The representative of the external auditor, head of internal audit, and counter fraud specialist have the right of direct access to the Chair of the Committee to discuss any matter relevant to the purpose, duties and responsibilities of the Committee or to raise concerns.

Secretariat

The ~~Deputy~~ Company Secretary shall be the secretary to the Audit and Risk Committee and shall provide administrative support and advice to the chair and membership. The duties of the secretary shall include but not be limited to:

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

Membership

Members with voting rights

The Committee will comprise at least three non-executive directors who shall each have full voting rights. The Chair of the Trust shall not Chair, be a member of, nor have the right to attend Committee meetings without invitation by the Chair as and when appropriate and necessary.

The Committee is authorised to co-opt additional members to provide specialist skills, knowledge and experience. At least one Committee member should have recent and relevant financial experience.

Ex-officio attendees without voting rights

- ~~Chief Executive (as Accounting Officer) who shall discuss with the Committee at least annually the process for assurance that supports the annual governance statement. The Chief Executive should also be in attendance when the Committee considers the draft annual governance statement along with the annual report and accounts.~~
- Representatives of the Trust's internal auditors.
- Representatives of the Trust's external auditors.
- The Trust's counter fraud specialist who will be entitled to attend any committee meeting and have a right of access to all committee members

In attendance without voting rights

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

- Chief Executive Officer (as Accounting Officer) who shall discuss with the Committee at least annually the process for assurance that supports the annual governance statement. The Chief Executive Officer should also be in attendance when the Committee considers the draft annual governance statement along with the annual report and accounts.
- Chief Finance Officer~~.~~
- Chief Nursing Officer~~e~~
- The secretary to the Committee (for the purposes described above).
- Designated deputies (as described below).
- Any other member of the Board of Directors, ~~-~~senior member of Trust staff or advisor considered appropriate by the chair of the Committee, particularly when the Committee will consider areas of risk or operation that are their responsibility.

Quorum

For any meeting of the Committee to proceed, two non-executive director members of the Committee must be present. A duly convened meeting of the Committee at which a quorum is present shall be competent to exercise all or any of the authorities, powers and discretions vested in or exercisable by the Committee.

Attendance

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

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 on behalf of the Committee attendee.

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

Papers

Meeting agendas and papers to be distributed to members and individuals invited to attend at least five clear days* prior to the meeting.

Reporting

The Secretary shall minute the proceedings and decisions of all meetings of the Committee, including recording the names of those present and in attendance. Draft minutes will be submitted for formal agreement at the next committee meeting.

The Committee chair shall prepare a report of each Committee meeting for submission to the Board of Directors at its next formal business meeting. The report shall draw attention to any issues which require disclosure to the Board of Directors including where executive action is continually failing to address significant weaknesses.

Issues of concern and/or urgency will be reported to the Board of Directors in between its formal business meetings by other means and/or as part of other meeting agendas as necessary and agreed with the Trust chair. Instances of this nature will be reported to the Board of Directors at its next formal business meeting.

The Committee will also report to the Board of Directors at least annually on its work in support of the annual governance statement, specifically commenting on:

- The fitness for purpose of the assurance framework
- The completeness and 'embeddedness' of risk management in the organisation
- The integration of governance arrangements
- The appropriateness of the evidence that shows the organisation is fulfilling regulatory requirements relating to its existence as a functioning business
- The robustness of the processes behind the quality accounts

The annual report should also describe how the Committee has fulfilled its terms of reference and give details of any significant issues that the Committee considered in relation to the financial statements and how they were addressed.

In addition, the Committee shall make an annual report to the council of governors in relation to the performance of the external auditor to enable the council of governors to consider whether or not to re-appoint them.

The Committee chair shall report at quarterly meetings of the Council of Governors.

Review

The committee will review on an annual basis its own performance and terms of reference to ensure that it is operating effectively and in line with best practice. The outcomes of this review will be reported in writing to the Board. The next scheduled review of these terms of reference will be undertaken by the Committee in ~~December 2023~~ March 2025 in anticipation of approval by the Board of Directors at its meeting in ~~March~~ ~~2024~~ May 2025.
*** Definitions**
In accordance with the Trust's constitution, 'clear day' means a day of the week not including a Saturday, Sunday or public holiday.

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, multi-year 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 programme 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~~Company secretary or their nominee shall be the secretary to the Committee and shall provide administrative support and advice to the Cchair 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 Eexecutive Officer
- ~~One executive director~~ Chief Strategy Officer

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 Nursing Officer~~e~~
- ~~Deputy Medical Director~~Chief Medical Officer
- Chief People Officer
- ~~Director of Operations~~Chief Operating Officer
- ~~Chief Information Officer~~
- Deputy Director of Strategy and ~~Partnerships~~Improvement
- Any member of the Board of Directors or senior manager considered appropriate by the chair of the Committee.

Quorum

For any meeting of the Committee to proceed, two~~one~~ non-executive directors and one~~two~~ executive director~~s~~ 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 2025~~3~~4 in anticipation of approval by the Board of Directors at its meeting in March 2025~~3~~4.

*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:	02/05/2024		**Agenda reference:**	**9-24**	
Report title:	NHS Sussex Committee in common terms of reference				
Sponsor:	James Lowell, Chief executive officer				
Author:	Leonora May, Company secretary				
Appendices:	Appendix one: Committee in common terms of reference				
Executive summary					
Purpose of report:	To present the NHS Sussex Committee in common terms of reference for Approval				
Summary of key issues	• The first meeting of the Committee in common will be held on 8 May 2024 • No formal functions are delegated to the committee and decisions are made by committee members on the basis of their own delegated authority. Each organisation remains sovereign • There are currently no proposed changes to the Scheme of delegation for this purpose • The Board will receive regular updated regarding the work of the Committee in common				
Recommendation:	The Board is asked to **approve** the Committee in common terms of reference				
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:	BAF8- developing and maintaining effective relationships with partner organisations				
Corporate risk register:	None- system risk management will be a focus for the CiC				
Regulation:	None				
Legal:	Health and Care Act 2022, duty to collaborate, public at large				
Resources:	As set out within report				
Assurance route					
Previously considered by:	ELT- January and March 2024 Audit and risk committee- 20 March 2024				
	Date:		Decision:		
Next steps:	First meeting on 8 May 2024				

Report to:	Board of Directors
Agenda item:	9-24
Date of meeting:	2 May 2024
Report from:	James Lowell, Chief executive officer
Report author:	Leonora May, Company secretary
Date of report:	19 April 2024
Appendices:	Appendix one: Committee in common ToR

NHS Sussex Committee in Common terms of reference

Introduction

A committee in common is an arrangement where each participating organisation uses its statutory powers to establish a statutory committee which has delegated functions or decision making powers in respect of the parent organisation only. Further guidance on collaborative working and committees in common is available here.

As part of the development of the NHS Sussex provider collaborative, each of the organisational leaders have agreed in principle to form a Sussex NHS Committee-In-Common (CIC) and the first meeting will be held on 8 May 2024. The proposed membership will include the Chair, CEO and two Non-Executive Directors (NEDs) from NHS Sussex, the Chair, CEO and one NED from each of the seven provider Trusts, plus three leaders from the new Sussex Primary Care Leadership structure.

The Audit and risk committee reviewed the terms of reference at its meeting on 20 March 2024.

Purpose

NHS organisations in Sussex will need to collaborate to deliver many of the aims of Improving Lives Together. At present this is managed through the System Oversight Board and its working groups. It was agreed via discussions with the Chair and CEO forum in late 2023 that in addition to establishing an acute and community provider collaborative we would also establish a Committee in Common to ensure shared direction, grip and oversight of our strategy and strategic financial challenges. This proposal has been agreed by the NHS Sussex Board.

When the committees begin to meet in common, the System oversight Board will be disestablished, and its functions will be distributed to the Committee in common or provider collaboratives.

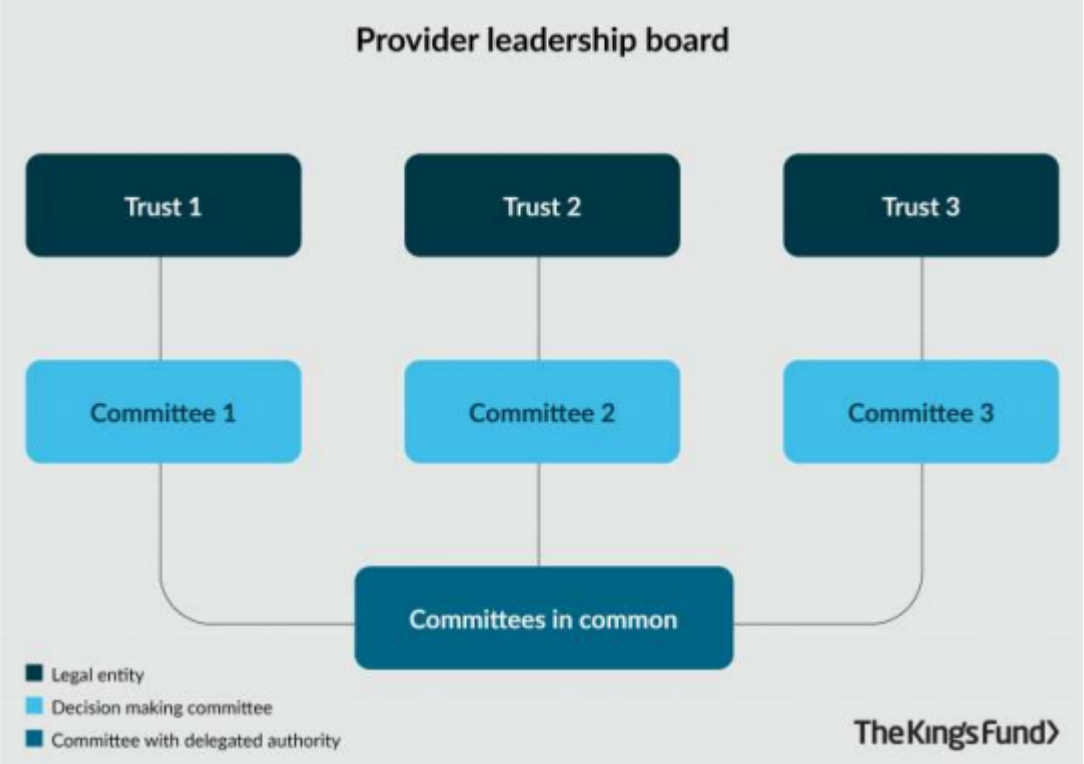
The committee in common and decisions

Each organisation will establish a committee with the same terms of reference and purpose and similar membership, proposed as the organisational Chair, CEO and a Non-Executive Director. These committees will then meet in common with a shared agenda based on a collectively-agreed forward look. The draft terms of reference are appended to this report.

No formal functions are delegated to the committee and decisions are made by committee members on the basis of their own delegated authority. Each organisation remains sovereign. All efforts will be made to design agendas and preparatory work in a way that enables collective decision-making. In the event of the committees

(when meeting in common) being unable to make a decision, members may need to confer with wider board members.

Where the committees when meeting in common agree that work needs to be taken forwards they will agree a lead organisation who can coordinate and convene to deliver it.



The organisations
The committee in common will have a membership of NHS organisations with responsibility for delivering the system strategy. This is NHS Sussex, University Hospitals Sussex NHS Foundation Trust, Sussex Community NHS Foundation Trust, Sussex Partnership NHS Foundation Trust, East Sussex NHS Healthcare Trust, Surrey and Sussex Healthcare NHS Trust, Queen Victoria Hospital NHS Foundation Trust and the South East Coast Ambulance Service.

Timeline
Organisations are asked to take the terms of reference and a covering paper through their governance in Q1 24/25. The committee will hold its first meeting on 8 May 2024.

Resources
From time to time the committees when they meet in common may agree that specific pieces of analysis or policy work are required to make progress on a priority. When this happens attendees will agree a lead and how this will be resourced.

Local government
Local government partners will continue to engage in the Sussex strategy via the Assembly, HOSC, HWB boards and their membership of the NHS Sussex Board. In addition Local Government partners may join working groups or delivery boards for

issues. The Committee in Common's remit is the NHS aspects of delivering the Sussex Integrated Care Strategy.

Conflict of interest management
Each organisation will declare conflicts of interest in the usual way. Where committees meet in common any potential conflicts of interest will be dealt with on a case by case basis, based on a meeting's agenda.

Work plan
The schedule and forward look of the committees when meeting in common will be brought to the initial (or a preliminary) meeting of the committees for agreement. It will be expected to cover the core remits in the terms of reference, both in terms of routine stocktakes and specific focus items:

- Data-led oversight of NHS contribution to shared strategy and delivery plan
- Establish a shared NHS Medium Term Financial Plan in Sussex over next five years
- Collective leadership of clinical and financial transformation of NHS in Sussex

Recommendation
The Board is asked to **approve** the Committee in common terms of reference.

Sussex NHS Committees in Common

TERMS OF REFERENCE FOR A COMMITTEE OF THE BOARD TO MEET IN COMMON WITH COMMITTEES OF OTHER ORGANISATIONS

TERMS OF REFERENCE

1 Introduction

1.1 NHS organisations in Sussex are establishing a new governance structure – via a set of Committees in Common (CiC) - to enable collaborative working to drive delivery of our shared strategy 'Improving Lives Together'.

1.2 The organisations establishing committees to meet in common will be the NHS Sussex Integrated Care Board, East Sussex NHS Healthcare Trust, Queen Victoria Hospital NHS Foundation Trust, South East Coast Ambulance Service NHS Foundation Trust, Surrey and Sussex Healthcare NHS Trust, Sussex Community NHS Foundation Trust, Sussex Partnership NHS Foundation Trust, University Hospitals Sussex NHS Foundation Trust and the Sussex Primary Care Collaborative.

1.3 Each organisation has agreed to establish a committee which shall work in common with the other CiCs, but which will each take its decisions independently on behalf of its own organisation.

1.4 While this governance model permits a committee to meet separately, it is expected that they will usually only meet in common and assurance and escalations will go to sovereign organisations' Boards.

1.5 Each organisation has decided to adopt terms of reference in substantially the same form to other organisations, except that the membership of each committee will be different.

2 Aims and Objectives of the [insert organisation name] CiC

2.1 The aims and objectives of the CiC are to work with the other CiCs to:

- Work together to improve the population health outcomes, reduce the health inequalities and enhance the productivity of the NHS services in Sussex
- Collectively lead the NHS contribution to the Sussex Integrated Care System strategy 'Improving Lives Together' and delivery of the in-year aims of the Shared Delivery Plan (Joint Forward Plan under the Health and Care Act 2022)
- Collectively lead the clinical and financial transformation of the NHS in Sussex to deliver new, integrated and affordable models of care over the next 5 years

3 Specific Functions

3.1 The functions of the committee will be carried out via powers delegated to the committee members by [*insert organisation name*] Board.

3.2 **Data-led oversight of NHS contribution to shared strategy and delivery plan**

Each year a Shared Delivery Plan will be agreed (Joint Forward Plan as per the Health and Care Act 2022) in line with the system's strategy. The CiCs will collectively take decisions to:

- Agree a schedule of work to review each component of the plan and progress of the plan as a whole.
- Review a standard routine set of insight and analytical information on progress against objectives.
- Recommend and steer deep-dive analyses to identify issues and agree actions for ICB and system delivery partners to resolve delivery problems
- Work with other governance fora to ensure actions can be taken forward by the right organisations
- Review the annual refresh of the delivery plan and make recommendations on the associated targets, trajectories and oversight approaches

3.3 **Establish a shared NHS Medium Term Financial Plan in Sussex over next 5 years**

The NHS in Sussex will agree a shared set of financial goals to operate within a finite funding envelope and work to meet our medium-term plans. In this context the committee will:

- Assess the population and demographic growth to forecast the demand for all key NHS services in each Integrated Community Team footprint
- Assess the cost growth of delivering these NHS services in each Integrated Community Team footprint against the forecasted financial allocations from NHS England
- Assess the clinical effectiveness and financial productivity of existing service models to identify the greatest opportunities for improvement across Sussex
- Collectively assess data and insight to form a shared view of the major opportunities, challenges, risks, barriers and mitigations to the delivery of the Medium Term Financial Plan
- Define the programmes, project management resources and leadership accountabilities to achieve the Medium Term Financial Plan goals

3.4 **Collective leadership of clinical and financial transformation of NHS in Sussex**

The CiC will empower clinical and subject matter experts to lead the development of new, integrated and affordable models of NHS care in Sussex over the next 5 years to deliver the biggest health benefits to the greatest number of patients and service users by:

- Engaging and involving clinical leaders from all levels within the system on the prioritisation and development of new models of care and integrated patient pathways across different providers
- Seeking national expert advice to learn from the experience of other systems in transforming clinical and integrated care pathways
- Engaging and involving digital health and process improvement experts to support the digitisation and automation of new integrated care pathways
- Agreeing Senior Responsible Officers with appropriate delegated authority to create specific, measurable, realistic and timebound plans to deliver the specific clinical and financial transformations with the required individuals, organisations and collaboratives
- Tracking actions to ensure implementation, follow up and support where needed

3.5 **Review effectiveness and terms of reference of the committee on annual basis**

The CiC will assess its own effectiveness and terms of reference on an annual basis to ensure that its aims, objectives and specific functions are still relevant so that recommendations for improvement can be made to the Board of each member organisation for review and approval.

4 Establishment

4.1 The [*insert organisation name*] CiC is a committee of [*insert organisation name*] Board and therefore can only make decisions binding [*insert organisation name*]. None of the organisations other than [*insert organisation name*] can be bound by a decision taken by [*insert organisation name*] CiC.

5 Membership

5.1 The [*insert organisation name*] CiC shall be constituted of directors and non-executive directors of [*insert organisation name*]. Namely:

5.1.1 **[*insert organisation name*]** Chair; and

5.1.2 **[*insert organisation name*]** Chief Executive,

5.1.3 **[*insert organisation name]*** Non-executive director with skills relevant to the CiC's functions

and each shall be referred to as a "Member".

5.2 Each [*insert organisation name*] CiC Member shall nominate a deputy to attend [*insert organisation name*] CiC meetings on their behalf when necessary.

5.3 The Nominated Deputy for [*insert organisation name*] CiC's Chair shall be a Non-Executive Director of [*insert organisation name*] and the Nominated Deputy for [*insert organisation name*] Chief Executive shall be an Executive Director of [*insert organisation name*].

5.4 In the absence of the [*insert organisation name*] CiC Chair Member and/or the [*insert organisation name*] Chief Executive Member, a Nominated Deputy shall be entitled to:

5.4.1 attend **[*insert organisation name*]** CiC's meetings;

5.4.2 be counted towards the quorum of a meeting of **[*insert organisation name*]** CiC's; and

5.4.3 exercise Member voting rights subject to delegated authority.

6 Non-voting attendees

6.1 Only members of the committee in common have the right to attend meetings, however all meetings of the committee will also be attended any other attendees that the committee considers have expertise that would be relevant to the responsibilities of the committee or specific agenda items.

6.2 Other individuals may be invited to attend all or part of any meeting as and when appropriate to assist it with its discussions on any particular matter.

6.3 The Chair may ask any or all of those who are in attendance, but who are not members, to withdraw to facilitate open and frank discussion of particular matters.

7 Meetings

7.1 Subject to paragraph 10 below meetings in common shall take place every other month.

7.2 Meetings of the [*insert organisation name*] CiC shall be held in public.

7.3 Meetings in common will be chaired by the NHS Sussex Chair and supported by a secretariat from NHS Sussex (see below).

7.4 A vice-chair should be nominated and appointed by the CiC. In the absence of the [*insert organisation name*] CiC Chair the Nominated vice-chair [*insert organisation name*] shall chair the meeting.

7.5 Any CiC Chair may request an extraordinary meeting of the CiCs (working in common) on the basis of urgency etc. via the secretariat, with timings agreed by mutual consent.

7.6 When there is an urgent matter where a decision is required outside of the meeting (which cannot wait for the next scheduled meeting), the Chair of Committee may make a decision after conferring with at least two other members ("Chair's Action").

7.7 When Chair's Action has been taken then the next quorate meeting of the Committee must ratify it. Urgent decisions will only be taken when there is insufficient time available for the decision to be delayed until the next meeting.

8 Quorum and Voting

8.1 Each Member of the [*insert organisation name*] CiC shall have one vote. The [*insert organisation name*] CiC shall reach decisions by consensus of the Members present.

8.2 The quorum for an individual CiC shall be two (2) Members.

8.3 If any Member is disqualified from voting due to a conflict of interest, they shall not count towards the quorum for the purposes of that agenda item.

9 Conflicts of Interest

9.1 Members of the [*insert organisation name*] CiC shall comply with the provisions on conflicts of interest contained in [*insert organisation name*] Constitution/Standing Orders, and NHS Conflicts of Interest guidance.

9.2 All Members of the [*insert organisation name*] CiC shall declare any new interest at the beginning of any [*insert organisation name*] CiC meeting and at any point during a [*insert organisation name*] CiC meeting if relevant.

10 Attendance at meetings

10.1 [*insert organisation name*] shall ensure that, except for urgent or unavoidable reasons, [*insert organisation name*] CiC Members (or their Nominated Deputy) shall attend [*insert organisation name*] CiC meetings (in person or virtually) and fully participate in all [*insert organisation name*] CiC meetings.

11 Behaviours and conduct

11.1 Members will be expected to conduct business in line with their organisation's values and objectives.

11.2 Members of and those attending the committee shall behave in accordance with their organisational constitution, Standing Orders, Standards of Business Conduct Policy

11.3 Members have a duty to demonstrate leadership in the observation of the NHS code of conduct and to work to the Nolan Principles which are selflessness, integrity, objectivity, accountability, openness, honesty and leadership.

11.4 The committee will apply best practice in its deliberations and in decision-making processes. It will conduct its business in accordance with national guidance and relevant codes of conduct.

11.5 All members are expected to comply with relevant policies and procedures regarding confidentiality and information governance, noting the sensitivity of information to be discussed when committees meet individually or in common.

12 Secretariat

12.1 The Committees, when meeting in common, shall be supported with a secretariat function which will include ensuring that:

- The agenda and papers are prepared and distributed in accordance with the Standing Orders having been agreed by the Chair with the support of the relevant executive leads;
- Attendance of those invited to each meeting is monitored and highlighted to the Chair those that do not meet the minimum requirements;
- Good quality minutes are taken in accordance with the standing orders and agreed with the chair and that a record of matters arising, action points and issues to be carried forward are kept;
- The committee is updated on pertinent issues, areas of interest and

policy developments;

- Action points are taken forward between meetings and progress against those actions is monitored; and
- Committee papers will be stored and archived.

12.2 The secretariat shall be responsible circulation of a committee report and minutes to members within a week of the meeting for agreement

12.3 Where a CiC meets individually (not in common) an individual organisation will be responsible for secretariat arrangements.

APPROVED BY QUEEN VICTORIA HOSPITAL NHS FT BOARD ON 2 MAY 2024

Report cover-page					
References					
Meeting title:	Board of Directors				
Meeting date:	02/05/2024		**Agenda reference:**	10-24	
Report title:	Board assurance framework (BAF) and Corporate risk register (CRR)				
Sponsor:	Leonora May, Company secretary Nicky Reeves, Chief nursing officer				
Author:	Leonora May, Company secretary Nicky Reeves, Chief nursing officer				
Appendices:	Appendix one: Board assurance framework summaries Appendix two: Board assurance framework Appendix three: Corporate risk register				
Executive summary					
Purpose of report:	To present the Board assurance framework (BAF) and Corporate risk register (CRR) to the Board				
Summary of key issues	- All BAFs reviewed in detail by the appropriate sub-committees during April 2024. Any assurance regarding committee assessments of the effectiveness of controls is included within the sub-committee assurance reports to the Board - The updates to the BAFs made between Q4 2023/24 and Q1 2024/25 are included within the BAF summaries at appendix one - An executive summary for each BAF is included within the report				
Recommendation:	To **review** the BAF and: - Confirm that the BAF is appropriately focussed on, and accurately describes, the key risks that may impact on the Trust's ability to deliver its strategic objectives - Advise if there are any specific matters in relation to the strategic risks presented in the BAF that require follow up at a sub-committee (e.g. deep dives into risk assessments or overall assurance levels)				
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:	Whole BAF included				
Corporate risk register:	Corporate risks linked to BAF risks				
Regulation:	CQC				
Legal:	BAF 5 compliance				
Resources:	None				
Assurance route					
Previously considered by:	Board sub-committees during April 2024				
Next steps:	NA				

Report to:	Board Directors
Agenda item:	10-24
Date of meeting:	2 May 2024
Report from:	Leonora May, Company secretary Nicky Reeves, Chief nursing officer
Report author:	Leonora May, Company secretary Nicky Reeves, Chief nursing officer
Date of report:	19 April 2024
Appendices:	Appendix one: Board assurance framework summaries Appendix two: Board assurance framework Appendix three: Corporate risk register

Board assurance framework (BAF) and Corporate risk register (CRR)

Board assurance framework (BAF)

Since the Board's last review, the BAF documents have been reviewed and updated including overall assurance ratings and scores. The updates made from Q4 2023/24 to Q1 2024/25 are set out within the BAF summaries at appendix one. None of the risks have yet achieved their target score. All strategic risks were reviewed by the responsible sub-committee during April which provided scrutiny on the content of the allocated risks in order to provide assurance to the Board on the effectiveness of existing controls and further actions being taken to address gaps identified. Assurance regarding committee assessments of the effectiveness of controls is included within the sub-committee assurance reports to the Board.

Executive summary BAF 1

The controls have been reviewed to ensure that they are strategic and high level. There are now seven key controls for this strategic risk. Key actions completed to manage the strategic risk include:

- A review of the process for updating out of date policies
- A review of gaps in CQC actions from previous inspections and actions taken to address them
- PSIRF methodology being rolled out
- Regular reporting to the committee in learning from serious incidents

The completion of these actions has resulted in four identified gaps in control reducing.

The current risk score has been reduced to 10, with the likelihood being reduced to 2 (unlikely). The consequence of the risk materialising remains a five (severe). The target risk rating has been updated to 5. The overall assurance RAG rating is amber for Q1 which demonstrates medium confidence indicating that there is further action to be taken to ensure that the controls are effective.

Executive summary BAF 2

Key actions completed to manage the strategic risk include the recruitment of a resourcing business partner, the establishment of kay staff networks to support workplace belonging and the continued development of the People and culture strategy.

The current risk score remains at 12 with further action to be taken to manage the risk required as set out within the BAF document. The overall assurance RAG rating

remains as amber for Q1 which demonstrates medium confidence indicating that there are some issues that need to be monitored and addressed.

Executive summary BAF3
The target date for this risk to meet its target score has been updated to 2031 in line with the longer term action to rebuild the hospital site. The target score has been reduced from 10 to 6. Key actions completed to manage the strategic risk include the recruitment of a substantive Director of estates and facilities. The gaps in controls have increased from 13 to 15 with external authorising engineers being appointed and attending safety groups identified as key gaps in control. The development of an asset register by an external provider is a key gap in assurance.

The current risk score remains at 15 with further action taken to manage the risk required as set out within the BAF document. The overall assurance RAG rating remains as amber for Q1 which demonstrates medium confidence indicating that there are some issues that need to be monitored and addressed.

Executive summary BAF 4
The controls have been reviewed to ensure that they are strategic and high level. There are now five key controls for this strategic risk. Key actions completed during the period include the review of the strategic options the phase three engagement plan and resource requirements. The overall assurance RAG rating is green for Q1 which demonstrates high confidence indicating that there are no serious issues and the controls are currently effective.

Executive summary BAF5
The date for this risk to meet its target score has been updated to September 2024 in line with the new action added related to the corporate governance review. The controls for this risk have been reviewed to ensure that they are strategic and high level. There are now five key controls for this risk. Key actions completed to reduce the gaps in assurance include the Audit and risk committee's review of compliance with the fit and proper persons framework, the draft annual governance statement and the receipt of RSM's local proactive exercise related to Conflicts of interest. A key action related to compliance with the fit and proper persons tests has been completed.

The majority of assurances have been rated as green and the overall assurance RAG rating for Q1 is green demonstrating high confidence indicating that there are no serious issues. The current risk score remains at 12.

Executive summary BAF6
Key actions are on track for completion by the dates set out within the BAF document.

The current risk score remains at 12 with further action taken to manage the risk required as set out within the BAF document. The overall assurance RAG rating remains as amber for Q1 which demonstrates medium confidence indicating that there are some issues that need to be monitored and addressed.

Executive summary BAF7
Key actions completed to manage the strategic risk include the development of the digital strategy, the delivery of cyber security training for the Board and the development of a communications plan to support data access security awareness. Further iterations of the digital strategy may be required following the development of the clinical strategy

The majority of assurances have been rated as green and the overall assurance RAG rating for Q1 is green demonstrating high confidence indicating that there are no serious issues. The current risk score remains at 12 with further action taken to manage the risk required as set out within the BAF document.

Executive summary BAF 8
Key actions completed to manage the strategic risk include the development of a Trust engagement plan and the development of system leadership roles for QVH executives and NED roles for the provider collaboratives. The current risk score remains at 12. The overall assurance RAG rating is green for Q1 which demonstrates high confidence indicating that there are no serious issues and the controls are currently effective.

Corporate risk register
The content and format of the CRR was refined to enable the executive leadership team and Board to have sufficient oversight of the key corporate level risks and how effectively they are being managed.

Corporate risks are those which score 15 and above and these risks inform the BAF scores and rationale; three of the ten risks are currently scoring 16 with the remaining seven scoring 15.

There are currently 10 corporate risks on the register, all reviewed at the relevant sub-committee meetings during April 2024, seven of which have been reviewed and updated by the executive leads. The full CRR has been included as appendix three to this report.

Recommendation
The Board is asked to:

- Confirm that the BAF is appropriately focussed on, and accurately describes, the key risks that may impact on the Trust's ability to deliver its strategic objectives
- Advise if there are any specific matters in relation to the strategic risks presented in the BAF that require follow up at a sub-committee (e.g. deep dives into risk assessments or overall assurance levels)
- **Note** the Corporate risk register

APPENDIX 1 – BAF summaries

1. SUMMARY OF STRATEGIC RISKS:

The table below presents a summary of the 8 strategic risk assessments included in the BAF and the anticipated dates for reaching the target score for each risk (note: target scores may need to be revised once the Board has agreed its risk appetite framework in April 2024). Each risk is assigned an overall assurance rating showing level of confidence in the controls.

REF	RISK TITLE	Principal Exec[1]	RISK ASSESSMENT[2]			TRAJECTORY	GOVERNANCE COMMITTEE	ASSURANCE RATING[3]
			Inherent	Current	Target	Date to reach target score		
01	**Patient services**	Chief Nursing officer	25	10	5	Dec 24	Q&S	**AMBER**
02	**Workforce strategy**	Chief People Officer	20	12	9	Mar 25	F&P	**AMBER**
03	**Physical infrastructure**	Chief Finance Officer	20	15	6	Apr 31	F&P	**AMBER**
04	**Long-term sustainability**	Chief Executive	25	12	6	Sep 24	SD	**GREEN**
05	**Compliance breach (non-clinical)**	Chief Executive	20	12	8	Sep 24	F&P	**GREEN**
06	**Financial sustainability**	Chief Finance Officer	25	12	9	Mar 29	F&P	**AMBER**
07	**Information assets**	Chief Strategy Officer	25	12	8	Jul 24	F&P	**GREEN**
08	**Partner organisations**	Chief Executive	25	12	6	Jul 24	SD	**GREEN**

[1] The role responsible for maintaining the risk assessment and overseeing the management of the risk
[2] Risk assessment definitions: Inherent = pre-controls, current = post controls, target = desired level of risk
[3] Overall assurance rating definitions: Red = low confidence indicating that there are serious issues that need to be addressed immediately for the controls to be effective, Amber = medium confidence indicating that there are some issues that need to be monitored and addressed, Green = high confidence indicating that there are no serious issues and the controls are effective

Risk Ref & Description: 01 – There is a risk that the Trust fails to deliver effective, safe, timely and quality patient services	**Quarter**	**Q3 2023/24**	**Q4 2023/24**	**Q1 2024/25**	**Q2 2024/23**
	Overall Assurance Rating (RAG)	**AMBER**	**AMBER**	**AMBER**	**N/A**
Causes: ineffective operational / clinical management (including management of resources and risks / incidents), failure of third-party service providers, ineffective and unpredictable staff behaviours (e.g., communication), physical infrastructure failure	**Number of controls in place**	**9**	**7**	**7**	**N/A**
Consequences: negative impacts on patient outcomes / experiences, potential harm to people, failing to meet regulatory performance targets, financial implications including losses, regulatory intervention, criminal prosecution, and reputational damage	**Gaps in Controls**	**14**	**10**	**10**	**N/A**
Strategic Aim: KSO 1, 2 and 3	**Assurances and RAG rating**[4]	**20** L1 (8) - 4G,2A,2R L2 (10) - 3G,7A L3 (2) - 1G,1A	**20** L1 (8)- 4G,3A,1R L2 (9)- 2G,6A L3 (3)-2G,1A	**19** L1 (8)- 4G,4A L2 (9)- 2G,6A L3 (2)-1G,1A	**N/A**
Committee: Quality and Safety Committee	**Gaps in assurance**	**9**	**9**	**9**	**N/A**
Principal Exec: Chief Nurse	**Current Risk Score**	**15**	**15**	**10**	**N/A**
Date added: September 2023	**Target Risk Score and Date**	**10** (Dec 24)	**10** (Dec 24)	**5** (Dec 24)	**N/A**
Date last discussed: 23 November 2024 (ELT)	**Risk appetite and max tolerance**	TBC	TBC	TBC	TBC

[4] L1 – first line, L2 – second line, L3 – third line
R – Red (low confidence), A – Amber (medium confidence), G – Green (high confidence)

Risk Ref & Description: 02 – There is a risk that the Trust's workforce strategy fails to address the key external and internal challenges to support delivery of its operational and strategic objectives	**Quarter**	**Q3 2023/24**	**Q4 2023/24**	**Q1 2024/25**	**Q2 2024/23**
	Overall Assurance Rating (RAG)	**AMBER**	**AMBER**	**AMBER**	N/A
Causes: Inadequate leadership and / or resources and a focus on reactive issues mean the workforce team, corporate and clinical services do not address the important workforce challenges and / or fail to keep up to date with national / regional requirements	**Number of controls in place**	**6**	**6**	**5**	N/A
Consequences: Potential reduction in clinical or corporate service capacity or quality with negative impact on care and / or patient and service user experience and outcomes, negative impact on staff health and wellbeing, financial implications including increased temporary staff spend, regulatory intervention, reputational damage, employee grievances / tribunals, higher staff turnover, or potential challenges in recruitment	**Gaps in Controls**	**22**	**22**	**21**	N/A
Strategic Aim: KSO 1-5	**Assurances and RAG rating**	**21** L1 (8) - 5G,3A L2 (12) - 5G,7A L3 (1) - 1G	**21** L1 (8)- 4G, 4A L2 (12)- 5G, 7A L3 (1)- 1G	**19** L1 (7) - 5G,2A L2 (10) - 5G,5A L3 (1) - 1G	N/A
Committee: Finance and Performance Committee	**Gaps in assurance**	**10**	**10**	**9**	N/A
Principal Exec: Chief People Officer	**Current Risk Score**	**12**	**12**	**12**	N/A
Date added: September 2023	**Target Risk Score and Date**	**9** (Mar 25)	**9** **(Mar 25)**	**9** (Mar 25)	N/A
Date last discussed: 23 November 2023 (ELT)	**Risk appetite and max tolerance**	TBC	TBC	TBC	TBC

Risk Ref & Description: 03 - There is a risk that the Trust's physical infrastructure (i.e. buildings and services) is not fit for purpose to support an effective, efficient and safe environment for operational delivery	**Quarter**	**Q3 2023/24**	**Q4 2023/24**	**Q1 2024/25**	**Q2 2024/23**
	Overall Assurance Rating (RAG)	**AMBER**	**AMBER**	**AMBER**	N/A
Causes: Ageing infrastructure, lack of financial investment resulting in back log of maintenance / repairs, ineffective governance, inadequate resources, failure of critical third-party suppliers	**Number of controls in place**	**9**	**9**	**9**	N/A
Consequences: Potential harm to individuals, disruption to / inefficiencies within clinical and support services, damage to physical infrastructure (i.e. the buildings and the services e.g. heating systems, electrical infrastructure, cooling and ventilation systems), financial loss, regulatory intervention, reputational damage, negative impact on staff morale	**Gaps in Controls**	**13**	**15**	**15**	N/A
Strategic Aim: KSO 1-5	**Assurances and RAG rating**	**12** L1 (3) - 2G,1R L2 (6) - 3G,3A L3 (3) - 1G,2A	**14** L1 (3)- 1G, 2R L2 (6)- 2G, 4A L3 (4)- 3A	**14** L1 (3) - 2G,1R L2 (6) - 3G,3A L3 (3) - 1G,2A	N/A
Committee: Finance and performance committee	**Gaps in assurance**	**9**	**9**	**11**	N/A
Principal Exec: Chief finance officer	**Current Risk Score**	**15**	**15**	**15**	N/A
Date added: 12 October 2023	**Target Risk Score and Date**	**10** (Jun 24)	**10** (Jun 24)	**6** (Apr 2031)	N/A
Date last discussed: 24 October 2023 (ELT)	**Risk appetite and max tolerance**	TBC	TBC	TBC	TBC

Risk Ref & Description: 04 – There is a risk that the Trust fails to secure its long-term sustainability leading to closure of services and /or the site	**Quarter**	**Q3 2023/24**	**Q4 2023/24**	**Q1 2024/25**	**Q2 2024/23**
	Overall Assurance Rating (RAG)	**AMBER**	**GREEN**	**GREEN**	N/A
Causes: Inadequate or ineffective strategic planning / delivery, lack of effective stakeholder engagement (internally and externally) / support, internal governance failures, inadequate leadership capability and capacity, failing to address environmental sustainability matters, emergent change at a trust, system or national level that may impact strategy requirements	**Number of controls in place**	**10**	**5**	**5**	N/A
Consequences: potential for loss of patient services, reduction in staff morale, challenges with recruitment and retention, loss of community employment and local facilities	**Gaps in Controls**	**2**	**1**	**1**	N/A
Strategic Aim: KSO 1-5	**Assurances and RAG rating**	**8** L1 (0) L2 (6) - 6G L3 (2) - 2G	**8** L1 (0) L2 (6) - 6G L3 (2) - 2G	**8** L1 (0) L2 (6) - 6G L3 (2) - 2G	N/A
Committee: Strategic Development Committee	**Gaps in assurance**	**1**	**0**	**0**	N/A
Principal Exec: Chief Executive Officer	**Current Risk Score**	**15**	**12**	**12**	N/A
Date added: September 2023	**Target Risk Score and Date**	**10** (Sep 24)	**6** (Sept 24)	**6** (Sept 24)	N/A
Date last discussed: 13 February 2024 (ELT)	**Risk appetite and max tolerance**	TBC	TBC	TBC	TBC

Risk Ref & Description: 05 – There is a risk that the Trust experiences a material legislative or regulatory compliance breach (non-clinical)	**Quarter**	**Q3 2023/24**	**Q4 2023/24**	**Q1 2024/25**	**Q2 2024/23**
	Overall Assurance Rating (RAG)	**AMBER**	**GREEN**	**GREEN**	N/A
Causes: failure to identify existing and new requirements, unhelpful behaviours (human error / intentional wrongdoing), staff not being adequately trained, failure of third party to deliver, failure of record keeping or IT systems, ineffective policy frameworks and processes	**Number of controls in place**	**9**	**5**	**5**	N/A
Consequences: potential harm to people, regulatory intervention, criminal prosecution, financial losses and reputational damage	**Gaps in Controls**	**16**	**6**	**6**	N/A
Strategic Aim: KSO 2, 3,4 and 5	**Assurances and RAG rating**	**12** L1 (0) L2 (8) - 3G,5A L3 (4) - 4G	**10** L1 (0) L2 (8)- 5G, 3A L3 (2)- 2G	**10** L1 (0) L2 (8)- 5G, 3A L3 (2)- 2G	N/A
Committee: Finance and Performance Committee	**Gaps in assurance**	**9**	**9**	**6**	N/A
Principal Exec: Chief Executive Officer	**Current Risk Score**	**15**	**12**	**12**	N/A
Date added: September 2023	**Target Risk Score Target Risk Score and Date**	**10** (Mar 24)	**8** (Mar 24)	**8** (Sep 24)	N/A
Date last discussed: 23 November 2023 (ELT)	**Risk appetite and max tolerance**	TBC	TBC	TBC	TBC

Risk Ref & Description: 06 – There is a risk that the Trust is unable to deliver medium to long term financial sustainability	**Quarter**	**Q3 2023/24**	**Q4 2023/24**	**Q1 2024/25**	**Q2 2024/23**
	Overall Assurance Rating (RAG)	**AMBER**	**AMBER**	**AMBER**	N/A
Causes: increasing demand outstrips resources available, impact of investment requirements and inflation, failure to deliver operational efficiencies and /or realise investment programme benefits, potential for unplanned costs (e.g., cyber-attack), lack of available workforce increasing agency spend, Ineffective management of multiple Integrated Care Systems financial transformational risks, impact of political changes and national directives	**Number of controls in place**	**10**	**10**	**10**	N/A
Consequences: possible loss of operational capacity and failure to provide timely treatment to patients, failure to generate funding for investments, potential for workforce restructuring, and /or reputational damage with loss of confidence from stakeholders (e.g., ICB)	**Gaps in Controls**	**11**	**10**	**10**	N/A
Strategic Aim: KSO 1 - 5	**Assurances and RAG rating**	**12** L1 (1) - 1A L2 (5) - 2G,3A L3 (6) - 2G,4A	**13** L1 (2)- 2A L2 (8)- 2G, 6A L3 (5)- 2G, 3A	**13** L1 (2)- 2A L2 (8)- 2G, 6A L3 (5)- 2G, 3A	N/A
Committee: Finance and Performance committee	**Gaps in assurance**	**5**	**8**	**8**	N/A
Principal Exec: Chief Finance Officer	**Current Risk Score**	**12**	**12**	**12**	N/A
Date added: September 2023	**Target Risk Score and Date**	**9** (Mar 29)	**9** (Mar 29)	**9** (Mar 29)	N/A
Date last discussed: 23 November 2023 (ELT)	**Risk appetite and max tolerance**	TBC	TBC	TBC	TBC

Risk Ref & Description: 07 - There is a risk that the Trust does not protect and develop its information assets to ensure that they are complete, accurate, accessible, and effectively utilised to support safe and efficient service delivery, fulfilment of strategic objectives, and meet compliance requirements	**Quarter**	**Q3 2023/24**	**Q4 2023/24**	**Q1 2024/25**	**Q2 2024/25**
	Overall Assurance Rating (RAG)	**AMBER**	**GREEN**	**GREEN**	N/A
Causes: inadequate policies / procedures, staff behaviours, limited funding, insufficient implementation and support resources (capacity and capability), external factors (e.g. cyber-attack, third party performance and management, national and ICS governance relating to funding & process requirements)	**Number of controls in place**	**10**	**11**	**11**	N/A
Consequences: potential for patient harm, inability to deliver services, negative impact on staff, data compromised (confidentiality, integrity and availability) and potentially lost, non-compliance with legislation and best practice standards, poor decision making, reputational damage and financial loss	**Gaps in Controls**	**8**	**7**	**7**	N/A
Strategic Aim: KSO 1 - 5	**Assurances and RAG rating**	**13** L1 (1) - 1G L2 (9) - 8G,1A L3 (3) - 2G,1A	**14** L1 (1)- 1G L2 (10)- 9G, 1A L3 (3)- 2G, 1A	**14** L1 (1)- 1G L2 (10)- 9G, 1A L3 (3)- 2G, 1A	N/A
Committee: Finance and Performance Committee	**Gaps in assurance**	**4**	**4**	**4**	N/A
Principal Exec: Chief Strategy Officer	**Current Risk Score**	**12**	**12**	**12**	N/A
Date added: September 2023	**Target Risk Score**	**8** (Target date = Jul 24)	**8** (Target date = Jul 24)	**8** (Target date = Jul 24)	N/A
Date last discussed: 13 November (ELT)	**Risk appetite and max tolerance**	TBC	TBC	TBC	TBC

Risk Ref & Description: 08 There is a risk that the Trust does not develop and maintain collaborative relationships with partner organisations built on shared objectives and mutual trust that may impact adversely on the ability to deliver a sustainable future and trust strategy and improve the health of the populations we serve	**Quarter**	**Q3 2023/24**	**Q4 2023/24**	**Q1 2024/25**	**Q2 2024/23**
	Overall Assurance Rating (RAG)	**AMBER**	**GREEN**	**GREEN**	N/A
Causes: the Trust and /or system partners do not effectively engage with the system framework or direct arrangements, ineffective communication, absence of shared goals	**Number of controls in place**	**4**	**4**	**4**	N/A
Consequences: failure to achieve system and Trust objectives, negative impact on patient outcomes and experience	**Gaps in Controls**	**5**	**3**	**4**	N/A
Strategic Aim: KSO 1, 2 and 3	**Assurances and RAG rating**	**9** L1 (3) - 3G L2 (5) - 4G,1A L3 (1) - 1A	**12** L1 (3) - 3G L2 (7) -6G,1A L3 (2) – 1G,1A	**12** L1 (3) - 3G L2 (7) -6G,1A L3 (2) – 1G,1A	N/A
Committee: Strategic Development Committee	**Gaps in assurance**	**2**	**0**	**0**	N/A
Principal Exec: Chief Executive Officer	**Current Risk Score**	**15**	**12**	**12**	N/A
Date added: September 2023	**Target Risk Score**	**10** (Target date = Jul 24)	**6** (Target date = Jul 24)	**6** (Target date = Jul 24)	N/A
Date last discussed: 13 February 2024 (ELT)	**Risk appetite and max tolerance**	TBC	**TBC**	**TBC**	TBC

Strategic Aim: KSOs 1, 2 and 3	Overall Assurance Rating (RAG)	Q3 2023/24	Q4 2023/24	Q1 2024/25	Q2
		AMBER	AMBER	AMBER	N/A
Risk Ref & Description: 01 – There is a risk that the Trust fails to deliver safe, effective, caring, responsive and well-led patient services **Causes:** ineffective operational / clinical management (including management of resources and risks / incidents), failure of third-party service providers, ineffective and unpredictable staff behaviours (e.g., communication), physical infrastructure failure **Consequences:** negative impacts on patient outcomes / experiences, potential harm to people, failing to meet regulatory performance targets, financial implications including losses, regulatory intervention, criminal prosecution, and reputational damage					
Committee	Quality and Safety Committee	Date Added:		September 2023	
Principal Exec	Chief Nursing Officer	Date Reviewed:		12 April 2024	
Supporting Exec(s)	Chief Medical Officer Director of Operations	Last discussed:		16 April 2024 (ELT)	
Risk Assessment	**Consequence**	**Likelihood**		**Score**	
Inherent Risk Rating	5 (Severe)	5 (Almost Certain)		25	
Current Risk Rating	5 (Severe)	2 (Unlikely)		10	
Target Risk Rating	5 (Severe)	1 (Rare)		5 (Target date = Dec 24)	
Controls (what are we doing about risk)	**Gaps in Controls (where are we failing to put systems in place)**	**Assurances and RAG rating (how do we know if it's working)**		**Gaps in assurance (what additional assurance is needed)**	
1. Governing documents, policies and procedures including horizon scanning for changes to legislation and care standards and mandatory staff training and staff induction.	Not all staff are aware of governing documents, policies and procedures (refer to action 3) QNet search function and naming process for policies makes location of documents challenging at times (refer to action 14) Process for staff checking for new policies and procedures and keeping up to date (refer action 3 and longer term actions) Introduction to policy locations at local induction (refer to action 3 and longer term actions Review of which networks we should be aligned with externally (refer to action 11) Not meeting all national standards (refer action 13)	1st line: Governance meetings for all services which do not meet national standards. Minutes available at Clinical Governance Group (April 2024, Amber) 2nd line: Mandatory Training reports generated by Learning and Development Centre and shared to department heads (April 2024, Green) Minutes of meetings seen in Q&S committee for Nursing Quality Forum (April 2024, Green) Out of date policy report seen at Audit and Risk Committee (December 2023, Green)		Lack of assurance that workforce compliance checks and local inductions are completed for all areas and that staff are aware of governing documents, policies and procedures – (refer to longer term actions) Currently no overall MAST reporting to FPC and ELT for scrutiny (refer to action 2) There is a requirement, set by ELT to review the effectiveness of local induction and MAST training – Internal audit review to be scheduled (refer to longer term actions) There is no integrated assurance framework (refer to action 10) Confirmation is required as to route of assurance for information shared via Hospital Management Team Meeting (refer action 4)	
2. Documented agreement of compliance responsibilities with service providers such as independent sector,	Not managing all third party contracts appropriately which leads to risk of service delivery (refer to action 15)	1st Line: Monthly governance meeting with ICS to review, incidents and risks (April 2024, Green)			

Sterile services suppliers and Service level agreement provider		Use of Datix reporting to review issues(April 2024, Green) Medical Devices Group meeting reviews new kit (April 2024, Amber) Approval Process of change of practice via Clinical Governance Group well embedded (April 2024 Green)	Medical Devices Group clinical lead stepping down in May. (April 2024, Amber) (refer action 16)
3. Clearly defined and documented responsibilities, especially in leadership roles including the use of the appraisal framework. Right people in right roles ensuring we have appropriate clinical engagement and that we follow robust recruitment processes	Not all staff are up to date with appraisals or have up to date job descriptions	2nd Line Appraisal compliance reported by HR team on monthly basis (April 2024, Green) 2rd Line Staff Survey results (April 2024, Green)	Internal audits to review; number of staff with up to date job descriptions, appraisal quality, and recruitment process (refer to longer term action)
4. CQC preparation utilising benchmarking and self assessment allows us to understand potential gaps and areas for development	None	1st Line: CQC preparation self-assessment has been completed and is being reviewed to identify gaps (April 2024, Amber) 1st line 5 Rolling Quality Review Visits (April 2024 Amber) 1st Line CQC preparation updates and feedback at ELT, Clinical Governance groups, Quality and Safety Committee and Nursing Quality Forum and Board seminar. (April 2024, Green)	None
5. Learning from incidents and SIs. Patient Safety and Incident Response Framework (PSIRF) policy and plan in place	None	2nd Line: Q&S and CGG review serious incidents and Formal internal investigations as required (last tabled April 2024, Green) 3rd Line Minutes of ICB quality review meetings and SI panels – action plans monitored via Q&S (April 2024, Green) Internal Audit review risk management on an annual basis (April 2024, Amber)	None
6. Clinical Audit programmes to identify risks to patient safety and quality of care.	Sharing learning from clinical audit activity to be robustly rolled out via clinical governance group (refer to action 9)	2nd line: Q&S committee and Audit & Risk Committee (ARC) see the progress against clinical audit plan and output planned for April 2024 (April 2024, Amber)	Assurance reporting to ARC re clinical audit learnings being rolled out via clinical governance group (refer to action 9)

7. Freedom to Speak Up (F2SU) Framework in place to support the timely and effective remediation of staff concerns.	Review of F2SU in progress to identify any control gaps (refer to action 1)	2nd line: Board receive quarterly freedom to speak up reports including updates on numbers of "speak ups", whistleblowing and "Tell Nicky (April 2024, Amber) ARC receives regular FTSU reporting (April 2024, Amber)	Q&S committee will review F2SU tool kit and action plan until the cultural change is embedded within the organisation (refer action 1) Assurance from external FTSU provider

Immediate Actions	**Timescale**	**Lead**	**Status** (complete, on track, off track, not yet started)
1. Deliver action plan to address gaps identified in the FTSU toolkit review with assurance reporting to Q&S Committee. Roll out of new FTSU methodology April 2024	April 2024	Chief Nurse	On track
2. ELT review of MAST data	July 2024	CPO	MAST data seen at directorate level
3. Develop policy lists for local inductions, add process for socialisation of new policies to the Policy for policies and explore digital solution for easy access	June 2024	CPO and Head of Risk	Not yet started
4. Identify governance routes for HLT and CD Meetings	April 2024	CMO and CS	Review of Trust corporate governance in line with well led review.
5. To reinvigorate process for reviewing out of date policies	February 2024	Head of Risk	Complete
6. To review gaps in CQC actions from previous inspection and take action to address	December 2023	Chief Nurse	Complete. Action plans being managed via ELT
7. Roll out of PSIRF methodology	January 2024	Head of Risk	Complete
8. To develop action plan addressing learning from CQC self-assessment	January 2024	Chief Nurse	Complete. Board presentation and information pack created for Board members
9. Clinical audit learnings to be robustly rolled out via clinical governance group with assurance reporting to ARC	May 2024	CMO	On track
10. Development of integrated assurance framework	April 2024	Chief strategy officer	On track
11. Review of which external networks the Trust should be linked to	July 2024	CNO CMO	On track
12. Regular reporting on learning from serious incidents to the quality and safety committee established	April 2024	CNO CMO	Complete. CMO to take learning to QSC
13. Review national standards and gap analysis (linked to Corporate risk register number 3)	April 2024	CMO, CDs	On track
14. Review QNet search function and consider renaming some of the frequent accessed policies	May 2024	Comms manager	On track
15. Assessment of all Clinical SLAs to identify areas of concern	June 2024	CFO and CMO	Not yet started
16. Appointment of new medical devices lead clinician	June 2024	CMO	Not yet started

Longer term actions (with indicative timeframe e.g. Q1 2024)

Policy guide for clinicians with QR code – Business case for Qnet refresh if supported would deliver enhanced search function.
Commission internal audit to review a range of Workforce and OD related processes including recruitment, job description quality, appraisal quality, effectiveness of local induction and MAST training (May 24) – Chief People Officer
Commission internal audit to review how the Trust manages staff awareness of governing documents, policies and procedures

Links to Corporate Risk Register	Risks 1 & 2 Patient Transfers, 3 – National Clinical Standards, 4 - Procurement management, 5 – Compliance with Standards 6 – Major incident, 8 – Speaking Up, and 12 – Mental Capacity Act

Strategic Aim: KSO 1-5	Assurance Rating (RAG)	Q3 2023/24	Q4 2023/24	Q1 2024/25	Q2 2024/25
		AMBER	AMBER	AMBER	N/A

Risk Ref & Description: 02 – There is a risk that the Trust's **workforce strategy** fails to address the key external and internal challenges to support delivery of its operational and strategic objectives

Causes: Inadequate leadership and / or resources and a focus on reactive issues mean the workforce team, corporate and clinical services do not address the important workforce challenges (e.g., capacity and capability, education and training, health and well-being, engagement and morale, culture and behaviours, equality, diversity and inclusion, ineffective third party provider functions, industrial action and key person dependencies) and / or fail to keep up to date with national / regional requirements

Consequences: Potential reduction in clinical or corporate service capacity or quality with negative impact on care and / or patient and service user experience and outcomes, negative impact on staff health and wellbeing, financial implications including increased temporary staff spend, regulatory intervention, reputational damage, employee grievances / tribunals, higher staff turnover, or potential challenges in recruitment

Committee	Finance and Performance Committee	Date Added:	December 2023
Principal Exec	Chief People Officer	Date Reviewed:	25 March 2024
Supporting Exec(s)	NA	Last discussed:	ELT 2 April 2024
Risk Assessment	**Consequence**	**Likelihood**	**Score**
Inherent Risk Rating	5 (Severe)	4 (Likely)	20
Current Risk Rating	3 (Moderate)	4 (Likely)	12
Target Risk Rating	3 (Moderate)	3 (Possible)	9 (Target date = March 2025)

Controls (what are we doing about risk)	Gaps in Controls (where are we failing to put systems in place)	Assurances and RAG rating (how do we know if it's working)	Gaps in assurance (what additional assurance is needed)
Recruitment – supporting our current and future workforce needs			
1. Embedding the Trust People and Culture Strategy in order to be **a great place to work** with the right staffing and where individuals and teams are able to do their best work.	Development and implementation of **new People and Culture Strategy** in line with the Sussex People Plan. (Refer to action 1). **Review the end to end recruitment** process, inc: clarity on time to hire, summary recruitment pipeline reporting and review of recruitment / vacancy risks (Refer to action 2). Lack of resource to provide **adequate business partner support** to services in managing their recruitment / retention issues. (Refer to action 3). Absence of a policy or procedure for **managing medical rotation**, inc. regular reporting on training gaps and mitigations. (Refer to action 4). Lack of **EDI lens applied to policy development** and review. (Refer to action 5) Inclusion of **local induction** as part of Trust KPI's (Refer to action 6) and implementation of new **appraisal** framework (Refer to action 7). Ensuring effective **Speak up**, listen up and follow up of staff concerns. (Refer to action 8). Legacy **Trust values** require review supported by a **behavioural framework** to enable culture and OD work (Refer to action 9).	1st Line: Monthly meeting between CPO, CNO and Freedom to Speak up Guardian (Nov 23, Green). JCNC & JLNC (bi-monthly, Amber). Monthly Senior Management Team (SMT) and Service Performance Review (PR) monitoring of operational performance (Monthly, Amber). Monthly service meetings / Local Faculty Group meetings with medical trainees (Monthly, Amber). 2nd Line: Bi-monthly exception reporting to F&P and Board on Trust performance (Apr 2024, Amber). Monitoring and review of workforce strategy through Strategy Development Group (SDG) (Mar 24, Amber). Bi-annual reporting of speak up concerns to Audit committee and Board (Mar 24, Green) 3rd line: Annual GMC Survey linked to action 4 (June 23, Green).	New People and Culture Strategy to be reviewed by the Strategic Development Committee. ELT, Board Seminar Apr 24 and implementation managed though F&P. EDI Group being stood up. Lack of triumvirate working and action planning and escalation of feedback from Local Faculty Groups - redefining our organisation work underway, consultation for rewire open through Mar 24. New triumvirate teams transition from Apr 24

	Management of **temporary staffing** use and spend. (Refer to long term actions)		
Retention – Looking after our people and their sense of belonging			
2. Actively **looking after the wellbeing of all our staff** and ensure a safe and healthy working environment.	Lack of contract for **salary sacrifice** (Vivup) **and Employee Assistance Programme** (Care First) from Feb 24. (Refer to action 10). Lack of timely and effective **review of national staff survey data** and implementation of local and Trust actions, reviewed on an annual cycle. (Refer to action 11). Lack of **health and wellbeing framework** / strategy. (Refer to action 12) Lack of resource to develop and implement more preventative **VPR** initiatives. (Refer to action 13). Lack of resource and budget for health and wellbeing events and publicity. (Refer to action 14).	1st Line: Monthly meeting with OH service providers (Feb 24, Green). 2nd Line: Annual reporting of Staff Survey and Bi-monthly exception reporting for OH and Health and wellbeing through Health and Safety & Quality and Safety and onto Board (Feb 24, Green). Monthly reporting on VPR to ICB (Feb 24, Green)	Lack of monthly review of staff survey actions, health and wellbeing at SMT and PR's. Currently ICB assurance only covers a small number of projects, inc. VRP
3. Implementing our EDI objectives in order to be compassionate and inclusive, eliminate discrimination and **ensuring everyone feels that they belong**	Absence of **EDI Group and networks** (Refer to action 5) There is a need to develop a longer term EDI implementation plan. (Refer to long term actions)	1st line: Action plan progress tracked within Workforce on a weekly basis (Feb 24, Green). 2nd Line: Bi-monthly reporting in workforce performance report to F&P and Board (Dec 23, Amber). Monthly reporting on EIA 6 HIA to ICB (Starting in Feb 24).	Development of proxy EDI outcome metrics aligned to NHS requirements
4. **Inspiring our leaders** in a clinically led culture of kindness, compassion and learning through our existing support for leadership and development.	Lack of **leadership and development framework** (refer to action 15) covering talent (refer to action 16) and leadership (including cultural competence), **just culture, civility** and **high performance** team work and improvement. (Refer to longer term actions). Implementation of clinically led directorate and business unit leadership model, supported by integrated assurance framework and new scheme of delegation. (Refer to long term actions).	2nd line: Bi-monthly exception reporting in workforce performance report to Education and Development Group, F&P and Board (Amber).	None
Development and reform – working as one team and developing a multi-skilled workforce			
5. **Supporting all our staff in their education and development** for the workplace today and tomorrow through: • **strategies to mitigate local skill and recruitment challenges** and respond to national shortages • Embedded **education and training programmes**, covering induction, NHSE and	Failure to utilise the entire apprenticeship levy each year (tbc) Underperformance of local induction (all staff groups), appraisal (AfC staff only) and MAST compliance (Medical staff only). (Refer to action 18). There is a need to develop long term workforce planning tools to support new roles and ways of organising work. (Refer to action 19).	1st line: Monthly MAST training reports for managers (Mar 24, Green). 2nd line: Bi-monthly exception reporting in workforce performance report to Education and Development Group, F&P and Board (Apr 24, Green). Annual apprenticeship report (Sept 23, Green).	Lack audit of local induction and appraisal completion including objective setting / PDP. Need to review Education and Development Group TOR Audit of local induction and appraisal completion including objective setting / PDP.

non-mandatory training / CPD funding, **work experience** and **apprenticeship** supported by bi-monthly Education and Development Group (EDG).			

Immediate Actions	**Timescale**	**Lead**	**Status** (complete, on track, off track, not started)
1. Development of new People and Culture Strategy	Sept 24	CPO	On track
2. End to end recruitment task and finish group established	Sept 24	Head of Resourcing	Not started
3. POAP for new resourcing Business Partner	Dec 23	CPO	Complete
4. Managing medical rotation guidance	Mar 24	Head of Med Ed	Not started
5. Establishment of new EDI Group and re-establish staff networks	Dec 23	CPO	Complete
6. Inclusion of local induction as part of Trust KPI's	March 24	Deputy CPO	Not started
7. Implementation of new appraisal framework	Dec 23	Deputy CPO	On track
8. Implementation of new Speak Up toolkit recommendations	Oct 23	CPO / CNO	Off track
9. Review of Trust values - Tender	Dec 23	CSO	On track
10. Tendering of salary sacrifice and employee assistance programme	Mar 24	Deputy CPO	Not started
11. Focus on local staff survey action planning	April 24	Head of OD	Not started
12. Design and implementation of health and wellbeing plan	Mar 24	Head of ER	Not started
13. VPR implementation in line with ICB plans / case for additional support as part of business planning	Mar 24	Deputy CPO	On track
14. Review resource and budget for health and wellbeing initiatives	Nov 23	CPO	On track
15. Design and implementation of Trust leadership and development framework	June 24	CPO / Head of OD	On track
16. Succession planning for Exec team implemented	Jun 24	CPO	On track
17. Mediation training for managers	Apr 24	Head of ER	Not started
18. Actively manage underperformance of medical MAST training	Apr 24	Head of Med Ed	Not started
19. Development of workforce planning tools and training	Jun 24	CPO / Head of OD	Not started

Longer term actions (with indicative timeframe e.g. Q1 2024)

- New People and Culture Strategy to be reviewed by the Strategic Development Committee (September 2024)
- Development of values and behavioural framework (September 2024)
- Development of sub-strategies within People Strategy, Inc.:
  - Resourcing
  - Wellbeing strategy
  - Talent Management and Succession planning
  - Systematic process to support staff development, and career progression (Talent Management)
  - Education strategy
- People strategy, linked to medical, nursing, AHP and strategies by staff group
- Implementation of clinically led directorate and business unit leadership model, supported by integrated assurance framework and new scheme of delegation.
- Improved understanding around temporary staffing use / medical job planning / productivity through new Integrated Assurance Process
- Embedded processes for medium and long term workforce planning with links to transformation

Links to Corporate Risk Register	

Strategic Aim: KSO 1, 2, 3, 4 and 5	Overall Assurance Rating (RAG)	Q3 2023/24	Q4 2023/24	Q1 2024/25	Q2 2024/25
		AMBER	AMBER	AMBER	N/A
Risk Ref & Description: 03 - There is a risk that the Trust's physical infrastructure (i.e. buildings and services) is not fit for purpose to support an effective, efficient and safe environment for operational delivery **Causes:** Ageing infrastructure, lack of financial investment resulting in back log of maintenance / repairs, ineffective governance, inadequate resources, failure of critical third-party suppliers **Consequences:** Potential harm to individuals, disruption to / inefficiencies within clinical and support services, damage to physical infrastructure (i.e. the buildings and the services e.g. heating systems, electrical infrastructure, cooling and ventilation systems), financial loss, regulatory intervention, reputational damage, negative impact on staff morale				
Committee	Finance and performance committee	Date Added:		12 October 2023	
Principal Exec	Chief finance officer	Date Reviewed:		25 March 2024	
Supporting Exec(s)	Chief strategy officer	Last discussed:		2 April 2024(ELT)	
Risk Assessment	**Consequence**	**Likelihood**		**Score**	
Inherent Risk Rating	5 (severe)	4 (likely)		20	
Current Risk Rating	5 (severe)	3 (possible)		15	
Target Risk Rating	3 (severe)	2 (unlikely)		6 (Target date = April 2031)	
Controls (what are we doing about risk)	**Gaps in Controls (where are we failing to put systems in place)**	**Assurances and RAG rating (how do we know if it's working)**		**Gaps in assurance (what additional assurance is needed)**	
1. Fully budgeted backlog maintenance schedule for 23/24 agreed in response to six facet survey (undertaken every 5 years by independent surveyor)	Produce a detailed 5 year backlog maintenance plan informed by the six facet survey (refer to action 2) plus any urgent estates issues arising Review survey results on an annual basis and adjust backlog maintenance plan as needed (refer to action 11)	1st line: Draft 5 year plan has been produced and being reviewed. Will be reviewed monthly (Green) 2nd line: Backlog maintenance schedule for 24/25 will be reviewed with Finance monthly to track progress and spend (Green) Summarised backlog maintenance reporting to capital programme group (CPG) monthly (Amber) Estates and facilities reporting to F&P (quarterly) covers a status update on the backlog maintenance plan progress (Amber) 3rd line: Independent six facet survey which gives a complete assessment of the status risk of entire estate (not due until 2028 per NHS Estates guidance)		Formal report to CPG outlining the detail of the maintenance plan (refer to action 4) Improve quality and detail of report to F&P in January 2024 (refer to action 5)	
2. Contracts in place allowing access to specialist expertise. External Authorising Engineers, (AEs), for medical gasses, water, fire, lifts, ventilation and electrical to independently test controls, and provide support in the event of deterioration of the essential services (e.g. advice on remediation)	AE's must be appointed in writing and perform an annual audit of the site with recommendations for improvement. AE's would attend their relevant Safety Group meetings as set out in the HTM's. QVH do not yet have all the necessary safety groups set up.	2nd line: AEs attend and contribute to QVH safety groups meetings which are minuted. Contributions include the provision of interim and annual reports; the latter provides assurance on the controls in place. Assurance rating determined as Amber based on the		Estates team to create a spreadsheet to show service, name of AE, contract period and reporting arrangements (refer to action 6)	

Findings from third party reviews are sighted by estates team to raise / update the departmental risk register		attendance and receipt of reports, not the findings of the reports 3rd line: Annual reports from AEs showing the status of controls in place (e.g. up to date policies, qualifications of staff etc). Assurance rating determined as Amber based on the findings of the reports Annual Asbestos Management Survey to identify high risk areas for removal (June 2023, Amber) There has not been a plan in place to remove asbestos other than when area is developed.	Estates to provide a summary report to F&P to highlight any exceptions arising from the AE annual reports (refer to action 7) A quote has been requested from a framework specialist contractor to undertake a full asbestos survey and produce the Asbestos register. Awaiting quote.
3. Policies and standard operating procedures in place. Mechanism in place for regular review and ratification of policies.	SOPs are not centralised and require a review and possible update to ensure they are fit for purpose (refer to action 3) Training for staff on SOPs (refer to action 3)	2nd line: The monthly estates and facilities steering group (attended by risk function) have oversight of the status of policies and SOPs. Meetings are minuted (Nov 23, Policies = Green, SOPS = Amber)	1st line: Internal review of effectiveness of standard operating procedures (Long term action once the SOPS have been updated)
4. Business continuity plans (BCPs) for dealing with a range of estates issues, for example electricity and water failure.	Review and updating of existing business continuity plans to ensure these are fit for purpose. This should include a review of the full scope of potential scenarios that need planning for (refer to longer term actions) Training for staff regarding business continuity plans for estates (refer to longer term actions) Trust wide testing of business continuity plans (refer to longer term actions)	No formal assurance mechanisms in place; controls are viewed as requiring urgent improvement building in learnings from electricity failure to main theatres incident in August 23	2nd line: Reporting on the status of BCP reviews / tests to the monthly estates and facilities steering group and QVH's Emergency Planning Lead
5. Effective management of critical suppliers including resilience planning (e.g., identification of alternative providers)	Absence of formal Contract Management processes (refer to longer term actions) Lacking comprehensive list of critical suppliers (refer to action 12)	1st line: Monthly or quarterly service reviews with critical suppliers (Nov 23, Red) New critical suppliers' procurement process on-going	Estates team to create schedule for quarterly service review meetings in 2024, ~~with all suppliers to have had initial meeting by 31 March 2024 (refer to longer term action)~~
6. Planned preventative maintenance (PPM) covering all plant (e.g. regular servicing / inspections) to ensure compliance with statutory legislation / regulations and NHS guidance	No central asset register covering all essential plant (refer to action 1) Fully integrated CAFM system needed for estates and facilities which would incorporate SFG20 to schedule PPM's based on updated asset register (refer to longer term actions)	1st line: Reporting progress on PPM to F&P quarterly (Feb 24, Red)	Asset register is currently being undertaken by external company. Micad CAFM system has been purchased

7. Premises Assurance Model (PAM) annual submission to NHSE by September showing the status of the estate. This is a self- assessment tool across areas including policies / procedures, roles and responsibilities, risk assessment, maintenance, training and development etc. which is used by the estates team to drive a development plan		None identified	1st line: Summarised PAM results to be routinely reviewed and reported by the Estates team to F&P (refer to action 9)
8. Roles and responsibilities defined and documented within the estates team	Estates structure, including roles and responsibilities, require review and updating e.g. to ensure all Authorised Person roles are fulfilled (refer action 8)	3rd line: Annual performance management reviews of AP's are carried out by the AE's with findings reporting in the annual report (Amber)	
9. Risk management framework in place for the identification, management and reporting of estates risks	Estates risk register requires a review and update (refer action 10)	2nd line: The monthly estates and facilities steering group (attended by risk function) have oversight of the estates risk register. Meetings are minuted (Amber)	

Immediate Actions	**Timescale**	**Lead**	**Status** (complete, on track, off track, not yet started)
1. To produce a central Asset list for all essential plant	30 May 2024	Interim associate director of estates and facilities (IADEF)	In progress – completion in Q1 2024/25
2. Produce a 5 year back log Maintenance Plan	29 February 2024	IADEF	Completed
3. SOP review and development of training programme for 2024	30 May 2024	IADEF	In progress – completion in Q4 23/24
4. Formal report to CPG outlining the detail of the maintenance plan	30 November 2023	IADEF	In progress – completion in Q4 23/24
5. Improve quality and detail of report to F&P	29 February 2024	IADEF	In progress – completion in Q4 23/24
6. Estates team to create a spreadsheet to show service, name of AE, contract period and reporting arrangements	30 April 2024	IADEF	In progress – completion April 2024
7. Estates to provide a summary report to F&P to highlight any exceptions arising from the AE annual reports	31 March 2024	IADEF	In progress – completion in March 2024
8. Estates structure, including roles and responsibilities, require review and updating	30 April 2024	IADEF	In progress – completion in Q1 24/25
9. Commence summarised reporting of PAM results to F&P	30 April 2024	IADEF	In progress – completion in January 2024
10. Review and update estates risk register	31 March 2024	IADEF	In progress – completion in Q4 23/24
11. Review six facet survey results and adjust backlog maintenance plan as needed with sign off by CFO and F&P (Feb 2024 and annually thereafter)	29 February 2024	IADEF	In progress – completion in Q4 23/24
12. Create comprehensive list of critical suppliers with support from procurement team	30 May 2024	IADEF	In progress – completion in Q1 24/25
13. Recruitment of a substantive Associate Director of Estates and Facilities	Completed	Chief Finance Officer	Completed

Longer term actions (with indicative timeframe e.g. Q1 2024)

- Development of the Estates Strategy - Started February 2024, dependant on the clinical strategy Target completion August 2024
- Rebuild the Hospital Site – New hospital Programme – Estimated timeline 1st April 2031
- Purchase and launch new CAFM system with SFG20 software to support planned preventative maintenance – May 2024
- Estates team to consider assurance mechanisms once asset register and updated PPM are in place – May 2024
- Establish robust contract management processes and improve compliance with procurement regulations – May 2024
- Annual review of six facet survey results and adjust backlog maintenance plan as needed with sign off by CFO and F&P – May 2024
- BCP review and development of training / testing programme for 2024 – May 2024
- Reporting on the status of BCP reviews / tests to the monthly estates and facilities steering group and Emergency Planning Lead – May 2024
- Estates team to create schedule for quarterly service review meetings in 2024, with all suppliers to have had initial meeting by May 2024
- Internal review of effectiveness of standard operating procedures – May 2024

Links to Corporate Risk Register	6 - Major incident

Strategic Aim: KSOs 1, 2, 3, 4 and 5	Overall Assurance Rating (RAG)	Q3 2023/24	Q4 2023/24	Q1 2024/25	Q2 2024/25
		AMBER	GREEN	GREEN	N/A
Risk Ref & Description: <u>04 – There is a risk that the Trust fails to secure its long-term sustainability leading to closure of services and /or the site</u> **Causes:** Inadequate or ineffective strategic planning / delivery, lack of effective stakeholder engagement (internally and externally) / support, internal governance failures, inadequate leadership capability and capacity, failing to address environmental sustainability matters, emergent change at a trust, system or national level that may impact strategy requirements **Consequences:** potential for loss of patient services, reduction in staff morale, challenges with recruitment and retention, loss of community employment and local facilities					
Committee	Strategic Development Committee	Date Added:		September 2023	
Principal Exec	Chief Executive Officer	Date Reviewed:		28 March 2024	
Supporting Exec(s)	Chief Strategy Officer	Last discussed:		ELT 2 April 2024	
Risk Assessment	**Consequence**	**Likelihood**		**Score**	
Inherent Risk Rating	5 (severe)	5 (almost certain)		25	
Current Risk Rating	4 (major)	3 (possible)		12	
Target Risk Rating	3 (moderate)	2 (unlikely)		6 (Target date = September 24)	
Controls (what are we doing about risk)	**Gaps in Controls (where are we failing to put systems in place)**	**Assurances and RAG rating (how do we know if it's working)**		**Gaps in assurance (what additional assurance is needed)**	
1. Detailed strategy development framework and milestone roadmap approved by Board in April 2023 Outline strategy structure in place setting out the elements of the strategy including the enabling (e.g. digital) and golden thread strategies (e.g. green plan) Position updated within board seminar / private discussions by Chief Strategy Officer (CSO)	None	<u>2nd line:</u> Strategy updates provided to hospital management team on a monthly basis (commenced Nov 23 ongoing, Green) Update provided to Board seminar (Feb 24, Green) <u>3rd line:</u> High level options board paper share with ICB who reported being supportive of the approach (Jan 24, Green)		None	
2. Detailed strategy development programme plan setting out key milestones and actions. Weekly monitoring of plan within strategy function to ensure delivery and initiate any required actions to variance Milestone roadmap approved by Board in November 2023	None	<u>2nd line:</u> Milestone roadmap updates to ELT meetings on a monthly basis as part of SDC paper review (Feb 24, Green) Framework and milestone update provided to Board seminar (Feb 24, Green) Milestone update to be provided at SDC meetings by CSO with subsequent written committee assurance report provided by SDC Chair to the Board (Feb 24 Green)		None	
3. Clear and robust internal governance arrangements for decision making aligned to strategy objectives have been	None	<u>2nd line:</u>		None	

agreed by Chief Executive Officer / Board Chair and documented. This includes the initiation of the Strategic Development Committee (SDC) to oversee strategic development / implementation and provide assurance and advice to the Board		Annual committee review process provides assurance to the Board that the SDC is delivering in line with its terms of reference (Green). 3rd Line Governor working group in place to provide additional assurance regarding the committee assurance (Green)	
4. Financial resources budgeted in year to support capacity and capability for strategy development requirements. Resource plan held within strategy team and reviewed by CSO on a monthly basis	Resource for 2024/25 to be identified and budgeted as part of business planning (refer to action 3)	None (assurances in place as part of budgeting process captured within BAF Risk 6 Financial Sustainability)	None
5. Clear and comprehensive stakeholder engagement plans to ensure effective stakeholder engagement with internal and external stakeholders including ICB and system partners across KSS (Kent, Surrey and Sussex). Refer to BAF 8 Partnerships for details.	Refer to BAF 8 Partnerships for details.	Refer to BAF 8 Partnerships for details.	Refer to BAF 8 Partnerships for details.

Immediate Actions	**Timescale**	**Lead**	**Status** (complete, on track, off track, not yet started)
1. Strategy framework and milestone plan to be updated / shared at ELT on a fortnightly basis	1. 19/10/23	CSO	Complete
2. Decision making framework for discussion at board seminar and subsequent development	2. 12/10/23	CSO	Complete
3. Review of resource requirements and updated plan	3. In progress	CSO	Complete

Longer term actions (with indicative timeframe e.g. Q1 2024/25)
1. Review of strategic options – January 2024 - March 2024 Board – January Board paper complete and March complete 2. Phase 3 engagement plans – January – March 2024 – Plan complete and reviewed at February SDC

Links to Corporate Risk Register	None

Strategic Aim: KSO 2, 3,4 and 5	Overall Assurance Rating (RAG)	Q3 2023/24	Q4 2023/24	Q1 2024/25	Q2 2024/25
		AMBER	GREEN	GREEN	N/A

Risk Ref & Description: <u>05 – There is a risk that the Trust experiences a material legislative or regulatory compliance breach (non-clinical)</u>
(This would include financial breaches such as fraud, theft, misuse of NHS funds; breaches of legislation including health and safety; breaches of NHS statutory requirements including licence conditions. This does not include; data breaches which are covered by BAF07 – information assets, or clinical breaches which are covered by BAF01.)
Causes: failure to identify existing and new requirements, unhelpful behaviours (human error / intentional wrongdoing), staff not being adequately trained, failure of third party to deliver, failure of record keeping or IT systems, ineffective policy frameworks and processes
Consequences: potential harm to people, regulatory intervention, criminal prosecution, financial losses and reputational damage

Committee	Finance &Performance Committee	Date Added:	September 2023
Principal Exec	Chief Executive Officer	Date Reviewed:	28 March 2024
Supporting Exec(s)	Chief Finance Officer Company Secretary	Last discussed:	ELT 2 April 2024
Risk Assessment	**Consequence**	**Likelihood**	**Score**
Inherent Risk Rating	5 (Severe)	4 (Likely)	20
Current Risk Rating	4 (Major)	3 (Possible)	12
Target Risk Rating	4 (Major)	2 (Unlikely)	8 (Target date = September 24)

Controls (what are we doing about risk)	Gaps in Controls (where are we failing to put systems in place)	Assurances and RAG rating (how do we know if it's working)	Gaps in assurance (what additional assurance is needed)
1. Governing documents including Trust Constitution, Standing orders, Standing financial instructions, Scheme of delegation, Terms of reference and policies (non-clinical)	Code of conduct for Governors needs updating (refer to action 8) Training for budget holders regarding standing financial instructions and scheme of delegation (Refer to action 2) Absence of introduction to policy locations at local induction and of core mandatory policies list (e.g. policies for line managers, information governance, business standards) and lack of adequate training on policy creation / maintenance ("policy for policies") (refer to action 3) New fit and proper person record for Board members and self-attestation forms completed (refer to action 5)	<u>2nd Line:</u> Reporting to ARC of compliance with governing documents (e.g at every meeting CFO reports on losses and special payments, contracts over £30k, payments of invoices without a PO, waivers, shows some non-compliance) (March 2024, Amber) Policy log and review process reported to ARC annually shows some policies are out of date (December 2023, Amber) with Board assurance via the committee assurance report Annual report to Audit & Risk Committee (ARC) on compliance with business standards policy shows all declarations for 2023/24 are complete (December 23, Green) <u>3rd Line:</u> External audit of compliance with SFIs etc annually which is included in the annual report shows no material concerns (June 2023, Green)	Review of licence conditions and code of governance compliance by ARC (scheduled for April 2024)
2. Processes in place including: - staff induction (corporate and local non-clinical) with mandatory and statutory training (MAST) - horizon scanning for changes to legislation and communication of changes in statutory and regulatory requirements		<u>2nd line:</u> Internal reporting of MAST training compliance to executive leadership team, general managers, heads of departments and line managers once per month shows 90% compliance (March 2024, Green)	Reporting of MAST compliance for Trust is done currently for the whole organisation so specific team gaps are not being flagged. ELT and F&P review of MAST data will be included with integrated assurance report (refer to action 4)

- review of compliance against Constitutional documents and statutory and regulatory requirements - Compliance incident framework in place enabling the appropriate investigation, resolution and reporting of incidents tracked through Datix (non-clinical)		Report to ARC and Board- Review of Annual governance statement annually demonstrates a sounds system of internal control (June 2023, Green) Self-certification of compliance with Trust licence conditions reported to the Board shows compliance (March 2024, Green)	Assurance that workforce compliance checks and local inductions have been completed and are effective (refer to action 3)
3. CQC preparation action plan for the well-led domain	Continuous improvement framework (refer action 7)	2nd line: Gap analysis against CQC well led KLOE's completed and reported to ELT shows work completed to address actions from previous inspections. QI framework being procured (January 2024, Green)	Reporting on effectiveness of actions completed to address recommendations from the well-led review (refer action 5) Reporting of effectiveness of continuous improvement framework (refer action 7)
4. External counter fraud support provided by external specialist provider who delivers an annual work programme to meet compliance requirements	None identified	3rd Line: Assurance reporting to ARC from local counter fraud specialist (RSM) quarterly shows no material concerns (March 2024, Green)	
5. Freedom to Speak Up framework in place	External freedom to speak up guardian in place (planned for Q1 2024/25)	2nd line: Board receive quarterly freedom to speak up reports including updates on numbers of "speak ups", whistleblowing and "Tell Nicky" demonstrate requirement for external freedom to speak up guardian (Board January 2024, Amber)	Reporting on effectiveness of freedom to speak up function once external freedom to speak up guardian in place

Immediate Actions	**Timescale**	**Lead**	**Status** (complete, on track, off track, not yet started)
1. Delivery and reporting of Trust-wide programme of increased visibility of exec and non-exec colleagues	April 2024	CNO and CS	On track
2. Targeted communication to staff groups to increase awareness of requirements of governing documents and regulatory requirements including training for budget holders regarding standing financial instructions and scheme of delegation	April 2024	CFO and CS	On track
3. Develop policy lists for local inductions, add process for socialisation of new policies to the Policy for policies, develop training for creation and maintenance of policies	May 2024	CPO and HoR	On track
4. Development of integrated assurance framework	May 2024	CSO	On track
5. Fit and proper person information for each Board member collated and available on ESR, as well as new self-attestation forms completed	March 2024	CS	Complete
6. Reporting on effectiveness of actions completed to address recommendations from the well led review	May 2024	CS	On track
7. Implement continuous improvement framework	September 2024	CSO	On track
8. Code of conduct for governors to be updated	May 2024	CS	On track
9. Review of Trust wide Corporate Governance and implementation of new framework	September 2024	CS	On track

Longer term actions (with indicative timeframe e.g. Q1 2024)	
None	
Links to Corporate Risk Register	Risks 4 - procurement, 6- major incident, 8- speaking up

Strategic Aim: KSO 1, 2, 3,4 and 5	Overall Assurance Rating (RAG)	Q3 2023/24	Q4 2023/24	Q1 2024/25	Q2 2024/25
		AMBER	AMBER	AMBER	N/A
Risk Ref & Description: 06 – There is a risk that the Trust is unable to deliver medium to long term financial sustainability **Causes:** increasing demand outstrips resources available, impact of investment requirements and inflation, failure to deliver operational efficiencies and /or realise investment programme benefits, potential for unplanned costs (e.g., cyber-attack), lack of available workforce increasing agency spend, Ineffective management of multiple Integrated Care Systems financial transformational risks, impact of political changes and national directives **Consequences:** possible loss of operational capacity and failure to provide timely treatment to patients, failure to generate funding for investments, potential for workforce restructuring, and /or reputational damage with loss of confidence from stakeholders (e.g., ICB)				
Committee	Finance and performance committee	Date Added:		September 2023	
Principal Exec	Chief Finance Officer	Date Reviewed:		22 March 2024	
Supporting Exec(s)	Chief Executive Officer	Last discussed:		ELT 2 April 2024	
Risk Assessment	**Consequence**	**Likelihood**		**Score**	
Inherent Risk Rating	5 (Severe)	5 (Almost certain)		25	
Current Risk Rating	4 (Major)	3 (Possible)		12	
Target Risk Rating	3 (Moderate)	3 (Possible)		9 (Target date = March 2029)	
Controls (what are we doing about risk)	**Gaps in Controls (where are we failing to put systems in place)**	**Assurances and RAG rating (how do we know if it's working)**		**Gaps in assurance (what additional assurance is needed)**	
1. Annual business planning process, overseen by steering group, engages the whole organisation to pull together workload for the year and cost of delivery. Included within this is also the efficiency programme to maximise use of resources and identification of risks. The financial plan produced in line with the System Medium term financial plan.	The late publication of National Planning guidance; to mitigate this, key assumptions are made based on existing guidance and early review of planning guidance is scheduled to understand the impact on the plan and ensure timely briefings can be issued to the organisation. No further action required.	2nd line: Progress updates and outputs are reported through the internal governance framework including steering group, ELT, F&P, Board (Green) through Nov to Mar 3rd line: Progress updates and outputs are reported to the system (March 2023, Green) Internal audit – review of planning process for 23/24 completed May 23 (3rd line, Green- note this was an advisory review so no audit opinion was issued, but findings support a Green rating).		To link the medium term financial plan with the Trust Strategy when approved. + Triangulation and validation of the Business plan for 2024/25. (refer to action 9)	
2. Monthly financial reporting scrutinised by finance team, ELT, F&P and Board	Challenges with triangulating information across finance, workforce and activity / operations – scorecard required (refer to action 5).	3rd line: Internal Audit - Financial Management with reasonable assurance opinion (Q2 2023, Amber)		Financial services audit due to be completed in Q4 (3rd line, RAG rating TBC based on audit opinion)	
3. Budget holder meetings with Finance Business Partner are held monthly to discuss financial position and actions to mitigate risks identified	No Formal Budget holder training to budget mangers since Covid19 (refer to action 2)	1st and 2nd line: Monthly directorate performance review meetings provide assurance that budget holder meetings have occurred, and the financial position is understood (Amber)		Budget Holder Training pack was left by previous employee for implementation, this needs further work. A roll out plan will be in place before end of April 2024.	
4. Directorate performance reviews held monthly to enable the Directorates to raise risks and the Executive to scrutinise the Directorate budgets e.g workforce pressures, agency spend, non pay and Income.	No Formal Budget holder training to budget mangers since Covid19 (refer to action 2). Challenges with triangulating information across finance, workforce and activity / operations – scorecard required (refer to action 5)	1st and 2nd line: Reporting to ELT & F&P committees (Amber)		Budget Holder Training pack was left by previous employee for implementation, this needs further work. A roll out plan will be in place before end of April 2024.	

5. ICB review of monthly provider finance report provides external scrutiny and CFO peer challenge on financial risks at a system level which enables the Trust to put in place appropriate mitigations	The Trust may not be subject to the same level of scrutiny as larger Trusts within the system; mitigation is for the Trust to flag risks upwards to the ICB.	3rd line: System governance in place to evidence review of provider reports via the monthly Financial, Productivity and Sustainability board chaired by ICB CEO and attended by system CFOs, CEOs and COOs with minutes prepared (Amber)	No formal feedback loop to QVH Board to share outcomes of ICS review
6. Financial policies and procedures in place (including standing orders and financial instructions, scheme of delegation) with an annual review mechanism to ensure that these remain up to date	Financial governance training not in place currently (refer to action 3)	2nd line: Reviewed policies are approved by Audit Committee and Board on an annual basis (Green) Audit Committee receives assurance regarding compliance with policies through items such as waiver reports, PO compliance report, contract renewal report, financial internal audit reports and the annual external audit report (Amber)	None identified
7. Staff training - Training for budget holders on the management of budgets, understanding of financial planning, financial governance.	No Formal Budget holder training (refer to action 2)		Budget holder training not yet started. Reporting of budget holder training completed to ELT, F&P on compliance. Budget Holder Training pack was left by previous employee for implementation, this needs further work. A roll out plan will be in place before end of April 2024.
8. Risk management processes in place to facilitate the identification and management of finance related risks	Lack of comprehensive Staff Training	2nd line: Audit Committee reporting on design and implementation of risk management framework (Amber) Reporting of financial risks on Corporate Risk Register (Amber)	None identified
9. Supplier management processes including elements of due diligence	Absence of robust contract management processes including financial due diligence of new suppliers and a degree of non-compliance with procurement regulations (refer to action 1)	2nd line: Internal audit report on contract management. Only partial assurance (Amber)	Audit committee Action plan is needed to improvement contract management processes (refer to action 7)
10. System framework: (a) system first principle provides the facility for financial assistance and enables cash drawdowns to support service delivery (b) provider collaboration drives greater levels of productivity and efficiencies to support individual organisations to hit financial targets	System framework is managed by the ICBs which remain in development (refer to action 8)	3rd line System governance in place to evidence review of system efficiency and productivity programmes via the monthly Financial, Productivity and Sustainability board chaired by ICB CEO and attended by system CFOs, CEOs and COOs with minutes prepared (Amber)	No formal feedback loop to QVH Board to share outcomes of ICS review

Immediate Actions	**Timescale**	**Lead**	**Status** (complete, on track, off track, not yet started)
1. Establish robust contract management processes and improve compliance with procurement regulations	July 2024	Chief Finance officer	Work is underway for cleansing
2. Rollout of formal Budget holder training	April 2024	Chief Finance officer	On track for roll out to start Q1 24/25
3. Financial governance training for budget holders	March 2024	Chief Finance Officer	On track for roll out to start Q1 24/25
4. Rollout of Risk Management Training	March 2024	Head of Risk	On track for completion Q4 23/24
5. Develop balance scorecard	April 2024	ELT	Q4 development
6. ICB Finance reports share with ELT, F&P & Board	March 2024	ELT	Q4 Completion

7. Develop an action plan to improve contract management processes 8. Work with the system to develop provider collaboratives to drive productivity and efficiency 9. Triangulation and validation of assumptions in financial plan by external body	July 2024 March 2025 May 2024	Chief Finance Officer ELT Chief Finance Officer	First draft action plan submitted March 24 On Track for completion Q4 23/24 Work is underway for completion
Longer term actions (with indicative timeframe e.g. Q1 2024)			
- Introduce new financial reports that allow strategic oversight and operational performance to be measured (Q1 2024/25) - Introduce focused Programme Delivery for all efficiencies identified through business planning (Q1 2024/25) - Identify opportunities for income growth as part of system collaboration (Q1 2024/25)			
Links to Corporate Risk Register	Risks 4 – Procurement, 6 - Major Incident, 10 – Financial Plan		

Strategic Aim: KSOs 1 to 5	Overall Assurance Rating (RAG)	Q3 2023/24	Q4 2023/24	Q1 2024/25	Q4
		AMBER	GREEN	GREEN	GREEN

Risk Ref & Description: 07 - There is a risk that the Trust does not protect and develop its information assets to ensure that they are complete, accurate, accessible, and effectively utilised to support safe and efficient service delivery, fulfilment of strategic objectives, and meet compliance requirements

Causes: inadequate policies / procedures, staff behaviours, limited funding, insufficient implementation and support resources (capacity and capability), external factors (e.g. cyber-attack, third party performance and management, national and ICS governance relating to funding & process requirements)

Consequences: potential for patient harm, inability to deliver services, negative impact on staff, data compromised (confidentiality, integrity and availability) and potentially lost, non-compliance with legislation and best practice standards, poor decision making, reputational damage and financial loss.

Committee	Finance and Performance Committee	Date Added:	September 2023
Principal Exec	Chief Strategy Officer	Date Reviewed:	08 April 2024
Supporting Exec(s)	Director of operations	Last discussed:	26 February 2024 (FPC)
Risk Assessment	**Consequence**	**Likelihood**	**Score**
Inherent Risk Rating	5 (Severe)	5 (Almost certain)	25
Current Risk Rating	4 (Major)	3 (Possible)	12
Target Risk Rating	4 (Major)	2 (Unlikely)	8 (Target date = July 2024)

Controls (what are we doing about risk)	Gaps in Controls (where are we failing to put systems in place)	Assurances and RAG rating (how do we know if it's working)	Gaps in assurance (what additional assurance is needed)
1. Digital services policies and procedures (Information governance, information technology and security) in place. Policy review period in place for regular review and updates made in line with agreed timescales. 2. A trust wide policy administrator is in place to undertake a weekly review of expired policies	Not all staff adhere to the policies and / or know the details of them (refer to longer term action)	2nd line: Trust wide policy review carried as part of CQC preparation (Green) Reporting by the corporate governance team on expired policies / policy refresh at IMT, IGG, performance review meetings and F&P (cyclical and trust wide). Meetings are minuted (Green) An annual report on policy activity including expired policies is also submitted to the Audit & Risk Committee (Green)	None
3. Annual mandatory information governance and data security training in place. Mandatory training reports in place and circulated by OD team for monitoring compliance	There is inconsistent delivery of compliance rates and no systematic formal review (refer to action 1)	2nd line: Monthly reporting of compliance internally produced by L&D team and issued to service mangers for following up non-compliance shows 90% compliance (Green) L&D produce a snapshot mandatory report as part of the annual DSPT submission to NHSE where the target is 95% compliance (June 24, Green) DSPT submission is presented to the IGG and Audit Committee (May / Jun 24, Green) 3rd line:	None

		Internal audit review a sub-set of the DSPT submission (Apr 24, Green)		
4. Patient administration system induction training on appointment (linked to user access controls - access is not provided until training is delivered). Training and access requests forms are recorded in the Clinical Systems team folders	None	None		Policy principles are clearly defined and upheld therefore it is not considered to be beneficial to put in place any assurance which would need to be a manual and resource intensive process.
5. Ad hoc communications take place trust wide via Connect newsletter regarding password, security, phishing and malware awareness and required action recommendations	Lacking a communications plan to support awareness (refer to action 2)	None		To provide progress report on communications plan to IMT once agreed (refer to action 2)
6. Ongoing security updates, reactive vulnerability scanning and penetration testing – remediation plans monitored through IMT group and SIRO	Enhanced proactive monitoring tools to be installed in 2024/25 (refer to action 3)	2nd line Reporting to IMT monthly with associated work plans to address remediation plans (Amber) Monthly reports for vulnerabilities KPIs provided to IMT. Meetings are minuted (Green) Quarterly report to performance review on estate posture vulnerabilities. Meetings are minuted (Green)		None
7. IT system disaster recovery plans in place and regularly reviewed and tested. Annual tabletop business continuity plans	Lack of scheduled complete business continuity IT exercise (refer to longer term action)	3rd Line: External / third party provider leading tabletop digital business continuity exercise with feedback report provided to CIO with IMT having oversight of remediation plans (Amber). Results of the exercise are reported as part of the DSPT		None
8. Information asset register in place (as an online form) and regularly updated (updates are date stamped). Training provided for information asset owners and administrators to understand the role.	None	3rd Line An extract of the updated asset register is included as part of DSPT evidence (Green)		None
9. Project resources in place for in project deployments.	Insufficient project management support for some initiatives. Some areas of insufficient governance in relation to digital programme deployment (refer to longer term action)	1st line: Digital led projects will reports RAG status on resourcing through to the digital committee on a monthly basis (Green)		Gaps for some trust wide projects in terms of both programme governance and resourcing (refer to actions 5 and 7)
10. Digital strategy in place	Strategy will be reviewed and amended, if necessary, following the approval of the clinical strategy.	2nd LINE: Development of digital strategy is an enabling strategy within overall strategy framework. Timelines and updates on the draft strategy have been presented to SDC and Board Seminar (Feb 2024, Green)		Final strategy to be approved following approval of the Trust Clinical Strategy (Action 4)
11. Development of an integrated assurance framework to support the effective usage of data aligned to strategic priorities				
Immediate Actions		**Timescale**	**Lead**	**Status**

			(complete, on track, off track)
1. IG training to be included within integrated assurance framework deployment	April 2024	CSO	On track
2. Enhancing the communications plan to support data access security awareness with progress report to IMT	January 2024	Head of IT / Comms Manager	Comms plan completed.
3. Include a SIEM tool into business planning for 24/25	January - March 2024	Head of IT	Agreed to be included in Business Plan for 2024/25
4. Development of digital strategy with Board support	June 2024	DCIO / CFO	Complete. Board Approve Feb 2024. Further iterations maybe needed following finalisation of Clinical Strategy.
5. Reconciliation of all digital programmes and reporting to digital steering committee	April 2024	DCIO/CFO/ICS	In progress as part of wider governance review in April 2024.
6. Board development dates for cyber security training	February 2024	CFO / DCIO	Completed
7. Management of programmes and project governance to be considered within trust wide governance review	April 2024	CFO / DCIO	In progress
Longer term actions (with indicative timeframe e.g. Q1 2024)			
• Project resource assessment and planning exercise – Quarter 1 2024. Interim PMO lead recruitment in progress. • Plan a full business continuity exercise - TBD • Review of trust wide approach regarding policy compliance and understanding – TBD (refer to other BAFs as requires a consolidated approach) • Mapping of trust wide programme and project governance – in progress as part of wider governance review. 2024 • Data migration, data quality strategy to be drafted under the EPR programme strategy (Q1 24/25 FY)			
Links to Corporate Risk Register	Risk 6 – Major Incident, Risk 7 – Digital Maturity		

Strategic Aim: KSO 1, 2 and 3	Overall Assurance Rating (RAG)	Q3 2023/24	Q4 2023/24	Q1 2024/25	Q2 2024/25
		AMBER	GREEN	GREEN	N/A

Risk Ref & Description: **08 There is a risk that the Trust does not develop and maintain collaborative relationships with partner organisations built on shared objectives and mutual trust that may impact adversely on the ability to deliver a sustainable future and trust strategy and improve the health of the populations we serve**
Causes: the Trust and /or system partners do not effectively engage with the system framework or direct arrangements, ineffective communication, absence of shared goals
Consequences: failure to achieve system and Trust objectives, negative impact on patient outcomes and experience

Committee	Strategic development committee	Date Added:	September 2023
Principal Exec	Chief Executive Officer	Date Reviewed:	28 March 2024
Supporting Exec(s)	Chief Strategy Officer	Last discussed:	2 April 2024 (ELT)
Risk Assessment	**Consequence**	**Likelihood**	**Score**
Inherent Risk Rating	5 (Severe)	5 (Almost certain)	25
Current Risk Rating	4 (Major)	3 (Possible)	12
Target Risk Rating	3 (Moderate)	2 (Unlikely)	6 (Target date = Jul 24)
Controls (what are we doing about risk)	**Gaps in Controls (where are we failing to put systems in place)**	**Assurances and RAG rating (how do we know if it's working)**	**Gaps in assurance (what additional assurance is needed)**
1. Engagement plan in place with key internal and external stakeholders (e.g. staff, system partners, governors, local population, NHSE etc) as a core element of the strategy system development.	None identified System partner engagement outside of strategy	1st line: Engagement tracker in place to report progress against plan; this is reviewed weekly by the strategy team (Green) 2nd line: The first phase engagement plan was presented to the Strategic Development Committee (SDC) on July 2023 (Green). Second phase engagement plan complete and planned for review at ELT and SDC February 2024. Verbal engagement updates to continue to be reported to SDC on a monthly basis. Engagement update reported to Governors (quarterly), JLNC (quarterly), HMT (monthly) and Board (at seminars) with respective meeting minutes evidencing the discussions held on progress reported. Revised engagement plan to be shared with governor SDC working group February 2024 (Green) 3rd line: Independent review of stakeholder feedback gathered as part of the engagement plan received in January 2024. Report provides positive assurance regarding engagement activities undertaken (Green)	None identified

2. The trust continues to work purposely and proactively to be a trusted system partner in the Sussex ICS to deliver the shared delivery plan and agreed priorities. The trust executive have developed strong working relationships in the ICS and partner organisations. Board level representation at system meetings and where appropriate, QVH Executives have taken on leadership roles for ICS programmes within the system oversight board workstreams (these responsibilities are specified within the QVH Exec portfolios which are subject to performance management reviews)	Lack of QVH partnership plan and strategy; this will be developed as an enabling strategy within the overall Trust strategy development programme There are potential opportunities for additional QVH Executives to assume system leadership roles (refer to action 4)	1st line: Engagement tracker in place to report progress against plan for engagement pertaining to strategy development; this is reviewed weekly by the strategy team (Green) 2nd Line: CEO Board update includes high level updates on system relationships (Amber) 3rd Line: Workstreams report updates into the System Oversight Board (monthly) and these meetings are minuted (Amber)	None identified
3. The trust executive is building relationships with the neighbouring ICS (Kent and Medway, Surrey Heartlands) to align opportunities including matters pertaining to the Trust strategy. Senior representation in place at Cancer Alliance meetings and CEO and Director of Strategy connections across providers	Further development of relationships is required where new system leaders are in place (refer to action 4) and a comprehensive engagement plan to be developed	1st line: Engagement tracker in place to report progress against plan for engagement pertaining to strategy; this is reviewed weekly by the strategy team (Green) 2nd line: Verbal engagement updates reported to SDC on a monthly basis with subsequent written committee assurance report provided by SDC Chair to the Board. Update communications and engagement plan to be shared and discussed at February 2024 SDC (September 23, Green) Engagement update reported to Governors (quarterly), JLNC (quarterly), HMT (monthly), Governor working group (monthly) and Board (at seminars). Respective meeting minutes provide evidence that discussions are held on progress reported in the update (Green)	None identified
4. The well led review in Dec 2022 provided a useful source of partner feedback. The trust is implementing a well led action plan to address recommendations of the review and inform its ongoing engagement plans	None identified	2nd line: Action plan reported bi-monthly to ELT (Green) Assurance reporting regarding external partner engagement and relationships presented to SDC on ongoing basis as part of strategy updates (Green)	None identified

Immediate Actions	**Timescale**	**Lead**	**Status** (complete, on track, off track, not yet started)
1. Full engagement plan (in addition to strategy development plan)	February 2024	DCCA / Comms	Complete
2. Review well led plan for specific recommendations to strengthen external partner relationships and build action updates into assurance reporting	December 2023	Manager CEO / DCCA	Complete
3. Independent review of strategy stakeholder feedback	December 2023	CSO	Complete

4. Consider potential opportunities for additional QVH Executives to assume system leadership roles	January 2024	CEO / Executives	CMO / CSO / NED leadership roles for provider collaboratives
Longer term actions (with indicative timeframe e.g. Q1 2024)			
• Develop partnership strategy – Q1 2024 • Engagement and provide leadership support to ICS provider collaborative developments – TBC with system timescales and requirements			
Links to Corporate Risk Register	Risk 13 – partnership and commissioner risk		

Risk Report (For use with Datix WEB)

ID	Opened	Title	Description	Risk Cause	Controls in place	Executive Lead	Handler	Risk Type	Rating (Initial)	Rating (current)	Rating (Target)	Progress/Updates	KSO
1351	11/02/2024	Financial sustainability	Risk that the Trust fails to develop a sustainable strategic plan, aligned financial plan, deliver planned patient activity targets, secure associated income from commissioners, deliver agreed levels of efficiency improvement, and maintain effective control of costs, there will be an adverse impact on the longer term financial sustainability of the Trust. Causes include: 1. Failure to secure investment from Sussex ICB and other Commissioners 2. Failure to manage and deliver efficiency and cost improvement plans in the longer term. 3. Failure to manage and mitigate the impact of funding convergence and other Allocation adjustments over the longer term. 4. Failure to manage inflationary cost pressures and mitigate them 5. Failure to allocate and/or attract significant revenue and additional capital will inhibit the Trust's ability to adhere to statutory compliance, as well as the ability to rectify the identified backlog maintenance. 6. Failure to develop and deliver a strategic financial plan and exercise which makes a		5. The development of robust and credible financial plans based on agreed National and Local planning guidance 3. Internal financial control and management procedures which support the delivery of services within available funding and resources 3. Adherence to Trust Standing Orders and Standing Financial Instructions• Regular Financial and Performance reports to relevant Committees and Board 4. A rolling Internal Audit programme 5. External Audit of Accounts and Reports 6. Care Quality Commission (CQC) assessments 7. A range of external reports to NHSE	Wheeler, Maria	Tallett, Ellie	Finance	20	16	6	11/2/24: No change this time to the financial risk score. The Financial position is likely to achieve break even with Contracts agreed and most areas of financial known and provided against.	KSO4: Financial Sustainability
1354	19/03/2024	Limited spoke site pathway oversight and governance	There is a risk of limited governance and oversight of patient pathways at our spoke sites, caused by patient details being held within our partner trusts, resulting in limited reporting and operational oversight	1. Pathways are not managed by QVH, and are managed by our partner trusts. 2. QVH does not have full access across spoke site systems, and limited reporting. 3. Management oversight and partner trust engagement is variable across our spoke site teams.	No RCA is being carried out by the General Manager to outline the risks, mitigations and controls in place. This will outline recommendations to strengthen our spoke site oversight.	Timmins, Kirsten	Tramontin, Marc	Patient Safety, Outcomes and Experience	15	15	4		
1352	11/02/2024	Mental capacity act	There is a risk that patients are not being assessed as per Mental Capacity act caused by variability in the assessment of patients capacity, resulting in patients being treated without appropriate capacity assessments.	Lack of knowledge and Skills Challenges with patient pathway particularly linked to skin patients Lack of early identification of the issues during the pathway	5. Awareness raised in meetings 6. Bespoke training for schedulers and secretaries 6. Barrister workshop annually two hour specialist MCA training 6. Training for consultants 5. Adult mental capacity lead in place	Reeves, Nicola	Blackburn, Liz	Regulatory and Compliance	20	16	8	**April 2024** - Audit complete, findings will be shared at Clinical Governance Group in May. MCA education for staff to be incorporated in to existing meeting structures rather than standalone training. Will be raised and discussed during strategic safeguarding meeting in April. February 2024 - MCA audit in progress January 2024 - Medical MCA training in December cancelled due to lack of uptake. MCA Audit ongoing	KSO1: Outstanding Patient Experience, KSO2: World Class Clinical Services
1345	11/02/2024	National clinical standards	There is a risk that the Trust does not meet national clinical standards for the services that it provides due to resource constraints, resulting in patient harm or a negative impact on patient outcomes/ experiences		5. Existing functional SLA for paediatrics and part time physician 2. Clinical services review 3. Use of Early Warning Systems such as PEWS and NEWS2 to identify deteriorating patient. 4. Outreach in place	Cubison, Tania	Cubison, Tania	Regulatory and Compliance	20	12	10	Jan 24. Gap analysis refreshed, discussions re new appointments in ITU/medicine underway. T and F group planned for ITU cons cover. December 2023 - NEWS2 in place, QVH PEWS in place in paediatrics to be rationalised with national guidance	KSO1: Outstanding Patient Experience, KSO2: World Class Clinical Services
1262	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 and future of the hospital.	Risk exists due to multiple causes including the absence of an agreed strategic plan, challenges re: resilience and capability of some required trust services, estate condition, workforce challenges and financial considerations.	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	Ings, Abigail	Brasier, Kathy	Regulatory and Compliance	15	15	10	**April 2024** - Development of existing strategies in progress inline with three year plan. Clinical strategy engagement workshops complete and strategy development underway with CMO and CNO March 2024 - Initial review of developing the future for QVH - clinical service review and defining our local population paper agreed and supported at trust Board. February 2024 - strategy development continues inline with agreed milestones January 2024 - Hybrid model approved at trust Board September 28th - Phase 1 complete Phase 2 - Co-design workshops x2 have taken place - QVH staff and Local population. Data collection underway. 2 further sessions planned in the next two weeks Resourcing - Project Support Officer commence dis post WC 25.09.2023 with PM due to start 02.10.2023 Engagement continues with internal and external stakeholders, tracker maintained and themes collated. Stakeholder Engagement Group first meeting has taken place. Low level of attendance due to a variety of issues, minutes to be shared and individuals touched base with to ensure aware of process and are in agreement. Financial baseline including service line reporting in train with benchmarking data aligned. Initial scenario setting options will be formulated following final workshops, linking in with the clinical baseline and SWOT analysis. Review of reset of trust vision and values to be mapped through, work underway to address options available. Engagement HQ platform due to be live next week WC 9.10.2023 working in conjunction with Sussex ICS. August 2023 - Phase 1 engagement strategy underway, with significant engagement with stakeholders both internally and externally. Engagement tracker continues to capture overarching themes to be collated. Phase 2 includes three population co-design workshops. All planned and invitations sent for late September into October 2023. Resourcing - posts now closed, short listed and interviews set up. Clinical baseline stock take including enabling services SWOT analysis to be tabled and socialised for moderation at HMT 21.08.2023. Working with CFO and finance team to demonstrate financial baseline position and service level detail, work underway. 20.07.2023 - Strategy engagement plan completed following internal and external stakeholder mapping and associated work. Being socialised via face to face and virtual forums. Engagement tracker in place and updated to ensure capture of all conversations and relevant themes are identified. Clinical stock take completed. Co-design, phase 2 of the engagement plan	KSO1: Outstanding Patient Experience, KSO2: World Class Clinical Services, KSO3: Operational Excellence, KSO4: Financial Sustainability, undefined
1353	11/02/2024	Partnership and commissioner risk	There is a risk that changes to wider NHS provider partner and commissioner arrangements may impact the future organisational resilience for QVH		5. Engagement plan for strategy development in place to ensure effective external engagement 2. Executive level connections to system and commissioner forums and leaders	Ings, Abigail	Ings, Abigail	Regulatory and Compliance	20	15	12	**April 2024** - Phase 3 engagement plan complete and in progress, CEO/ Chair ICB and provider engagement continuing. CSO and CEO aligned to specialist commissioning strategic review work programme. 1. Phase 1 and 2 engagement complete including partnership discussions. 2. Targeted discussions taking place at CEO and Chair level with key provider partners and ICBs 3. QVH is co-leading the acute provider collaborative in Sussex and CEO and Chair members of the committee in common 4. CMO / CSO allocated to support / provide leadership to provider collaborative programme	
1342	05/02/2024	Patient transfers (1)	There is a risk of the Trust accepting patients with a higher level of complex care required than is available on the site due to poor decision making and/ or miscommunication, resulting in the need to transfer the patient to an alternative site which could have a negative impact on patient safety, health outcomes and experiences.		5. Monitoring of patient transfer records to identify any potential negative impacts on outcomes and experience in order to identify lessons learnt 2. Guidance and standard operating procedures for accepting patients	Reeves, Nicola	Blackburn, Liz	Patient Safety, Outcomes and Experience	20	15	10	**April 2024** - PSIRF plan approved. Score to be reviewed during Q1- February 2024 - PSIRF plan and policy with ICB for ratification December 2023 - MDT working	KSO1: Outstanding Patient Experience, KSO2: World Class Clinical Services
1348	11/02/2024	Patient transfers (2)	There is a risk that a patient already accepted by the Trust for treatment requires a level of complex care that is not available on the site due to a deterioration in condition, resulting in the need to transfer the patient to an alternative site which could have a negative impact on patient safety, health outcomes and experiences		5. Existing functional SLA for paediatrics and part time physician. 2. Use of Early Warning systems such as PEWS and NEWS2 3. Relevant staff have undergone Advanced Life Support training and Emergency Paediatric Life support and specific SIM training for airway management and deterioration	Reeves, Nicola	Blackburn, Liz	Patient Safety, Outcomes and Experience	20	15	10	**April 2024** - Clinical systems team have identified cost pressure of £25k to make changes to Ezbo. CNO and CFO to discuss February 2024 - Skill being reviewed, needs to be entered in to existing EDBs software, with the supplier December 2023 - NEWS2 in place, QVH PEWS in place in paediatrics to be rationalised with national guidance. January 2024 - PEW guidance still be reviewed	KSO1: Outstanding Patient Experience, KSO2: World Class Clinical Services
1189	08/12/2020	Radiology workforce: succession planning	There is a risk that, due to insufficient staff, the consistent provision of imaging and reporting across all modalities will be adversely affected. 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 staff wellbeing metrics - Worse financial position if reliant on agency/locum staff and outsourced reports. - Less resilience in the imaging service - CDC expectation of 7 day working. Not possible currently within available workforce.	-National shortage of qualified staff -Specialist centre so less engagement from newly qualified staff - Marketing QVH against other surrounding trusts who have higher pay or higher profile - small workforce means less resiliency in times of flux - multiple retirements with no experienced replacements. Some other of the workforce at / approaching retirement age - difficulties recruiting - multiple failed recruitment drives previously and currently - system level parity of pay for similar roles - national shortage of trained radiologists/ sonographers / Radiographers. - growth in activity and local QVH provision with no incremental increase for reporting staff These causes can result in delayed imaging and diagnosis from reporting. Failure to meet DM01 and Report turnaround metrics. Ability to cause clinical harm due to delayed reports being issued. More staff attrition due to low morale. Increased pressure on staff resulting in burn out. Increased likelihood of reporting errors and radiation errors.	- monitoring staff levels using bank / agency staff if needed - advert of apprentice roles to future proof radiographers - team engagement for career conversations/ wellbeing check ins -HEE funding for courses being utilised -Consultant recruitment being undertaken - Outsourcing of reporting - Hybrid working - Job description redesign/ new ways of working (middle grade role) - training assistant practitioners	Timmins, Kirsten	Golanki, Sarah	Regulatory and Compliance	15	15	9	**12.09.2023** - Medical workforce and ultrasound workforce currently most at risk due to vacancies. Currently have 1SPA vacant in consultant with another impending 2.1 vacancy and a maternity leave. Outsourcing as much as possible but this is at increased cost to the trust. Recent failed recruitment of 10PA fixed term consultant. Going back out to advert. Other SPA vacancy out to advert. PCHP submitted for 4P for an additional WTE 1.0 Consultant. Ultrasound - 2.6wte vacancy rate due to retirement, resignation and maternity. 1.0WTE appointed to but awaiting start date. Offered to bank position as well. Agency requested as well for short term. Radiographers - some minor vacancy (2 days etc) out to advert. 25/02/2024: Risk Lead changed to new CDO. 27.3.24 - Apprentice AP has qualified and her RDA post out to advert. Bank sonographer not engaging with recruitment controls - her personal situation has changed since application. Recruited overseas consultant radiologist, checks in progress. Enhanced specialist sonographer has reduced her hours due to personal circumstances - her hours are out to advert. We have concerns about the competence of one of our newly qualified band 5 radiographers. She's been receiving additional support since her second week at QVH and advice is being sought through employee relations. Recruited full-time sonographer to combo of retiree post and part of maternity leave post. Remaining maternity leave post is still vacant. Band 7 reporting / supt radiographer position. Reporting is going to radiographer who has just completed her preceptorship. Supt hours will go to an internal advert. There are residual band 6 radiographer hours which will go out to advert. 31/05/24 - Further new b3 started over festive period. Recruited bank sonographer. Maternity leave sonographer position candidates unsuitable. Two short listed for sonographer 0.4 WTE post and interviews booked (current sonographer in retiring). B7 reporting / supt radiographer handed in notice this week, so a further vacancy. No suitable candidates for locum consultant general radiologist post. RSM in discussion with interim COO and clinical lead radiologist re. plan going forward. Outsourcing to reduce backlog of reporting to reduce risk of harm from delayed reporting. PACS manager being pulled back to Uckfa, there is a different risk relating to the risks associated with this.	KSO1: Outstanding Patient Experience, KSO2: World Class Clinical Services, KSO3: Operational Excellence, KSO5: Organisational Excellence
1350	11/02/2024	Speaking up	There is a risk that the Trust's speak up framework is inadequate to ensure that concerns are raised and dealt with appropriately, resulting in the potential for risks to materialise including patient and workforce safety and reputational damage		5. FTSU guardian in place 2. FTSU policy in place and available to all staff 3. Raising awareness regarding FTSU- recent all staff meetings 4. Now established monthly review meeting between FTSU, chief people officer and chief nurse 5. Change in Speak Up provison - moving to an external body to provice QVH support	Reeves, Nicola	Reeves, Nicola	Regulatory and Compliance	20	16	8	**April 2024** - New provider should be in place mid April 2024. Initiation meetings in progress to ensure smooth transition. February 2024 - Internal audit in to speak up arrangements in progress. New provider going through procurement checks January 2024 - update to A&R. Report to Jan Board. Outsource company identified	KSO1: Outstanding Patient Experience, KSO2: World Class Clinical Services

Report cover-page					
References					
Meeting title:	Board of Directors				
Meeting date:	02/05/2024		**Agenda reference:**	**11-24**	
Report title:	Audit and Risk Committee assurance report				
Sponsor:	Paul Dillon-Robinson, Audit and Risk Committee chair				
Author:	Paul Dillon-Robinson, Audit and Risk Committee chair				
Appendices:	None				
Executive summary					
Purpose of report:	To alert, assure and advise the Board regarding matters considered at the last committee meeting on 20th March 2024.				
Summary of key issues	• NHS Sussex Committee in Common • Contract management improvement plan • Potential disclosure in annual governance statement				
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:	No specific BAFs covered, but role of committee is to assure the complete assurance framework. Individual BAFs allocated to other committees				
Corporate risk register:	None				
Regulation:	Compliance with financial reporting, NHS E and NHS Sussex requirements				
Legal:	None				
Resources:	None				
Assurance route					
Previously considered by:	NA				
	Date:		Decision:		
Next steps:	NA				

Report to:	Board Directors
Agenda item:	Audit and Risk Committee assurance report
Date of meeting:	2 May 2024
Report from:	Paul Dillon-Robinson, Audit and Risk Committee chair
Report author:	Paul Dillon-Robinson, Audit and Risk Committee chair
Date of report:	24 April 2024
Appendices:	None

Audit and Risk Committee ("ARC") assurance report – meeting 20th March 2024

Key agenda items

- **NHS Sussex Committee in Common**
- **Contract management improvement plan**
- **Assurances on a range of governance related issues**
- **Developments in risk assurance, already achieved and to take forward**
- **Progress with the annual report and accounts, with associated audit**

Alert

The committee looked at the draft terms of reference for the **NHS Sussex Committee in Common**. This is a significant development in system governance and is a new way of working, for both the NHS and in Sussex. The ARC highlighted that the Board will need to understand the risks and implications of these arrangements and how they link into our own scheme of delegation and reporting.

A **contract management** improvement plan, in part prompted by a limited assurance internal audit report, was discussed at the meeting and the importance of improvement in this area emphasised. A new Head of Procurement will be key in driving and delivering this, but there will need to be an interim focus on significant contracts (by value and/or impact) whilst the longer-term changes are embedded.

An initial self-assessment of 36 areas of "**grip and control**" required by NHS Sussex, focussed on driving efficiencies, was discussed which will lead to a Tactical Measures Programme. This highlights the importance of these basic controls in underlying financial sustainability.

The **Annual Report**, including the annual governance statement, is being drafted in line with requirements set out in the NHS FT Annual Reporting Manual. The committee encouraged efforts to reduce the length whilst being compliant. In terms of the **Annual Governance Statement**, the likely disclosures will be around the additional licence conditions, fire safety enforcement notice, waiting list data quality and contract management. It was suggested that reference to system working and governance would be appropriate.

Whilst the Trust has generally complied with the **Code of Governance for NHS Provider Trusts**, minor non-compliance will be considered for disclosure in the Annual Governance Statement relating to the SID chairing the ARC, better succession planning needed, policy for removal of governor to be finalised and non-executive director pay is not strictly compliant.

Assure
The annual committee self-effectiveness review, which was a full review broken down between processes and effectiveness, was generally positive and actions were agreed for improvement in terms of pulling together assurance reporting on the risk management system, how to capture ICS system risks and assurance on data quality.

Assurance was given that :

- there have been no material breaches of standing orders, standing financial instructions
- the Trust has complied with its licence conditions
- the Trust would make its annual submission to NHS England on the Fit and Proper Person Test, on 31 March 2024, confirming completion of all requirements
- progress is being made to reduce the number of single tender waivers

In reviewing the annual risk reports from the Quality & Safety and the Finance & Performance committees, assurance was given that there is oversight of these risks and the actions taken to mitigate them. This was within the context of the changes being made this year to the corporate risks and assurance framework. The committee, however, believes that the emphasis going forward should be less on the process and more on the effectiveness of the actual risk management.

Progress with the annual accounts, including the audit, was going well and the new external auditors (Azets) were building constructive relationships. They had concluded their initial value for money assessment, and would be undertaking further work on the impact of the changes in governance and risk management.

In support of the annual governance statement the draft Head of Internal Audit opinion from RSM is currently that "*The Trust has an adequate and effective framework for governance, risk management and internal control. However, our work has identified further enhancements to the framework for governance, risk management and internal control to ensure that it remains adequate and effective."* This is similar to last year.

The most recent counter fraud work has been undertaking data matching of staff details with Companies House. Some small anomalies are being followed up, but no direct conflict with current suppliers has been identified.

Advise
The committee agreed to recommend to the board that:

- the ARC's terms of reference be approved by the board, noting that revised NHS and Treasury guidance was due later this year and changes might be appropriate then.
- the proposed changes to the scheme of delegation and standing financial instructions be approved

The committee agreed the internal audit plan for the first part of the year, in light of the impending tender

Risks discussed and new risks identified
The risks from the introduction of the NHS Sussex Committee in Common were discussed.

The role of the committee in assuring on the system of risk management, and the work done by other committees, was covered and regarded as an area that will require further work in 2024/25.

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

Report cover-page					
References					
Meeting title:	Board of Directors				
Meeting date:	02/05/2024		**Agenda reference:**	**12-24**	
Report title:	Finance & performance committee assurance report				
Sponsor:	Peter O'Donnell, Non-executive director & committee Chair				
Author:	Peter O'Donnell, Non-executive director & committee Chair Ellie Simpkin, Governance officer				
Appendices:	None				
Executive summary					
Purpose of report:	To alert, assure and advise the Board regarding matters considered at the last committee meeting.				
Summary of key issues	- Performance against the 62 day performance cancer waiting times declined in month 10 due to the focus on reducing the back log of long waiters. The number of patients waiting over 65 and 78 weeks for treatment continues to be an areas of focus for the Trust. - The trajectories for 2024-25 are being reviewed to ensure that they are robust and realistic, taking into account seasonality and the planned service developments. - The substantive vacancy rate has reduced, however there continues to be high levels of Bank and Agency usage across the organisation. The committee is not yet fully assured on the reasons for this. - The committee was informed of the presence of Reinforced Autoclaved Aerated Concrete (RAAC) on the site and has received assurance that the risk is relatively low and that timely and appropriate action is being taken. - The committee received a more detailed analysis of reasons for the Trust's gender pay gap, however, further assurance that the actions having a positive impact on reducing the pay gap is needed.				
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:					
	Date:		Decision:		
Next steps:					

Report to:	Board of Directors
Agenda item:	12-24
Date of meeting:	2 May 2024
Report from:	Peter O'Donnell, Non-executive director & committee Chair
Report author:	Peter O'Donnell, Non-executive director & committee Chair Ellie Simpkin, Governance officer
Date of report:	18 April 2024
Appendices:	None

Sub-committee assurance report
Finance & performance committee, 15 April 2024

Key agenda items

- Operational, workforce and financial performance
- Gender pay gap – update on actions
- Staff survey results and action planning
- Business planning 2024-25
- Estates update
- Strategic objectives 2024-25 - major projects update
- Review of Board Assurance Framework (BAF) 02, 03, 05, 06, 07 and review of Corporate Risk Register
- Cyber Security assurance

Alert

- The focus on the reducing the back log of patients waiting over 62 days for cancer treatment has resulted in a significant decrease in the performance against the 62 day performance cancer waiting times standard in month 10 with the Trust reporting 56.7% against the 85% target. Staff vacancies, industrial action and patient choice are also factors affecting performance. It is expected that there will be an improvement in performance in month 11.
- While the total RTT waiting list has remained static, the number of patients waiting over 65 and 78 weeks for treatment continues to be a challenge and an area of focus for the Trust.
- The substantive vacancy rate for the Trust has reduced to 2.92%, however there continues to be high levels of Bank and Agency usage across the organisation. The committee is not yet fully assured on the reasons for this and will be considering the matter further at future meetings.
- There was an increase in the time to hire between January 2024 and February 2024 which has been attributed to an increase in volumes of activity.
- The new Estates management team highlighted work underway to review asbestos compliance and compliance with Disability Discrimination Act 1998. The committee was informed of the presence of Reinforced Autoclaved Aerated Concrete (RAAC) on the site at location 58. A full structural survey has been carried out and the Trust is now part of the national RAAC programme supported by NHS England. Plans are underway to relocate staff with mitigating actions in place in the interim. The committee has received assurance that the risk is relatively low and that timely and appropriate action is being taken, however, there is concern over the time taken to identify the issue.

- The committee has asked that a review of estate services supplier management is undertaken to ensure that all suppliers hold appropriate accreditations and are providing quality, value for money services.

Assure

- The Trust continues to meet the Faster Diagnosis Standard (FDS) with month 10 reporting 83.5% against the 75% target. Driven by the recovery of the Sleep service, there is sustained improvement in the DMO1 diagnostic performance with the Trust achieving 94% against the 95% national standard in month 11. The Trust has maintained achievement of the 85% Getting it Right First Time (GIRFT) standard for QVH theatre utilisation.
- Workforce key performance indicators including staff turnover, sickness and mandatory and statutory training compliance remain positive.
- The committee was pleased to receive the positive staff survey results and looks forward to reviewing further updates on the actions being taken to address the areas for improvement including workload pressures, health and wellbeing, and bullying and harassment from service users.
- The Trust is maintaining its break-even position in month and forecast for year end and efficiency targets are being delivered.
- The committee received an update on the Fire Safety works. Good progress is being made and the team are confident that the action plan will be delivered on time.
- The committee has received good assurance on the Trust's cyber-security function and the controls which are in place to mitigate risks.

Advise

- The trajectories for 2024-25 are being reviewed to ensure that they are robust and realistic, taking into account seasonality and the planned service developments, which is welcomed by the committee.
- The validation of the waiting list continues. A review of the oversight and governance at spoke sites is being undertaken to ensure arrangements are robust. In May 2024 the committee is holding an education seminar on waiting list management. A report on the outcome of the review of waiting list management is expected at the June committee.
- The committee congratulated the team on the opening of the Local Anaesthetic Unit and was pleased that learnings on how the implementation could be improved are being captured.
- Whilst the committee welcomed a report which provided a more detailed analysis of reasons for the Trust's gender pay gap, further evidence is needed to provide assurance that the actions are having a positive impact on reducing the pay gap.
- The committee has requested a further update on the progress being made to improve appraisal quality and address the barriers to achieving the compliance target.
- The committee has also asked the Chief People Officer to consider how the cultural challenges for the organisation are reported and how assurance on these matters is received.
- The draft business plan for 2024-25 was reviewed. Further work is being undertaken on the operational targets and trajectories. The need to ensure that delivery of the capital plan is evenly throughout the year phased has been highlighted.

Risks discussed and new risks identified

- The BAFs for key strategic risks 02, 03, 05, 06, 07 have been reviewed. The committee believes that there is further work to do on developing the BAFs

and has asked that future reports provide an explanation on actions which are not progressing as planned.

- With regard to BAF 03 (physical infrastructure), the committee has asked that there is increased focused on improving the robustness and resilience of the estate over a more reasonable timeframe.

Recommendation

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

Report cover-page					
References					
Meeting title:	Board of Directors				
Meeting date:	02/05/2024	**Agenda reference:**	**13-24**		
Report title:	**Operational performance**				
Sponsor:	Kirsten Timmins, Chief Operating Officer				
Author:	Kirsten Timmins, Chief Operating Officer Maddy Johnson, Business Support Manager				
Appendices:	None				
Executive summary					
Purpose of report:	This report outlines the highlights of the operational performance for M11, and M10 for Cancer performance.				
Summary of key issues:	Key highlights include; • Sustained good performance for cancer FDS, activity against plan and theatre utilisation • Improved performance for the diagnostic DMO1 target, particularly within Sleep, and a reduction in the backlog of cancer patients waiting over 62 days • Challenged areas are the cancer 62 and 31 day performance standards and the RTT long waiting position, especially 78 and 65 week waits				
Recommendation:	The Board is asked to **NOTE** the operational performance				
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:					
Regulation:	NHSE, ICB				
Legal:	None				
Resources:	None				
Assurance route					
Previously considered by:	NA				
	Date:		Decision:		
Next steps					

Report to:	Board of Directors
Agenda item:	13-24
Date of meeting:	2 May 2024
Report from:	Kirsten Timmins, Chief Operating Officer
Report author:	Maddy Johnson, Business Support Manager
Date of report:	21 March 2024
Appendices:	None

Operational performance

Introduction

This report summarises the QVH operational performance for M11, noting that Cancer Waiting Times (CWT) standards are reported a month behind at M10. The report highlights areas of good performance as well as areas where performance is challenged, along with mitigations in place. Please refer to the operational performance data report (appended) for full narrative and benchmarking data.

Areas of good performance

Within cancer performance, the Trust continues to meet the Faster Diagnosis Standard (FDS) in M10 reporting 83.5% against the 75% target; performance remains significantly above national and regional averages.

There has also been focused work in M10 to reduce the number of patients waiting over 62 days for cancer treatment, known as the 62 day backlog. The externally reported M11 backlog position (which excludes patients on a cancer pathway due to consultant upgrade or screening) was 35 against the year end target of 32, and performance is predicted to continue improving into M12 as patients are prioritised for treatment and additional wait list initiative (WLI) activity continues. While the overall 62 day and 104 day backlog is not meeting our internal trajectory, M10 is the fourth subsequent month of improvement towards the trajectory. Performance against the 62 day and 104 day backlog will continue to be monitored weekly.

Another key area of success is the M11 DMO1 diagnostic performance (the percentage of patients waiting less than 6 weeks for a diagnostic test). As a Trust, the total DMO1 position was 94% against the 95% national standard; the continued improvement is driven by a recovery of the Sleep DMO1 position which is reporting the highest figure since April 2020 and the second highest Sleep DMO1 position on QVH record. The forward look into M12 suggests the improved performance will be maintained.

Other aspects of good performance in M11 include delivering 101% of the M11 activity plan and 100% of the total activity plan year to date. The Trust also maintained achievement of the 85% GIRFT standard for QVH theatre utilisation, and achieved the target to deliver 25% of all outpatient activity as virtual activity for the first time since February 2023.

Areas of challenged performance

<u>62 day combined cancer performance</u>

There was a significant decrease in the Trust's performance against the 62 day performance cancer waiting times standard in M10, reporting 56.7% against the 85% target; this standard measures the percentage of patients receiving their first definitive treatment for suspected or confirmed cancers within 62 days from referral receipt. The decline in performance was largely impacted by a focused effort to reduce the backlog of patients who had already breached this 62 day target as mentioned earlier in this report, as well as seasonal delays over the Christmas period, industrial action in M9 and M10 and the retirement of a trust grade doctor in M9 which significantly reduced two week wait outpatient clinic capacity within Skin. The decline in performance was anticipated given the above, and escalated to the ICB in advance.

There are a number of specific actions in place to recover the 62 day performance position such as running additional WLI theatre lists and ad hoc outpatient clinic on Saturdays until year end, and ongoing recruitment to backfill the two week wait Skin clinic capacity; a preferred candidate has been identified and contract negotiations are in progress. The unvalidated M11 position has improved above 70%. Further work is planned to ensure trajectories going in to 2024/25 are robust. Performance will continue to be monitored closely at twice weekly service level meetings.

31 day combined cancer performance

The Trust's 31 day cancer performance also remains challenged in M10, reporting 76.1% against the 96% target; this standard measures the percentage of patients treated for cancer within 31 days from the date of decision to treat or the earliest clinically appropriate treatment date. The most challenged area is Skin; there are particular difficulties with capacity for the Sentinel Lymph Node Biopsy (SLNB) patient cohort, as well as limitations regarding the capacity of staff with the appropriate skill mix to be able to treat more complex patients.

To mitigate this, core actions include moving less complex patients to alternative lists in order to protect the capacity of consultants who are able to see more complex patients, as well as scheduling additional all day theatre lists for SLNB in M11 and continued utilisation of independent sector lists at TMC specifically for SLNB patients which will continue into Q1 of 2024/25. Performance will continue to be monitored closely at twice weekly service level meetings.

Long waiting RTT performance

The other area of challenged performance is long waiting RTT patients. While the total RTT waiting list has remained static, the number of patients waiting over 65 and 78 weeks for treatment continue to increase. A key NHS priority for 2023/24 had been to eliminate all RTT patients waiting over 65 weeks by year end, however this target has been amended in the draft 2024/25 planning guidance to eliminate 65 week waits by M6 2024/25.

Contributing factors to the deteriorating performance are multifaceted: alongside challenges with outpatient, theatre and pre-assessment capacity, staffing levels, patient complexity, late referrals and the impact of industrial action, the recent ongoing validation work has so far identified 92 pathways that have been reopened, 12 of which were patients waiting over 78 weeks.

There is significant focus on eliminating as many long waiting patients as possible by year end with proactive reallocation of theatre capacity between specialties and continued scheduling of additional activity through Saturday WLI theatre sessions for Plastics and Oral Maxillofacial patients, and in-week three session days for hand surgery patients. Staffing structures are also being reviewed and proposals for additional resource are being considered within the 2024/25 business planning process. The launch of the Local Anaesthetic Unit (LAU) in M12 will also have a positive impact on both cancer and RTT treatment capacity, providing capacity to see a maximum of 16 patients per day.

By 2023/24 year end, the Trust is forecast to report 9 patients waiting over 78 weeks and 99 patients waiting over 65 weeks. The patients waiting over 78 weeks are monitored weekly with assurance provided to the COO and the Sussex ICB regarding treatment plan progress.

While our position is not where we would like, when benchmarked against regional and national data, QVH is performing above average; in M10, the Sussex ICB reported 1.9% of RTT patients waiting over 65 weeks and the national position was 1.2%, whereas QVH reported 0.5% for the same period.

Industrial Action update
During M11 there was a period of junior doctor IA spanning 4 days which significantly reduced theatre and outpatient capacity across all specialties. During this period there was a plan is in place to protect urgent, clinical priority and long waiting patients where possible.

	M10	M11
Theatre appointment cancellations	29	27
Outpatient appointment cancellations	183	172
Theatre sessions lost	31	15

BMA junior doctors have, in March 2024, voted by over 97% in favour of extending the mandate for Industrial Action. Further Industrial Action will reduce theatre and outpatient capacity across all specialties. As with previous rounds of Industrial Action, the Trust will protect urgent, clinical priority and long waiting patients where possible.

Recommendation
The Board is asked to **NOTE** the operational performance.

Report cover-page					
References					
Meeting title:	Board of Directors				
Meeting date:	02/05/2024	**Agenda reference:**	**14-24**		
Report title:	Workforce and Organisation Development Report				
Sponsor:	Helen Edmunds, Chief People Officer				
Author:	Helen Edmunds, Chief People Officer				
Appendices:	None				
Executive summary					
Purpose of report:	Workforce performance update				
Summary of key issues	Workforce data – bank and agency increases due to additional activity. Time to hire has increased with digital solutions now in place to mitigate and reduce this for the future.				
Recommendation:	For the Board 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:	Finance and Performance Committee				
	Date:	15 April 2024	Decision:	Report content noted	
Next steps:	Ongoing review of workforce information and action plans.				

Report to:	Board
Agenda item:	14-24
Date of meeting:	2 May 2024
Report from:	Helen Edmunds Chief People Officer
Report authors:	Helen Edmunds Chief People Officer
Date of report:	17 April 2024
Appendices:	None

Workforce and Organisational Development report
(February data / performance unless otherwise stated)

Executive Summary

The Trust continue to maintain some of the best workforce key performance indicators (KPI's) and survey results in the region.

The substantive vacancy rate has reduced to 2.92%, however we continue to see high levels of Bank and Agency usage across the organisation. The majority of trust bank usage is within Operational Nursing and Perioperative Care for Band 5 and 6 Registered Nurses and band 2 HCA's.

The majority of agency staff usage falls within Operational Nursing and Perioperative for band 5 Registered Nurses and Registered Mental Health Nurses.

The trust maintains a positive position for turnover, sickness, appraisal and MAST levels and compliance.

In February 2024 we have moved forward with a number of workforce priorities including supporting the Anchor Institution work with our support and leadership of the Employment & Skill pillar, quantifying the comprehensive offering the trust already undertakes and identifying further opportunities to provide access to employment and development to our staff and in the communities we serve.

Workforce belonging sessions have taken place in February and March providing excellent conversations and feedback for the Trust to take forward in 24/25 to aid the belonging and retention of our workforce, feeding into our EDI plan.

Looking forward, the WRES, WDES and Gender Pay reporting period opens in April 2024 with key milestones and actions to ensure the organisation meets statutory obligations, with the scope for pay reporting widening to include ethnicity pay gaps alongside gender pay gaps. These will be reported at the June 2024 Finance and Performance Committee and July 2024 Board.

The Trust have recruited to a NHS People Promise Manager, funded by NHS England for 12 months to help the Trust in its delivery against the 7 elements of the NHS People Promise.

<u>Workforce KPI's</u>

Substantive vacancy has decreased to 30.61 WTE (2.92%). There was a decrease in starters with 8.51 WTE in February (5.6 Less than January) however there was also a reduction in leavers to 3.40 WTE (9.21 less than January).

Staff turnover has reduced slightly to 11.89% from 12.51% in the previous month and has remained stable throughout 23/24 with a reduction from 13.31% in the same month last year.

Trust sickness levels continue to improve, reducing from 4.25% in December 2023 to 3.93% in January 2024.

83.42% of our staff are compliant with having an appraisal within the last 12 months, this has remained static throughout 23/24. We will be reviewing areas where appraisals are outstanding and introducing a feedback mechanism for staff to monitor quality of appraisals.

We continue to record over 90% compliance with MAST training.

There has been an increase in bank and agency usage. Bank has increased to 94.33 from 89.10 in January and Agency to 23.64 from 20.05.

Bank use:

- The majority of trust bank usage is within Operational Nursing and Perioperative Care for Band 5 and Band 6 Registered Nurses and Band 2 HCA's
- Other key users of bank in February are sleep, particularly with band 3 admin and clerical staff, plastics and finance across a range of positions.
- Bank shifts were used to cover areas of vacancy and to cover additional activity.

Agency Use:

- The majority of agency staff usage falls within operational Nursing and Perioperative for Band 5 Registered Nurses and Registered Mental Health Nurses.

Occupational Health

The trust has concluded the tendering process for its Occupational Health contract for the next 2 years. The new contract will allow for more robust KPI's and performance. Our Occupational Health offering will also provide a more streamlined clearance process for new starters, reducing our time to hire and health surveillance of our staff.

Our current OH contract has been extended until September 2024 to allow for the procurement process of to be undertaken.

Widening Participation

Through the Education and Development Group, we are continuing to support the work on the Trust's Employment and Skills pillar to the Anchor Institution strategy. This includes our approach to apprenticeships which continue to grow year on year, our work experience opportunities and on-site recruitment events. There is also identification on the opportunities for widening our reach to the community including increasing our diversity and inclusion, offering internships, developing closer partnerships with local employment providers and widening our apprentice programme to include entry level roles but also support roles such as electricians and carpenters which are difficult to recruit to across the NHS.

Culture and OD

The Executive Leadership team have given their commitment to eliminating sexual misconduct by signing up to the Charter on Sexual Misconduct. The charter makes 10 key commitments and the Trust have pledged to have all in place by no later than July 2024, with a number already actioned.

Workplace belonging sessions facilitated by the EDI group have taken place in February and March 2024. There have been positive discussions regarding the Trust's approach to flexible working, improving advertising of roles and our ability to retain staff to build a better, more contemporary understanding of what works and what is possible. Career development also came to the fore with consideration in how we approach stretch assignments and shadowing as well as acting up opportunities. The outcome of these meetings will be discussed with the EDI group to implement actions we will take forward.

Time to Hire

Our time to hire has increased between January 2024 and February 2024 after making good progress since October 2023. There has been an increase in the volumes of activity and delays in Occupational Health clearances being received and delays in receiving right to work applications being processed since December 2023.

The introduction of electronic solutions for new starter on boarding and digital ID checks will have a positive impact as we move into 24/25. As part of the new OH contract, a more streamlined clearance process will be introduced. We are expecting to see a notable improvement in reducing time to hire by Q2, with this number continuing to reduce through the rest of year.

Look Forward

The Trust is entering the reporting period for a number of equality and diversity key national metrics including WRES, WDES and Gender Pay Gap. The Trust have been working through its EDI High Impact Action Plan in line with NHS Sussex and NHS England. We will continue to undertake work across all areas as part of our EDI plan to make continuous improvements in all areas, including a focus on our staff networks.

In 2024 alongside reporting on the gender pay gap, organisations are also required to report on the ethnicity pay gap.

Data for all these reports will be pulled as of 31 March 2024 in line with national reporting data requirements and timelines. The Trust WRES and WDES reports are required to be uploaded to the national data collection service publically published by 31 October 2024. The Trust's Gender pay data is required to be uploaded and published by 30 March 2025.

Recommendation

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

Report cover-page					
References					
Meeting title:	Board of Directors				
Meeting date:	02/05/2024		**Agenda reference:**	**15-24**	
Report title:	Financial Performance				
Sponsor:	Maria Wheeler, Chief Finance Officer				
Author:	Ellie Tallett Deputy Chief Finance Officer				
Appendices:	Appendix one: M11 financial performance				
Executive summary					
Purpose of report:	To provide an update on M11 financial performance				
Summary of key issues	The key headline planning items for update are: • The Trust are holding their break-even position in month and forecast for year end • Efficiencies have been delivered and are projected to be delivered at year end. • We are significantly underspent on Capital, but there is focus on M12 spend and we expect to recover by y/e. • At month 11 YTD Value Weighted Activity is estimated at 111% giving a year to date value of 113% (est). Full year is estimated at 114% due to WLI and LAU activity. • The current cash position is £8.6m, receivables £5.7m and payables £11.2m. The AOB work for year end will validate the receivable and payable position. • A stock take was carried out at the end of February and the stock has increased by £0.5m. This was too late to include in M11 figures and will be reflected in M12.				
Recommendation:	Board of Directors are asked to note the M11 update				
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:	Contributes to understanding financial sustainability and operational delivery requirements for 24/25				
Corporate risk register:	None				
Regulation:	None				
Legal:	None				
Resources:	None				
Assurance route					
Previously considered by:	Finance and performance committee				
	Date:		Decision:		
Next steps:	Letter to be submitted to commissioners				

Queen Victoria Hospital NHS
NHS Foundation Trust

Financial Performance M11 2024

Board of Directors – May 2024

Ellie Tallett. Deputy Chief Financial Officer

Executive Summary

Queen Victoria Hospital NHS Foundation Trust

Financial Metric	Period	Result Month 11
Income & Expenditure	**YTD**	**Breakeven**
	Year End Forecast	**Breakeven**
Cash at Bank	**YTD**	**£8.607m**
Capital Spend	**Plan YTD**	**£12.4m**
	Actual YTD	**£4.587m**
BPPC (Combined NHS & non NHS)	**YTD Volume (%)**	**93.6%**
	YTD Value (%)	**92.4%**
Efficiencies	**Plan YTD**	**£5.0m**
	Actual YTD	**£5.0m**
	Year End Forecast	**£5.5m (5.5%)**

Headlines:

- The Trust are holding their break even position
- Cash is stable
- Efficiencies are being delivered
- We are unspent on Capital at M11 but expected to recover by Y/E.
- Areas of the balance sheet require further analysis and that work is underway

Income & Expenditure

Queen Victoria Hospital NHS Foundation Trust

Financial Performance Month 11 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	6,928	7,920	7,802	(119)	81,237	87,122	87,119	(2)	95,042	94,653	(389)
Other Operating Income	572	246	726	479	3,939	2,711	4,429	1,718	2,958	4,230	1,272
Total Income	**7,499**	**8,167**	**8,527**	**361**	**85,176**	**89,833**	**91,549**	**1,715**	**98,000**	**98,883**	**883**
Pay											
Substantive	(4,513)	(5,086)	(5,137)	(51)	(49,139)	(55,945)	(53,939)	2,006	(61,031)	(59,269)	1,762
Bank	(388)	(257)	(340)	(83)	(3,757)	(2,811)	(3,918)	(1,106)	(3,068)	(3,597)	(529)
Agency	(43)	(40)	(240)	(200)	(995)	(442)	(1,640)	(1,198)	(482)	(1,780)	(1,298)
Total Pay	**(4,944)**	**(5,383)**	**(5,716)**	**(334)**	**(53,891)**	**(59,198)**	**(59,496)**	**(298)**	**(64,581)**	**(64,646)**	**(65)**
Total Non Pay	**(2,087)**	**(2,294)**	**(2,303)**	**(9)**	**(26,062)**	**(25,242)**	**(26,452)**	**(1,210)**	**(27,536)**	**(28,126)**	**(590)**
Non Operational Expenditure	(140)	(147)	(136)	11	(1,528)	(1,622)	(1,527)	95	(1,769)	(1,666)	103
Non Operating Income	42	30	50	20	197	330	568	238	360	618	258
Depreciation and amortisation	(391)	(373)	(445)	(72)	(4,112)	(4,101)	(4,893)	(791)	(4,474)	(5,340)	(866)
Total Non Operational Expenditure	**(489)**	**(490)**	**(531)**	**(41)**	**(5,443)**	**(5,393)**	**(5,852)**	**(459)**	**(5,883)**	**(6,388)**	**(505)**
Total Expenditure	**(7,519)**	**(8,167)**	**(8,551)**	**(384)**	**(85,396)**	**(89,833)**	**(91,800)**	**(1,966)**	**(98,000)**	**(99,160)**	**(1,160)**
Surplus / (Deficit)	**(20)**	**(0)**	**(23)**	**(23)**	**(220)**	**(0)**	**(251)**	**(251)**	**0**	**(277)**	**(277)**
TechnicalAdjustments	(343)		23	**23**	220		251	**251**		**277**	277
Adjusted Surplus / (Deficit)	**(363)**	**(0)**	**(0)**	**(0)**	**0**	**(0)**	**(0)**	**0**	**0**	**(0)**	**(0)**

- Substantive Pay costs are under plan year to date due to vacancies. However, this is offset by temporary staff costs. The increase trend of temporary staff costs needs to be managed to ensure expenditure stays within budget this reporting year.
- Increased Substantive staff costs & FTE are due to successful recruitment. Increase trend of temp staff is due to the increase in activity.

- At the close of February, the Trust has achieved a breakeven position and retained cash balances of £8.6m. The Forecast Outturn is Breakeven.
- Overperformance on Patient Activity income activity has generated additional £1.7m which we have agreed to give back to the system, this is not reflected in I&E income.
- Efficiencies of £5m have been delivered in line with the plan.

Patient Activity Income:

Queen Victoria Hospital NHS Foundation Trust

Impact of industrial action – estimated financial impacts presented in the table, based on shortfall in average daily income for that month when compared to the days with industrial action

- Activity: NHSE published ERF achievement is 110% for M1 to M8, with a current M11 estimated achievement of 111% compared to the same month in 19/20.
- The M11 estimated YTD position is 113% VWA.
- Estimated YTD ERF contract value adjustment is an over performance of £2.1M YTD.
- Forecast position at year end is 114% with the ERF value achieving £2.4m due to increase in WLI activity and planned activity for LAU in March.

	Value Weighted Activity (VWA) performance vs relevant month in 2019/20	Impact of Industrial Action - lost income
April	111%	£141k
May	116%	£0k
June	107%	£96k
July	109%	£342k
August	102%	£213k
September	108%	£132k
October	115%	£226k
November	116%	£0k
December	130% (Est)	£183k
January	123% (Est)	£124k
February	111% (Est)	£112k
Total	113% (YTD Estimate)	£1,569k

Efficiencies

Queen Victoria Hospital NHS Foundation Trust

Efficiency Savings 2023/24 YTD	Actual 30/09/2023 Month 6	Actual 31/10/2023 Month 7	Actual 30/11/2023 Month 8	Actual 31/12/2023 Month 9	Actual 31/01/2024 Month 10	Actual 29/02/2024 Month 11	Plan 29/02/2024 YTD	Actual 29/02/2024 YTD	Variance 29/02/2024 YTD	Plan 31/03/2024 Year ending	Forecast 31/03/2024 Year ending	Variance 31/03/2024 Year ending
	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000
Efficiency Savings - by category												
Pay Efficiencies												
Establishment reviews	288	282	288	286	286	286	3,164	3,155	(9)	3,452	3,452	0
Service re-design - pay	0	0	0	0	0	0	1,650	0	(1,650)	1,800	0	(1,800)
Other - pay (Non-recurrent Vacancies	168	167	169	171	171	171	0	1,822	1,822	0	1,950	1,950
Total Pay	**456**	**449**	**457**	**456**	**456**	**456**	4,814	**4,976**	**162**	5,252	5,402	150
Non-pay Efficiencies							0					
Medicines optimisation	0	0	0	0	0	0	0	0		0		0
Procurement (excl drugs) -non-clinica	3	3	3	3	3	3	0	33	33	0	33	33
Service re-design - Non-pay	0	0	0	0	0	0	183		(183)	201	0	(201)
Total Non-Pay	**3**	**3**	**3**	**3**	**3**	**3**	183	**33**	**(150)**	201	51	**(150)**
Total Income	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
Total Efficiencies	**459**	**452**	**460**	**459**	**459**	**459**	**4,997**	**5,009**	**12**	**5,453**	**5,453**	**0**

- The requirement for delivery of 5.5% efficiency was a national planning assumption. We have delivered £5m of savings against plan.
- £1.8m of savings has been delivered non recurrently through vacancy management.

Balance Sheet

Prior year end	£'000	Month end actual	Var on PY.
£64,028	**Non-current assets**	**£63,731**	**(£297)**
£1,072	Inventory	£1,213	£141
£8,403	Trade and other receivables	£5,764	(£2,639)
£11,725	Cash	£8,607	(£3,118)
£21,200	**Current assets**	**£15,584**	**(£5,616)**
(£944)	Borrowings	(£2,117)	(£1,173)
(£17,734)	Trade and other payables	(£11,241)	£6,493
(£2,637)	Other liabilities	(£3,104)	(£467)
(£21,315)	**Current liabilities**	**(£16,462)**	**£4,853**
(£2,106)	Borrowings	(£1,285)	(£297)
(£745)	Other liabilities	(£756)	(£297)
(£2,851)	**Non-current liabilities**	**(£2,041)**	**(£297)**
£61,062	**Net assets employed**	**£60,811**	**(£1,357)**
£24,546	Public dividend capital	£24,546	£0
£18,177	Retained earnings	£17,926	(£251)
£18,339	Revaluation reserve	£18,339	£0
£61,062	**Net assets employed**	**£60,811**	**(£251)**

Key messages:

- Non-current assets are £0.3m lower than year end, mainly being the net impact of investment expenditure and depreciation.
- Trade and other receivables are £5.7m (56% of average monthly income). Work is underway to recover debts as quickly as possible to aid the cash position, a review will take place of any large longstanding disputes within the balance which will also involve settling creditor debt once finalized.
- Cash has decreased by £3.1m since the start of the financial year, the Trust has been stable all year. The cash position improves significantly in March when £7m of PDC funding is received which will be partially utilised to make payment against EPR capital.

Capital

- Capital Expenditure is £4.587m at the close of February from a year to date plan (as per original planning assumptions at the start of the year) of £12.4m.

- The Forecast to year end is:
- ✓ £6,685m Budget for the EPR and CDC projects (funded by PDC)
- ✓ £4.787m Forecast for internally funded (funded by internally generated CRL)
- It has been highlighted to Capital leads in Estates and Medical Devices that they need to progress at pace to spend the capital allocation for 2023/24, March will be focused on ensuring all projected spend is achieved.
- IFRS16 leases; we currently have a confirmation that this class of capital will be fully funded from the allocated IFRS 16 funding made available to the system.
- During March significant capital spend has been processed including the first phase payment against EPR. We expect to have hit the CRL, subject to audit.

Capital Performance @M11 2023/24 DRAFT		YTD Actuals (£000)	YTD Plan (£000)	YTD Variance (£000)	Annual Plan (£000)	Forecast (£000)
Externally Funded (by PDC)	EPR - Central Programme	723	4,125	(3,402)	4,500	4,755
	CDC - Central Programme	603	1,769	(1,166)	1,930	1,930
	Estates - ORL Not Agreed by the ICS	0	930	(930)	1,014	0
	Total Externally Funded Schemes	1,326	6,824	(5,498)	7,444	6,685
Internally Funded	Medical Devices	849	550	299	600	1,346
	IM & T	562	903	(341)	985	1,511
	Estates - Backlog Maintenance	654	2,734	(2,079)	2,982	1,930
	Business cases	0	229	(229)	250	0
	Total Internally Funded Schemes	2,066	4,416	(2,350)	4,817	4,787
Unfunded (Funding stream tbc)	New Lease - MRI Scanner	787	787	0	0	787
	New Lease - Theatre Power Banks	408	408	(0)	0	408
	Total Unfunded Schemes	1,195	1,195	0	0	1,195
	Total 2023/24 Capex Programme	4,587	12,434	(7,847)	12,261	12,667

Sussex System Financial Summary @ month 11

Queen Victoria Hospital NHS Foundation Trust

Organisation (£000s)	YTD Plan	YTD Actual	Actual vs Plan Variance (adverse)/ favourable	Full Year Forecast (inc impact of Feb IA)	Forecast for March only Surplus/ (Deficit)
ESHT	-	(4,913)	(4,913)	(5,037)	(124)
QVH	4	(1)	(5)	-	1
SCFT	(244)	(450)	(206)	-	450
SPFT	(1,165)	(2,775)	(1,610)	-	2,775
UHSx	(1,689)	(19,355)	(17,666)	(10,230)	9,125
ICB	-	(17,102)	(17,102)	(18,661)	(1,559)
Total	**(3,094)**	**(44,596)**	**(41,502)**	**(33,928)**	**10,668**

Category (£000s)	YTD Plan	YTD Actual	Actual vs Plan Variance (adverse)/ favourable
Income	2,751,605	2,815,411	63,806
Agency	(55,040)	(79,526)	(24,486)
Other pay	(1,780,654)	(1,796,918)	(16,264)
Non-Pay	(877,596)	(930,744)	(53,148)
Non Operating Items	(41,408)	(35,716)	5,692
ICB	-	(17,102)	(17,102)
Total	**(3,094)**	**(44,596)**	**(41,502)**

Report cover-page					
References					
Meeting title:	Board of Directors				
Meeting date:	02/05/24		**Agenda reference:**	16-24	
Report title:	Quality and Safety Committee assurance report				
Sponsor:	Shaun O'Leary, Non-Executive Director & Committee Chair				
Author:	Riya Jose, Governance Officer				
Appendices:	None				
Executive summary					
Purpose of report:	To alert, assure and advise the Board regarding matters considered at the last committee meeting.				
Summary of key issues	➢ No serious incidents reported during the reporting period from February 2023 to March 2024. ➢ Identification of structural risks in one building onsite, including reinforced aerated autoclaved concrete (RAAC) classified as 'medium risk', requiring demolition within 6-12 months for safety. ➢ Comprehensive review and rescore of the Board Assurance Framework (BAF1) and Corporate Risk Register to incorporate new controls and actions, aimed at reducing potential risks to patient care quality and safety. ➢ QVH has achieved "substantial" compliance with NHSE's EPRR Core Standards for 2023, showing consistent improvement from previous years, but work on consolidating training and needs assessments needs completion. ➢ Significant policy updates, including revisions to the Health and Safety Policy, are approved.				
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:					
	Date:		Decision:		
Next steps:					

Report to:	Board Directors
Agenda item:	16-24
Date of meeting:	2 May 2024
Report from:	Shaun O'Leary, Non-executive director & committee Chair
Report author:	Riya Jose, Governance officer
Date of report:	23 April 2024
Appendices:	None

Sub-committee assurance report
Quality and Safety committee, 23 April 2024

Key agenda items

- Quality & Safety Board Report (February and March)
- EPRR Assurance Report
- Serious Incident briefing update (none during the period)
- Clinical Quality and Patient Safety Exception Report (including Clinical Harm Review)
- Infection Prevention & Control Quarterly Report Qtr4 (2023-2024)
- Guardian of safe working hours report
- Patient Experience Report Inc. FFT
- Further Reflections on patient stories
- Policy on Health and Safety

Alert

- During the reporting period from February 2023 to March 2024, no serious incidents were declared at QVH, indicating effective management of patient safety.
- A fire safety notice was issued due to failure to comply with a notice of deficiencies received in March 2023, highlighting immediate areas needing attention to meet safety regulations.(Actions being reported through F & P C)
- Reinforced aerated autoclaved concrete (RAAC) identified in one building as 'medium risk', requiring demolition within 6-12 months to ensure safety.(Actions being reported through F & P C)
- Queen Victoria Hospital continues to maintain "substantial" compliance with the NHSE EPRR Core Standards for 2023, demonstrating consistent improvement over previous years. The focus is now intensifying on further improvements, with targeted actions planned to address specific areas - mostly around training - aiming to achieve "full compliance" in the peer review later in 2024.
- There have been improvements in antimicrobial stewardship with a new appointment and an antimicrobial steering group now in place, chaired by the Deputy Medical Director. The group reviews risks monthly and focuses on compliance with proper prescribing practices.
- A case of CDiff was reported which is not attributable to the hospital, highlighting ongoing challenges in managing infections that originate outside the hospital environment.
- The need for consultant-level supervision for plastic surgery junior doctors has been identified as an urgent issue, with a deadline set for resolution by end June 2024

Assure

- Ongoing efforts are underway to ensure safe working conditions through regular monitoring of junior doctor rotas, addressing any arising issues promptly. Additionally, initiatives such as providing frozen food out of hours and improving WiFi availability in overnight accommodation are being implemented to enhance the overall working environment for junior doctors and improve safety for patients.
- The Trust has contained all reported infection outbreaks swiftly, with protocols in place to mitigate the spread and impact.
- Reflections on patient stories are used to foster a culture of continuous improvement, highlighting the importance of patient-centred care.
- The committee has observed the successful delivery of the first Schwartz round and expect this to become embedded in practice.
- The QVH CQC Preparedness Programme is progressing well, with ongoing efforts to assess compliance with NICE guidelines. Additionally, the Patient Safety Incident Response Framework (PSIRF) Plan and Policy has been approved by the ICB and implementation is underway.
- Oversight of all relevant ventilation and air handling units within the trust is now assured with maintenance and servicing, important for controlling environmental factors related to infection.
- The Trust continues to refine the clinical harm review process, incorporating lessons learned over the past three years. This includes improvement of cancer care pathways management, streamlining the handling of 62-day cancer breaches and introducing proactive measures for patients with progressive conditions to prevent delays that could lead to harm. Additionally, the implementation of new triage methods to effectively categorise patients based on treatment urgency is being prioritised to improve patient outcomes.

Advise

- Following extensive review, the Health and Safety Policy has been ratified, ensuring its compliance and alignment with relevant regulations and standards.
- Mandatory training requirements for the newly implemented PSIRF need to be completed by all relevant staff, including the Board, by September, to ensure everyone is familiar with the new standards and procedures.

Risks discussed and new risks identified

- The committee reviewed both BAF1 and the Corporate Risk Register, and robust discussion was had regarding the target consequence score of 5. the committee highlighted the necessity for a common understanding of risk appetite within the Trust to guide further refinements. This has been referred back to the Executive for resolution. Additionally, it was noted that the existing "freedom to speak up" risk will be closing shortly, coinciding with the commencement of the new specialist off-site service.

Recommendation

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

Report cover-page					
References					
Meeting title:	Board of Directors				
Meeting date:	02/05/2024		**Agenda reference:**	**17-24**	
Report title:	Learning from patient stories				
Sponsor:	Nicky Reeves, Chief nursing officer				
Author:	Chris Parrish, Patient experience manager				
Appendices:	None				
Executive summary					
Purpose of report:	To provide an update regarding learning from patient stories to the Board and actions undertaken				
Summary of key issues	The report highlights the five patient stories held at board and summarised the learning from these stories and what actions are completed or in progress to address any issues.				
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:	BAF1- safe, effective, caring, responsive and well-led patient services				
Corporate risk register:	None				
Regulation:	NA				
Legal:	NA				
Resources:	Existing				
Assurance route					
Previously considered by:	Quality and safety committee				
	Date:	23/04/2024	Decision:		
Next steps:	NA				

Report to:	Board Directors
Agenda item:	17-24
Date of meeting:	2 May 2024
Report from:	Nicky Reeves, Chief nursing officer
Report author:	Chris Parrish, Patient experience manager
Date of report:	19 April 2024
Appendices:	None

Learning from patient stories 2023/24

Introduction

The purpose of this Patient Story Review is to provide assurance on the actions subsequently taken to the Board meeting.

Executive summary

The Board hears a patient story at the start of the public bi monthly board meetings from either a patient who attends to share their story, or via an executive lead who reads the patient's story they have documented.

The patient story is heard to ensure, from the outset of the meeting, that the patient is at the forefront of our mind.

The story is not bought to reinvestigate any complaint but to hear how it feels to be a patient using QVH, and to take additional learning from each situation and feedback to colleagues.

The trust heard from five (5) patients during 2023/24 and stories relate to treatment, how they were communicated with and also include positive feedback as well as areas for review or learning.

Information regarding trend and theme analysis of quality measures and patient experience are not addressed in this review, this paper simply captures the learning from the stories.

Summary of patient stories

4 May 2023

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.

7 July 2023

The patient explained that she had raised a complaint after she was booked in to have breast reconstruction at QVH. Following delays, the surgery was scheduled and then cancelled on the day as the operation was deemed unsafe due to an MRI scan not being clear for required blood vessels. She expressed disappointment that the MRI scan had only been reviewed the night before the operation given that the scan had taken place 15 months before that.

7 September 2023

The executive lead shared a statement from a profoundly deaf sign language user who was treated as an inpatient and subsequently as an outpatient at QVH. The statement described a negative patient experience as a profoundly deaf sign language user due to a lack of disability awareness and lack of awareness of the Accessible Information Standards Act. During the patient's treatment, a British Sign Language interpreter (BSL) was not made available to the patient and her husband, who is also profoundly deaf but has lip reading and spoken language abilities. The patient's husband had acted as the sign language and spoken English translator. The patient's needs were attended to when the deputy chief nurse was notified.

2 November 2023

The patient gave an account of their experience of being a patient at QVH which had also led to a complaint. The patient described a night he had spent on the trauma ward. Three people were shouting and using what he described as offensive language on the ward late at night and despite asking them to be quiet, the issue continued. The nurses explained that there was nothing that they could do and moved the patient to a separate room. He explained that besides this incident, the treatment he received at QVH was exceptional.

11 January 2024

The executive lead shared a statement from a breast reconstruction patient to the Board who had previously raised a complaint. The patient felt rushed when providing a summary of her treatment to the staff and felt that the consultant had made comments in a casual manner about the possibility of her cancer returning which scared her. The patient described how she felt extremely vulnerable and self-conscious taking her clothes off in the small room with four members of staff present and questioned whether it was necessary for them all to be present. The patient shared this complaint in the hope that it may help future patients and that staff can ensure kindness and consideration is a priority.

Actions and learning

Proposed Action	Action Trigger	Action Description	Month Raised	Department(s)	Owner	Status
Individual Discussion	The surgical procedure on the patient was considered to be outside of guidelines (regarding discussing options with patients) as the surgeon did not speak to the patient during the operation.	The surgeon will discuss their actions and identify improvement opportunities with the appropriate individuals	May	Plastic Surgery	General Manager	Closed
Adjustment to working practice	The initial complaint invesigation only received comments from the surgeons in the theatre and not the wider team	The complaint investigation requires the views and opinions of the wider surgical team if procedural or guidelines are questioned		Patient Experience	Head of Risk, Safety and Patient Experience	Closed
Adjustment to working practice	The delay in a follow up to the patient's complaint response, where further information and opinion was sought	Follow up complaint responses will be provided within a set period to ensure timely management			Head of Risk, Safety and Patient Experience	Closed
Recognition	Where the complaint is against a surgeon and a junior doctor might be a witness, this may put the junior doctor in a difficult position	Recognition of this point in future work is required. No specific action has been identified			Head of Risk, Safety and Patient Experience	Closed
Complaint responses	The patient thought complaint responses should be given 'on the balance of probabilities' rather than acknowledge differing views so that lessons could be learnt	To determine if complaint responses should provide an outcome based on the 'balance of probabilities'			Head of Risk, Safety and Patient Experience	Closed
IT System improvement	A scan was taken on 20 December 2022 but not reviewed until the night before the operation	The connection between spoke site radiology/scan results and QVH tablets is being addressed with IT to ensure these are available when the clinicians want them	July	Plastic Surgery	General Manager	Closed
Improved Communication	The patient was incorrectly advised that both reconstruction and reshaping operations would take place on 6 April 2023	The messaging of pathways in this scenario is being improved as it was not understood by this patient.			General Manager	Closed
Alignment to working practice	The patient was not referred to Breast Reconstruction nurses	Since this patient's pathway started all patients are now referred on to a Breast Reconstruction nurse. Existing patients are being revisited to ensure all have been considered.			General Manager	Closed
Alignment to working practice	The patient did not receive an information pack	Since this patient's pathway started all patients are now given an information pack. Existing patients are being revisited to ensure all have been considered.			General Manager	Closed
Alignment to working practice	The patient was not invited to a Show and Tell	Since this patient's pathway started all patients are now invited to a Show and Tell. Existing patients are being revisited to ensure all have been considered.			General Manager	Closed
Improved Communication	The patient received no reply to their enquiry regarding their place on the waiting list for reconstruction surgery	The messaging of waiting times for patients on this pathway is being improved as it was not understood by this patient.			General Manager	Closed
Complaint responses	The patient referenced inaccuracies and omissions from the complaint response	To provide a 'plain english' response and remove formalities of complaint responses		Patient Experience	Head of Risk, Safety and Patient Experience	Closed

Proposed Action	Action Trigger	Action Description	Month Raised	Department(s)	Owner	Status
Training intervention	The patient was identified as profoundly deaf but no action was taken or escalated to provide an interpreter	To provide training for patient-facing staff that focuses on the needs of patients with hearing impediments.	September	Nursing	Learning and Development Offering	Ongoing
Update to Glossary of Terms	Inappropriate language was used by staff to understand the patient's medical condition	The Trust's Glossary of Terms will be updated with accurate and up to date terminology and disseminated to all staff		Nursing	Chief Nursing Officer	Under Review
Scheduling	The patient was scheduled during a period of industrial action	The Service teams are considering when patients should be scheduled around industrial action and not just on the implicated days		Service Teams	General Manager	Closed
Adjustment to working practice	Other patients were prioritised over this patient on 3 occasions during their stay	The Trauma Management Group will consider priority review patients who have been cancelled more than twice and demonstrate that reasonable adjustments are made.		Trauma Management Group	General Manager	Under Review
Training intervention	Ward rounds and general interactions were not fit for purpose to allow the patient to communicate	Training on how to book a BSL interpreter and the service offer will be provided (and reviewed).		All Staff	Chief Nursing Officer	Pilot Ongoing
Briefing		We will share the Provision of Translation and Interpreting Services to Non English Speakers and those with Communication Impediments Policy via our internal communications newsletter for all staff to access and understand.		All Staff	Chief Nursing Officer	Pilot Ongoing
Technical provisions		Technical resources to support patients with translation needs will be reviewed and funding sought for new opportunities		All Staff	Chief Nursing Officer	Pilot Ongoing
IT System improvement		Incorporate SMS service into the Provision of Translation and Interpreting Services to Non English Speakers and those with Communication Impediments Policy, where possible.		All Staff	Chief Nursing Officer	Under Review
Individual and Team Discussion		The teams involved will be provided with a report of this patient's stay and consider the lessons that can be learnt		Nursing	Chief Nursing Officer	Closed
Training intervention	The patient flagged three other patients shouting and using offensive language on the ward late at night, despite measures to control them the issue continued.	De-escalation training to nursing staff is required	November	Nursing	Learning and Development Offering	Ongoing
Briefing		All staff to be made aware how to, and when to, contact security for support		Executive Lead	Chief Finance Officer	Under Review
Improved Communication	The patient stated that when describing the procedure the consultant had used words which the patient thought to be flippant.	The trust now writes to patients who have had this surgery to ask about the adjectives that they would be comfortable with being used when talking about the procedure and outcome.	January	Executive Lead	Chief Medical Officer	Closed
Improved Communication	The patient stated that they felt they were rushed when giving their history and summary of their condition	The messaging of available time in this scenario is being improved as it was not understood by this patient.		Service Teams	General Manager	Closed
Estate Improvement	The Board raised concerns that other patients might find the clinical room space small, unnecessarily so for the colleagues attending	The curtain spaces within the clinical rooms is to be considered and potentially made bigger		Executive Lead	Chief Medical Officer	Under Review
Recognition	The Board recognised that colleagues needed to feel empowered to speak up against what they considered bad behaviour or inappropriate language	Recognition of this point in future work is required. No specific action has been identified		Service Teams	General Manager	Closed

Conclusion

The opportunity to hear the patient stories at Board is a hugely positive and informative section of the agenda. We propose to continue to encourage patients to come forwards and share their experiences with us during our Board meeting in an open and transparent way to ensure the voice of the patient is loud and clear at the board table.

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

Report cover-page					
References					
Meeting title:	Board of Directors				
Meeting date:	02/05/2024		**Agenda reference:**	**18-24**	
Report title:	Quality and Safety Board Report				
Sponsor:	Nicky Reeves, Chief Nursing Officer Tania Cubison Chief Medical Officer				
Author:	Amy Brownlie, Clinical audit and outcomes Specialist Nicky Reeves, Chief Nursing Officer				
Appendices:	None				
Executive summary					
Purpose of report:	To update the board on the quality and safety metrics and results				
Summary of key issues	First Schwartz round carried out in April 2024 Positive feedback on our smoking cessation nurses input in the patients pathway PLACE Task and Finish Groups are in progress				
Recommendation:	Board is asked to **note** 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:	None				
Corporate risk register:	none				
Regulation:	none				
Legal:	None				
Resources:	Existing				
Assurance route					
Previously considered by:	Q&S				
	Date:	23rd April 2024	Decision:	Approved for Board with minor amendments	
Next steps:					

Report to:	Board Directors
Agenda item:	18-24
Date of meeting:	2 May 2024
Report from:	Nicky Reeves, Chief Nursing Officer Tania Cubison, Chief Medical Officer
Report author:	
Date of report:	April 2024
Appendices:	None

Quality and safety report

Introduction

This report sets out the Quality and safety date from February and March 2024.

Executive summary

Patient safety corporate risk registers and the Board Assurance Framework for patient services have been discussed at the April Quality and Safety Committee

Regular monthly meeting of Allied Health Professionals and Health Care Scientist continue with CNO. There have been detailed discussions around workforce planning, educational opportunities and the challenges of the physical infrastructure impacting on service delivery. AHPs and HCS colleagues offer work experience opportunities to our local schools, which is well received. We have also taken advantage of apprenticeships within our services to create and build on innovative roles, this was recognised when the deputy chief scientific officer visited in February.

There are now “faster diagnosis” clinics being run by Speech and Language Therapists alongside ENT consultants and consideration as to extended scope roles in SLT. Our community service are also running training sessions for nursing home staff around dysphagia. These were designed by a SLT student who volunteered her time virtually. We plan for our new SLT assistant will lead on these in time.

We have held four clinically (CNO and CMO) led strategy workshops during March. All of these were well attended by the multidisciplinary teams and the learning from these will be incorporated in to our strategy creation.

Our first Schwartz round was delivered in April 2024 and we have a programme for the rest of the year.

We have been commended on the delivery of our smoking cessation work and our smoking cessation nurse by the ICB. Since going live in October 2023, 119 patients have been seen, with 55 quitting at 4 weeks (46% quit rate). The remaining patients quit at 3 months, unfortunately a very small cohort have relapsed. The nurse works three days week and the demand for this service is extremely high. Patients in Max Fax, Orthodontics, Plastic surgery and head and neck clinics are identified and the service is yielding some great results. Next steps include evaluation, review of outcomes, addressing health inequalities and sharing best practice and learning to ensure this becomes part of our “business as usual”

We achieved substantial compliance in the recent Emergency Preparedness Resilience and Response (EPRR) assurance peer review and the detail was shared in April Q&S committee. The action plan to move us to full compliance was discussed

in Q&S and focuses on ensuring our Training Needs Analysis and educational programme meets the needs of the trust.

The PLACE task and finish meetings continue and progress against the action plan is being made.

Safe Performance Indicators (1)

Metrics not appropriate for SPC XmR reporting

KPI Description	Mar -23	Apr-23	May -23	Jun-23	Jul-23	Aug -23	Sep -23	Oct-23	Nov -23	Dec -23	Jan-24	Feb -24	Mar -24
Number of Serious Incidents reported (including IG breaches)	0	0	0	0	0	0	1	0	1	0	0	0	0
Compliance with Duty of Candour % of instances complied with Duty of Candour, and no. of instances.	100 %		100 %				100 %		100 %			100 %	
	1	0	1	0	0	0	2	0	1	0	0	1	0
Number of Never Events	0	0	0	0	0	0	0	0	0	0	0	0	0
No of patient safety incidents with moderate harm	0	0	0	1	0	0	0	1	1	0	1	0	1
No of patient safety incidents with severe harm or death	1	0	0	0	0	0	0	0	0	0	0	0	0
Rate of Serious Incidents per 1,000 bed days	0.0	0.0	0.0	0.0	0.0	0.0	1.0	0.0	1.0	0.0	0.0	0.0	0.0
No of Mixed Sex Accommodation (MSA) breaches reported	0	0	0	0	0	0	0	0	0	0	0	0	0
No of falls resulting in moderate or severe harm or death	0	0	0	0	0	0	0	0	0	0	0	0	0
No. of pressure ulcer development category 2 (hospital acquired)	0	0	0	0	1	0	2	2	1	0	0	0	0
No of Grade 3 and 4 pressure ulcer reported (hospital acquired) (and ungradeable)	0	0	0	0	0	0	0	0	0	0	0	0	0

Pressure ulcer assessment completed on admission (%) (quarterly)				94%			95%			96%			
Ward patients with sepsis receiving antibiotic therapy within one hour (total number)	1	0	1	1	1	1	0	0	0	1	0	0	0
	100 %		100 %	100 %	100 %	100 %				100 %			
Number of HCAI Root Cause Analysis (RCA) and Post Infection Review (PIR) undertaken	No reportable infections	No reportable infections	No reportable infections	No reportable infections	1	1	No reportable infections	No reportable infections	No reportable infections	No reportable infections	2	1	No reportable infections
No of CDI reported (Trust acquired, post 72hrs after admission)	0	0	0	0	0	0	0	0	0	0	0	1	0
No of MRSAs reported (Trust acquired, post 48hrs after admission)	0	0	0	0	0	0	0	0	0	0	0	0	0
No of E.coli reported (Trust acquired, post 48hrs after admission)	0	0	0	0	1	1	0	0	0	0	0	0	0
No of MSSA reported (Trust acquired, post 48hrs after admission)	0	0	0	0	0	0	0	0	0	0	1	0	0
Confirmation Infection Control Audits are undertaken	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Crude mortality (all patients)	6	2	2	2	2	4	1	5	3	9	3	2	1

There was one moderate harm incident reported in relation to a missed fracture. This was reviewed by the Clinical governance group and learning will be incorporated into the plastic surgery handbook for staff inductions. There was one CDiff infection which is reportable but not attributable to QVH.

Safe Performance Indicators (2)

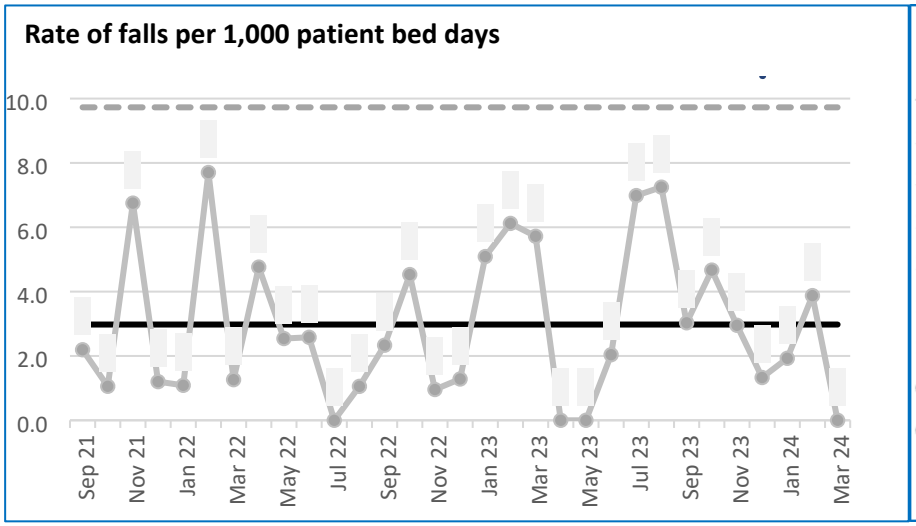
KPI	Latest month	Measure	Target /Limit	Variation	Assurance	Mean
Number of patient safety incidents with no harm near miss	Mar 24	24	-			37
No of medication administration incidents reported	Mar 24	2.0	-			3.3
Number of formal Complaints received	Mar 24	2	-			5
Number of Complaints per 1,000 bed days	Mar 24	2.1	-			5.8
% of complaints acknowledged within three working days	Mar 24	100%	99%			96%
FFT recommendation - Inpatient Adult	Mar 24	100%	90%			100%
FFT recommendation - Inpatient Children	Mar 24	100%	90%			99%
FFT recommendation - MIU	Mar 24	86%	90%			94%
FFT recommendation - Outpatients	Mar 24	95%	90%			95%
% FFT Recommendation Rate Overall	Mar 24	95%	90%			96%
FFT response - Inpatient	Mar 24	51%	25%			44%
FFT response - Inpatient Children	Mar 24	8%	25%			31%
FFT response - MIU	Mar 24	19%	25%			22%
FFT response - Outpatients	Mar 24	16%	25%			18%
FFT Response Rate overall	Mar 24	19%	25%			22%
No. of low/no harm falls	Mar 24	0	-			3
Rate of falls per 1,000 patient bed days	Mar 24	0.0	-			3.0
Patient falls assessment completed within 24 hrs of admissions	Mar 24	100%	100%			98%
Rate of pressure ulcer per 1,000 patient bed days	Mar 24	0.0	-			0.7
Occupational Health data no. of contaminated Sharps injuries for staff	Mar 24	3	-			3
Infection prevention and control training compliance (all staff clinical and non clinical)	Mar 24	90%	90%			92%
Emergency Re-Admissions within 30 days	Mar 24	2.2%	2.2%			2.3%
Safer staffing compliance (inc Site)	Nov 23	99%	99%			99%
% clinical staff appraisal (rolling 12 month period)	Mar 24	88%	90%			86%
% non-clinical staff appraisal (rolling 12 month period)	Mar 24	79%	90%			80%

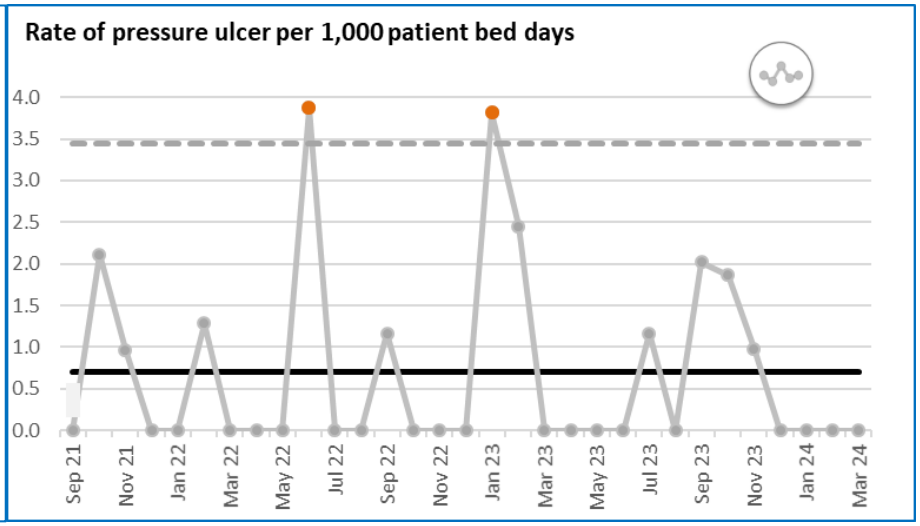
The number of medication incidents reported continues to show monthly variation but this does not demonstrate cause for concern. Other measures are within expected limits.

Safe Performance Indicators – Falls & Pressure Ulcers

Our falls rate continues to be variable but within expected limits and lower than the national average.

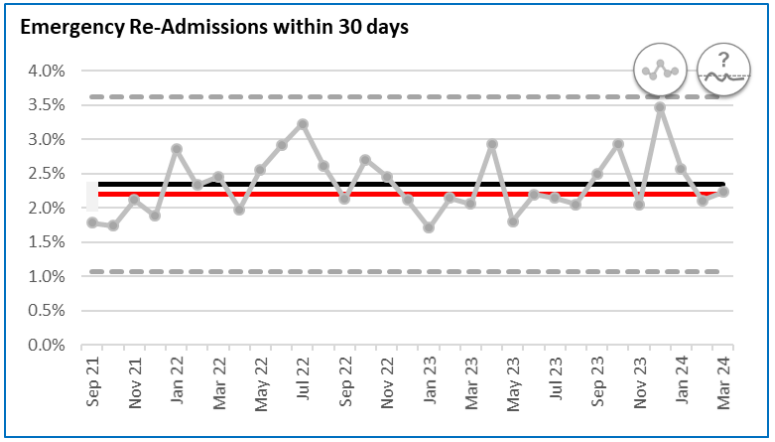
QVH acquired Pressure Ulcers continue to be within normal variability, with an average of less than 1 per month per 1000 bed days and none reported in Dec/Jan. Current processes provide assurance of care.

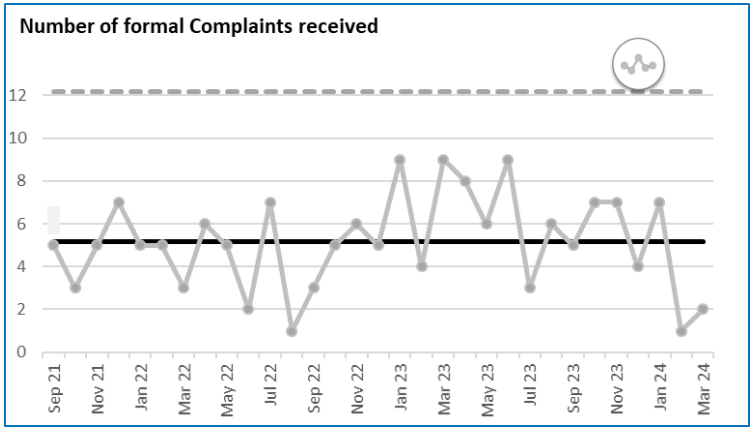




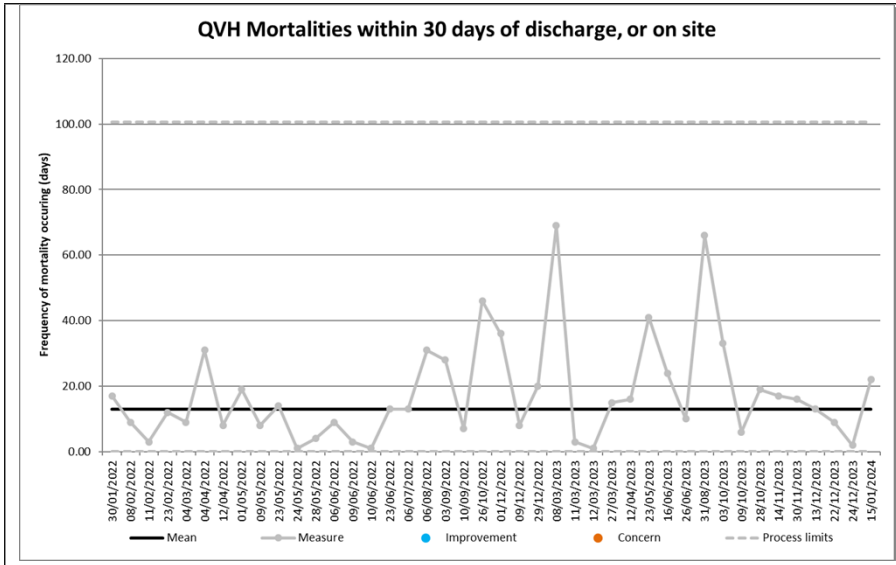
Effective Indicators

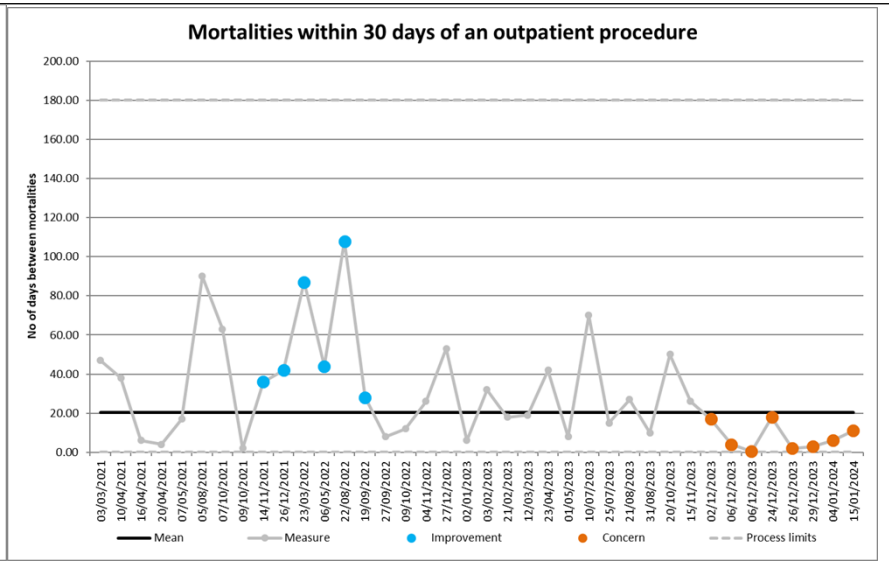
Re-admission rates remain within expected levels. Specialty governance leads review, and discuss any re-admissions of concern which are escalated to the CGG if required.





The number received over February/March is within expected variation of the 'new norm'. All complaints are shared with department leads to share within the team.





Mortalities are reviewed as per policy, and the frequency of occurrence of death is within expected variation.

Mortalities are reviewed as per policy, and the frequency of occurrence of death is within expected variation.

Nursing Workforce - Performance Indicators

Metrics	Q1 2023-24			Q2 2023-24			Q3 2023-24			Q4 2023-24			12 month average
Nursing Workforce	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	
Establishment WTE Including Bank & Agency	384	384	384	384	384	384	384	384	384	384	384	384	384
Establishment WTE excluding Bank & Agency	343	343	343	343	343	343	343	343	343	343	343	343	343
Staff In Post WTE	331	333	333	335	335	342	345	346	349	349	357	356	342
Agency Total worked in month WTE	8	6	7	7	11	8	8	10	12	12	15	18	10
Bank WTE Total worked in month WTE	35	33	34	32	37	38	36	37	33	42	46	54	38
Staff in Post Vacancy WTE	12	10	10	9	9	1	-1	-2	-5	-5	-14	-12	1
Vacancies % Including Bank & Agency Usage	2%	3%	2%	3%	0%	-1%	-1%	-2%	-3%	-5%	-9%	-11%	-2%

Staff in Post Vacancies %	4%	3%	3%	3%	3%	0%	0%	-1%	-2%	-2%	-4%	-4%	0%
Qualified Nurses (NMC) Vacancies WTE	13	15	17	17	17	15	12	10	11	11	9	9	13
Theatre Practitioners (AHP) Vacancies	2.04	2.04	1.04	1.04	2.04	-0.96	-0.96	-1.96	-1.72	-1.72	-1.72	-3.47	-0.4
Band 2 & 3 HCSW Vacancies WTE Clinical support to clinical staff	0	-3	-3	-6	-5	-3	-4	-4	-6	-7	-10	-11	-5
Band 2 & 3 HCSW Vacancies WTE Non clinical support to clinical staff	0	0	0	0	0	-1	0	0	1	1	1	1	0
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)	-2	-4	-5	-4	-5	-10	-9	-7	-6	-6	-11	-10	-6

Safe staffing levels have been maintained across the Trust. The anomalies in staffing establishments will be addressed in the new financial year as we set the new budgets moving forwards to accurately reflect staff in post.

Medical Workforce - Performance Indicators

Metrics	**Q1 2023-24**			**Q2 2023-24**			**Q3 2023-24**			**Q4 2023-24**			12 month rolling
Medical Workforce	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	
Turnover rate in month, excluding trainees	1%	0%	2%	0%	3%	3%	1%	0%	3%	0%	0%	2%	12%
Turnover in month including trainees 9%	6%	1%	1%	2%	10%	0%	4%	0%	2%	2%	7%	1%	41%
Management cases monthly	0	0	0	0	0	1	0	0	1	1	#N/A	#N/A	#N/A
Sickness rate monthly on total medical/dental headcount	1%	1%	1%	2%	1%	3%	2%	2%	2%	2%	3%		
Appraisal rate monthly (Clinical)	89%	88%	89%	90%	89%	89%	88%	87%	89%	87%	89%	89%	88%
Mandatory training monthly	86%	88%	89%	88%	89%	89%	89%	86%	88%	89%	90%	92%	
Exception Reporting –	2	0	1	2	0	2	1	0	0	2	#N/A	#N/A	

Education and Training													
Exception Reporting – Hours	0	4	8	1	5	3	6	7	1	0	#N/A	#N/A	

Metrics	**Q1 2023-24**			**Q2 2023-24**			**Q3 2023-24**			**Q4 2023-24**			12 month average
Workforce	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	
Trust rolling Annual Turnover % Excluding Trainee Doctors	8%	9%	9%	8%	8%	9%	9%	8%	8%	7%	8%	8%	
Starters WTE In month excluding HEE doctors	3	4	2	5	3	5	8	7	3	7	3	4	4
Leavers WTE In month excluding HEE doctors	3	4	2	2	1	2	5	0	3	3	3	3	3
12 month sickness rate (all sickness)	5.0%	4.9%	4.8%	4.7%	4.6%	4.6%	4.6%	4.7%	4.4%	4.4%	4.4%		
Monthly Sickness Absence % All Sickness	4.8%	3.2%	3.1%	3.6%	3.5%	5.1%	5.4%	6.1%	5.2%	4.9%	3.3%		

Medical and dental staffing

Induction in February went well, with excellent feedback from the trainees who attended. Plans are in place for the April induction.

Exception reporting; there has been an increase in hours related exception reports in February and March. The Guardian of Safe Working Hours works with departments to close reports and ensure action is taken.

Education

LEEP 4 places have been confirmed for those who have completed 1-3, this training will take place in April. A record number of applications were received for the next cohort, starting in May, and everyone who applied has been offered a place.

At the recent Local Faculty Group meetings and Junior Doctors Forum, trainees have raised concerns re training opportunities and post on call days on the registrar rota in OMFS, and supervision in plastics clinics. All concerns are being followed up on with the relevant department.

Recommendation

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

Recommendation
The Board is asked to **APPROVE/NOTE etc**