Bundle Public Board 10 July 2025

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Jackie Smith, Trust Chair

- 35-25 Minutes- PUBLIC Board meeting- 8 May 2025 DRAFT V1

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- 36-25 PUBLIC Matters arising

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- 38-25 Chair's report

39.25 Chief Executive's report
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- 39-25 CEO's report

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Jackie Doherty, Freedom to Speak Up Guardian

- 40-25 (FC) FTSU report
- 40-25 FTSU report

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Leonora May, Company secretary
Simon Marshall, interim Chief finance officer
Approval

- 41-25 SOs, RoP SoD and SFIs
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Leonora May, Company secretary
All executive directors

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Kirsten Timmins, Chief operating officer

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45.25 Staff survey results 2024
Helen Edmunds, Chief people officer

- 45-25 Staff survey results 2024

46.25 Annual review of learning from patient stories
Edmund Tabay, Chief nursing officer

- 46-25 Annual review of learning from patient stories

47.25 Audit & risk committee assurance
Paul Dillon-Robinson, Non-executive director and committee Chair

- 47-25 ARC assurance report July 2025 FINAL

47-25.1 ARC annual report 2024-25

48.25 Quality and safety committee assurance
Shaun O'Leary, Non-executive director and committee Chair
Quality annual reports:
- *Patient safety (duty of candour)*
- *Learning from deaths*
- *Safeguarding*
- *Infection, prevention and control*
- *Complaints*
- *Research and innovation*
- *Consultant revalidation (approval)*

Edmund Tabay, Chief nursing officer
Tamara Everington, Chief medical officer

48-25 QSC assurance report July 2025 FINAL
48-25.1 Patient Safety Annual Report FINAL
48-25.2 Annual Report Learning from deaths 2024-25
48-25.3 Safeguarding Annual report 2024-25
48-25.4 IPC Annual Report 2024-25
48-25.5 Complaints Annual Report 2024-25
48-25.6 Research & Innovation Annual Report 2024-25
48-25.7 Revalidation and Appraisal Annual Report 2024-25
48-25.7.1 Annex A Medical and Dental Appraisal

49.25 Financial, workforce and operational performance assurance
Peter O'Donnell, Non-Executive Director and committee Chair

49-25 FPC assurance report July 2025 FINAL

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

51.25 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 toLeonora.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 10 July 2025

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

MEMBERSHIP
BOARD OF DIRECTORS
July 2025

Members (voting):

Trust Chair	-	Jackie Smith
Senior Independent Director	-	Russell Hobby
Non-Executive Directors	-	Paul Dillon-Robinson
	-	Peter O'Donnell
	-	Shaun O'Leary
	-	Jo Emmanuel
Acting Chief Executive Officer	-	Abigail Jago
Chief Medical Officer	-	Tamara Everington
Chief Nursing Officer	-	Edmund Tabay
Interim Chief Finance Officer	-	Simon Marshall
Chief Operating Officer	-	Kirsten Timmins

In full attendance (non-voting):

Associate Non-Executive Directors	-	Aleema Shivji
	-	Vivek Chaudhri
Chief People Officer	-	Helen Edmunds
Interim Deputy Chief Executive Officer	-	Jane Dickson
Company Secretary	-	Leonora May

Annual declarations by directors 2025/26

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
Paul Dillon-Robinson Non-Executive Director	Trustee/ Director, Hurst Educational Trust Director of Hurst Transport Ltd and Hurst Facilities Ltd 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

Peter O'Donnell Non-Executive Director	Non-executive director for Nottingham Building Society Non-Executive Director at OneFamily	Nil	Nil	Nil	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. Ltd Director of RVHB Ltd Non-executive director of ImpactEd	Nil	Nil	Chief executive officer of the Kemnal Multi Academy Trust	Nil	Nil	Nil	Nil

Jo Emmanuel Non-Executive Director	Nil	Independent consultancy work for different NHS bodies for mental health, none directly linked to QVH	Nil	School governor for West St Leonards primary academy school	Nil	Nil	Nil	Nil
Abigail Jago Acting Chief Executive Officer	Nil	Nil	Nil	Nil	Nil	Nil	Nil	Nil
Tamara Everington Chief Medical Officer	Nil	Nil	Nil	Nil	Nil	Nil	Nil	Nil
Simon Marshall Interim Chief Finance Officer	Nil	Nil	Nil	Nil	Nil	Nil	Nil	Nil
Edmund Tabay Chief Nursing Officer	Nil	Nil	Nil	Regional lead for Filipino Senior Nurses Alliance Member of Jabali Men's network	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

Jane Dickson Interim Deputy Chief Executive Officer	Non-Executive Director for Ashford and St Peters Hospitals NHS FT Director of Mull Moments (private holiday lettings company)	Nil	Nil	Nil	Nil	Nil	Nil	Nil
Aleema Shivji Associate Non-Executive Director	Director of 5 Westborne Villas Freehold Ltd and 5 Chatham Place Freehold Ltd	Nil	Nil	Nil	Nil	Nil	Nil	Nil
Vivek Chaudhri Associate Non-Executive Director	Director of Global AI Leaders Network Director of Purposeful AI	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							
Jackie Smith Trust Chair	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Paul Dillon-Robinson Non-Executive Director	N/A	N/A	N/A	N/A	N/A	N/A	N/A
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
Jo Emmanuel Non-Executive Director	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Tamara Everington Chief Medical Officer	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Simon Marshall Interim Chief Finance Officer	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Edmund Tabay Chief Nursing Officer	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Abigail Jago Acting Chief Executive 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
Jane Dickson Interim Deputy Chief Executive Officer	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Aleema Shivji Associate Non-Executive Director	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Vivek Chaudhri Associate Non-Executive Director	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 10 July 2025
10.00-12.00

Agenda: session held in public		
WELCOME		
34-25	**Welcome, apologies and declarations of interest** *Jackie Smith, Trust Chair*	
STANDING ITEMS		**Purpose**
35-25	**Draft minutes of the public meeting held on 8 May 2025** *Jackie Smith, Trust Chair*	*Approval*
36-25	**Matters arising and actions pending from previous meetings** *Jackie Smith, Trust Chair*	*Review*
37-25	**Patient story** *Edmund Tabay, Chief nursing officer*	*Discussion*
38-25	**Chair's report** *Jackie Smith, Trust Chair*	*Assurance*
39-25	**Chief Executive's report** *Abigail Jago, acting Chief executive officer*	*Assurance*
GOVERNANCE, STRATEGY & RISK		
40-25	**Freedom to Speak Up Guardian report** *Jackie Doherty, Freedom to Speak Up Guardian*	*Assurance*
41-25	**Standing Orders, Scheme of Delegation and Reservation of Powers and Standing Financial Instructions** *Leonora May, Company secretary* *Simon Marshall, interim Chief finance officer*	*Approval*
42-25	**Strategy and culture committee** *Leonora May, Company secretary*	*Approval*
43-25	**Organisational risk register** *Leonora May, Company secretary* *All executive directors*	*Assurance*
PERFORMANCE		
44-25	**Integrated quality and performance report** *Kirsten Timmins, Chief operating officer*	*Assurance*
45-25	**Staff survey results 2024** *Helen Edmunds, Chief people officer*	*Assurance*

46-25	**Annual review of learning from patient stories** *Edmund Tabay, Chief nursing officer*	*Assurance*
COMMITTEE ASSURANCE REPORTS		
47-25	**Audit & risk committee assurance incl. Audit and risk committee annual report** *Paul Dillon-Robinson, Non-executive director and committee Chair*	*Assurance*
48-25	**Quality and safety committee assurance** *Shaun O'Leary, Non-executive director and committee Chair* **Quality annual reports:** • **Patient safety (duty of candour)** • **Learning from deaths** • **Safeguarding** • **Infection, prevention and control** • **Complaints** • **Research and innovation** • **Consultant revalidation (approval)** *Edmund Tabay, Chief nursing officer* *Tamara Everington, Chief medical officer*	*Assurance/ approval*
49-25	**Financial, workforce and operational performance assurance** *Peter O'Donnell, Non-Executive Director and committee Chair*	*Assurance*
MEETING CLOSURE		
50-25	**Any other business (by application to the Chair)** *Jackie Smith, Trust Chair*	*Discussion*
MEMBERS OF PUBLIC		
51-25	**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*	

	Minutes (DRAFT)	
Meeting:	**Board of Directors (session in public)** **10.00-12 noon 8 May 2025** **Education Centre, QVH**	
Present:	Jackie Smith (JS)	Trust Chair (voting) (Chair)
	Paul Dillon-Robinson (PDR)	Non-executive director (voting)
	Peter O'Donnell (POD)	Non-executive director (voting) [MS Teams]
	Shaun O'Leary (SOL)	Non-executive director (voting)
	Russell Hobby (RH)	Non-executive director (voting)
	Jo Emmanuel (JE)	Non-executive director (voting)
	Jon Bell (JB)	Interim Chief finance officer (voting)
	Tamara Everington (TE)	Chief medical officer (voting)
	Edmund Tabay (ET)	Chief nursing officer (voting)
	Kirsten Timmins (KT)	Chief operating officer (voting)
	Helen Edmunds (HE)	Chief people officer (non-voting)
	Abigail Jago (AJ)	Acting Chief executive officer (voting)
	Jane Dickson (JD)	Interim deputy Chief executive officer (non-voting)
	Aleema Shivji (AS)	Associate Non-executive director (non-voting)
	Vivek Chaudhri (VC)	Associate Non-executive director (non-voting)
In attendance:	Leonora May (LM)	Company Secretary (minutes)
	Simon Marshall (SM)	Interim Chief finance officer designate
Apologies:	None	
Members of the public:	5 members of staff, 11 governors and two members of public (for patient story)	

1-25 **Welcome, apologies and declarations of interest**

The Chair opened the meeting welcoming members of the Board, including SM as interim Chief finance officer designate to his first Board meeting, and those observing the meeting.

The Chair acknowledged that this was JB's last Board meeting as he was leaving the Trust tomorrow. She thanked him for the positive difference that he has made during the short time in the role.

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.

There were no apologies received.

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

2-25 **Draft minutes of the public meeting held on 6 March 2025**

The Board **agreed** that the minutes of the public Board meeting held on 6 March 2025 are a true and accurate record of that meeting and **approved** them on that basis.

3-25 **Matters arising and actions pending from previous meetings**

Action 3 (organisational risk register) was pending and TE gave the following update.
A working group chaired by the Chief medical officer has been established to develop the future model for the care of children at QVH building on the QVH strategy. An evaluation of estate opportunity to support improvements in clinical services is underway led by the Chief nursing officer. Mitigations are in place and actively managed to ensure risks are minimised within the current estate available for paediatric care.

	KT provided the Board with an update on action 4 (EPRR report) and specifically Fit testing numbers. She explained that fit testing had improved from 4.7% to 53.3% and recently dropped down to 51.2%. She acknowledged that this requires improvement and the Board endorsed the continued follow up described to ensure that the position improves. The Board **noted** the verbal and written updates for the actions.
4-25	**Patient story** [this item was taken before item 2-25] The Board welcomed the patient who was in attendance at the meeting to share her experience of QVH with the Board. The patient described her experience as follows. The patient had a traumatic experience in the operating theatre for which she made a complaint. The response she received to her complaint from the Chief executive was unsatisfactory. The letters stated that the experience she described in the theatre had not been documented. She felt that the letter suggested that she was lying. There was a lack of continuity with her care, and those involved did not seem to have access to her health files. The patient felt like she was not treated as an individual throughout her care until she was introduced to a consultant plastic surgeon who took time to discuss her treatment with her and options available to her. The Board extended apologies to the patient for the experience she described of QVH. AJ explained that this is not the level of care that QVH aspires to provide to patients. She acknowledged the importance of always ensuring that patients are treated as individuals. The Board agreed the importance of learning from this patients experience to ensure that it does not happen again. TE acknowledged the unsatisfactory response the patient received to her complaint. She emphasised the importance of the Trust listening to patients to improve and not being defensive. The Board thanked the patient for sharing her experience.
5-25	**Chair's report** JS presented the Chair's report to the Board. She highlighted that: - The results of the recent Council of Governors effectiveness review were positive with feedback indicating that the relationship between the Board and Council of Governors remains good. This will influence the decision regarding potential removal of the Trust's additional licence conditions - The Board recently completed its annual effectiveness review. The results indicated that the Board is effective and that relationships and the quality of reports have both improved. Board members would welcome increased focus on cultural issues at Board level - Key concern areas for the Board include the Trust's challenging financial position and underlying deficit and the delivery of cost improvement plans for 2025/26 The Board **noted** the contents of the report.
6-25	**Chief Executive's report** AJ presented the report to the Board, highlighting the following: - There continues to be significant changes which are impacting the whole of the NHS as well as QVH as a provider. The most significant change is that the NHS now needs to operate within its means. The Trust has an ambitious savings target of £7.5m and NHS Sussex has a significant deficit - Providers are at risk of losing autonomy if financial targets are not met

	- The QVH Strategy 2025-2030 is being stress tested within the context of national changes and pressures - The Trust's year end position was stronger than forecasted and the Trust delivered a small surplus, however, the Trust has an underlying deficit position - The NHS Staff survey results 2024 have been published and the Trust did well overall with strong staff engagement. There is however a need to focus on staff feeling safe to speak up and improving the experience of our disabled colleagues in the workplace - AJ welcomed SM to the Board. She extended thanks to JB for all that he had done during his time as interim Chief finance officer The Board acknowledged that the national changes present an opportunity for providers to take a more leading role and that it will be important for the Trust to take this opportunity for the benefit of patients. The Board noted the positive year end position and a Board member asked about areas of focus for 2025/26. AJ stated that the biggest priority will be financial grip and control to ensure delivery of the challenging cost improvement plan as well as strengthening compliance and internal control. The Board **noted** the contents of the report.
7-25	**Company secretary's report** LM presented the report to the Board. She highlighted the following. A number of compliance reports had been presented to the Audit and risk committee at its meeting in March. These confirmed that there has been improvement in compliance with the Code of governance for NHS provider trusts and there have been breaches of the Trust's governing documents during the year and these have related to contract management and approvals outside of the Scheme of delegation, procurement and waivers. The Trust is not aware of any breaches during quarter four. Work to address these issues includes a review of the governing documents and key policies to ensure that they are accessible to all staff and the development of a Trust wide governance handbook The draft Annual governance statement for 2024/25 has been presented to the Audit and risk committee and the auditors. The draft statement does conclude that significant control issues have been identified and that plans are in place to make improvements. The draft Head of Internal Audit opinion is that there are weaknesses in the system of governance, risk management an internal control. A Board member asked about the timescale for the potential removal of the Trust's additional licence conditions. In response, JS confirmed that the Trust has provided NHS England with information related to the QVH Strategy 2025-2030 and the development of the relationship between the Board and Council of Governors. She hoped that the Trust would receive a response before the end of June 2025. The Board acknowledged the improvement in compliance with governing documents in quarter four as stated within the report. AJ explained what she thought had made a difference in response to a question. She stated that this has been a significant focus for the executive team during the last quarter including leading by example and holding other to account. The governance and finance teams are working through updates to the Trust's governing documents to ensure that they are accessible to staff and they will be communicated and disseminated appropriately to ensure that all staff are aware of their responsibilities. The Board requested ongoing updates on required action to improve compliance. **ACTION AJ LM**

	PDR confirmed that the Audit and risk committee will oversee the development of the annual governance statement. He reemphasised the importance of it being transparent about the issues. Discussion was had regarding the draft Modern Slavery Statement and the Board agreed that it should be updated to reference work related to safeguarding and consideration should be given to the statement related to assurance for procurement practices. The Board: – **Noted** that the Trust has complied with its standard and additional licence conditions for 2024/25 – **Noted** the area of non-compliance with the Code of governance for NHS provider trusts – **Noted** non-compliance with the Trust's Governing documents – **Noted** the update related to the Annual governance statement 2024/25 – **Approved** the committee terms of reference as appended – **Approved** the Modern slavery statement for 2024/25 as appended subject to the above amendments being made
8-25	**Guardian of Safe Working report** TE presented the report in the absence of the Guardian of Safe Working who had sent her apologies to the meeting. SOL confirmed that the Quality and safety committee had reviewed the report and were satisfied that an issues related to accommodation had been resolved. He did highlight that there is operational detail behind the report that the committee were concerned about and that this will come back to the committee for further discussion. In response to a question, TE confirmed that she is confident that the Trust's financial challenges will not have an impact on safe working hours and patient care. Board members fed back that the report is difficult to understand and TE agreed to consider making the report more accessible next time. The Board **noted** the contents of the report.
9-25	**Organisational risk register** LM presented the report to the Board as read, highlighting that: - The highest scoring risk is related to compliance with the Mental Capacity Act - Two new high scoring risks are being added to the register. The first is in relation to the delivery of the cost improvement plan with an initial score of 20 and the second is in relation to elective recovery funding with an initial score of 16 - The current score for risk 11 (relationship between the Board and Council of Governors) has reduced given the results of the recent Council of Governors effectiveness review which were positive - The current score for risk 14 (non-compliance with governing documents) has been reduced given work completed to address weaknesses in governance arrangements - The current score for risk 115 (delivering breakeven for 2024/25) has been reduced given that the initial draft annual accounts are breakeven, however subject to audit A Board member asked what action is being taken in relation to compliance with the Mental Capacity Act given that the risk has been open for a long time. In response, TE stated that a dedicated task and finish group has been set up to work through actions. She thought that lack of training was not contributing to the issue and that systems and processes make it

	challenging for staff to recognise an issue in real time. SOL confirmed that the Quality and safety committee are monitoring actions related to this risk. The Board **noted** the contents of the report.
10-25	**Annual business plan 2025/26** JB presented the report to the Board who were asked to ratify the business plan or 2025/26 which it had previously approved in an extraordinary Board meeting. JB reported that the cost improvement plan at 6% amounts to a total of £7.5m which is very high risk for the Trust. The workforce plan shows a net reduction of c. 32 whole time equivalent posts during the year. The Trust meeting its performance targets depends on activity being paid for and there is a need to better understand the position related to elective recovery funding. JB reported that there is £7.4m of core capital available to the Trust this year, £2m of which is from the sale of the land. Capital resource available for estates work is limited and less than is required to manage the totality of the risks. The team are actively monitoring the highest estates risks. He acknowledged the challenges with capital spend at year end for 2024/25 and stated that the organisation is in a better place going into this financial year. The Board acknowledged the challenges and risks related to the plan. Discussion was had about the Trust's ability to forecast progress against the plan and JB confirmed that a full forecast will not be available for month one or month two but that monthly forecasts will be provided to the Finance and performance committee. JB confirmed that the Board will have an understanding of the trajectory at its meeting in July but that it will be too early in the quarter for robust forecasting. The Board requested an update on the trajectory and phasing of the cost improvement plan as soon as it is available. **ACTION SM** A Board member asked how confident the team are that activity levels can be met. KT acknowledged that the activity plan is very ambitious. She stated that plans are being put into place including transformation work for the outpatients department. The Trust is waiting for confirmation regarding income for the plan and KT confirmed that this will be monitored carefully. Discussion was had regarding the cost improvement plan. A Board member asked if there will be any quality issues as a result of delivery of the cost improvement plan. In response, AJ confirmed that for each proposed cost reduction, a quality impact assessment is being undertaken to understand the impact. The executive team are sighted in interdependencies and have a granular focus on what reductions mean for patient pathways. AJ reported that the team are moving at pace to identify cost improvement schemes internally but there is a need in some areas to collaborate in order to reduce costs. The Board acknowledged that the land sale had contributed significantly to this year's capital budget and suggested that this be communicated to staff at the appropriate time with information about what the money had been spent on to improve patient experience. A Board member sought further information regarding the reference to improved governance and oversight of the community diagnostic centres (CDCs) within the report. AJ explained that executive oversight now sits with the interim deputy Chief executive officer and that the CDC programme Board reports directly to the Executive leadership team. Oversight of CDC activity is now business as usual.

	The Board is **ratified** the business plan for 2025/26 as approved at its extraordinary meeting in March 2025, and **approved** the capital allocation for 2025/26, noting the revised approach.
11-25	**Integrated quality and performance report** The executive team presented the report highlighting the following: - The Trust delivered a financial breakeven position a year end - The long waiting position at year end was better than forecasted. The waiting list is being validated which is helping to improve the forward trajectory - Organisational culture remains a focus and it is recognised that there are different micro cultures across the Trust; some with good practices and some with challenging behaviours. Staff will need to be appropriately support during this period of change and uncertainty The Board **noted** the contents of the report.
12-25	**Six monthly safe staffing review** ET presented the report to the Board, reporting that safe staffing levels have been maintained supported by the safe nursing care tool and that there is a need to be flexible to manage nursing staffing levels on a daily basis. There is a need to recognise the current position across the NHS and deliver further efficiencies; part of this work will include a review of nursing staff levels. The Board agreed that there are opportunities for efficiency savings demonstrated by the information within the report and that the impact of this could have been clearer within the report. The Board **noted** the contents of the report.
13-25	**Audit and risk committee assurance** PDR presented the committee assurance report to the Board. He reported that the committee has reiterated the importance of actions from internal audit reports being complete in line with the deadline. The committee have continued to have oversight of contract management processes and there has been significant improvement. The Board **noted** the contents of the report.
14-25	**Quality and safety committee assurance** SOL presented the committee assurance report to the Board. Committee members had individually expressed dissatisfaction about aspects of the current practice for complaints and the committee has encouraged a less defensive approach which supports learning. He reported that a key issue for the committee to explore further is how learning is embedded in practice, this is particularly important in relation to feedback from patients. The committee has agreed to put aside some time to consider safety risks and issues related to electronic patient records (EPR). SOL highlighted that recent Health Watch and PLACE inspection results were positive. Discussion was had regarding patient stories and the Board agreed the importance of not becoming complacent due to the Trust performing well in the national inpatient survey. Discussion was had about how learning and action taken is fed back to the Board and LM

	confirmed that the annual review of learning from patient stories would be presented to the Board at its meeting in July 2025. The Board **noted** the contents of the report.
15-25	**Financial, workforce and operational performance assurance** POD presented the report to the Board. He commended the teams for the positive year end position, acknowledging that it was a challenge. POD confirmed that the committee have reviewed in detail and support the revised EPR business case, which the Board will consider in private due to commercial sensitivity. POD stated that the committee are considering risks related to the cost improvement programme. He highlighted the importance of the Board assuring itself that the requirements of the Board and governance as a whole are not impaired. He recognised that this is a challenging period for executive colleagues. In response to a question, KT provided an update on insourcing solutions being considered to help to reduce the waiting list. She confirmed that from June, an external company will support with moles within the QVH theatres which will be done under tariff and at cost and will help with reduced waiting lists. The Board **noted** the contents of the report
16-25	**Any other business (by application to the Chair)** There was no further business and the meeting closed.
17-25	**Questions from members of the public** One question was received from a governor ahead of the meeting. The question and the Board's response were as follows: Question How will the recent supreme court ruling on biological sex impact QVH? Response We are currently awaiting national guidance on what this means in practice for trans people working in healthcare and those accessing our services and we will provide further updates once this is produced. The Trust's policies have not changed at this time. We recognise that trans and non-binary staff and patients face unacceptably high levels of bullying and harassment and want to emphasise that the rights of transgender and non-binary patients, colleagues and visitors to QVH remain protected. QVH is committed to fostering a culture of inclusivity and belonging for all of our staff, patients and visitors. Our expectation is that everyone is treated with respect, kindness and compassion in line with our values. The Chair invited the lead governor to ask questions regarding any of the items discussed during the meeting on behalf of the governors. The lead governor asked the following questions and the following responses were given. Question Who is responsible for cyber security and can you assure us that necessary steps have been taken to protect our systems? Response

	HE is the SIRO. The data security protection toolkit is completed annually which assesses the Trust's cyber security mechanisms. The Trust does regular phishing exercises and complies with NHSE requirements. Question Can we revisit previous patient stories to understand what action has been taken since? Response Yes, the annual review of learning from patient stories will be presented to the Board at its meeting in July 2025. Question What impact will the Federation of Specialist Hospitals report have? Response It aligns with national policy so will support how we contribute towards that. It is helpful to align with peers where policy changes might disproportionately have an impact on specialist trusts. Question Do we have trained clinical safety officer for the EPR project? Response Yes, there are three clinical safety officers currently. Question How do we compile our performance metrics and how can we measure ourselves against other trusts? Response For 2025/26, a new format of the integrated quality and performance report is being developed and metrics and priority areas will be more accessible within the report. As part of this, the Trust will include regional and national benchmarks where they are available. Question Is there an update on the land sale governance review? Response Not at this time. The moneys received from the sale of the land had supported the Trust's capital position for 2025/26 and it will be important to engage with governors about what the money is spent on.

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	January 2025	98-25	Culture	Assessment of the organisational culture to be completed to enable the Board to understand the gap between where it is now and where it needs to be in line with the values and behaviour framework previously agreed by the Board	**HE**	~~**8 May 2025**~~ ~~**July 2025**~~ **September 2025**	May 2025: There is work underway to trinagulate information from the staff survey, people pulse survey, FTSU/ raising concerns, employee relations cases, listening sessions and datix to understand the micro cultures at QVH and where it needs to be alligned with our values and behaviour framework. There is variation across different departments and directorates in terms of behaviours but this is underpinned by a commitment to patient care. We know there have been challenges relating to governance and compliance. There are areas where there is a resistance to change and legacy practices and behaviours where support is needed. A management essentials programme is in development proposed to start in June 2025, along with change management support and work to further embed our values and behaviour framework. July 2025: Continued work in progress alongside strategic partnership work and KSO3 (behaviour framework). Ongoing assessment through period of change via the Strategy and culture committee once established.	**PENDING**
2	March 2025	131-25	Organsiational risk register	Provide the Board with an update on risk 38 (there is a risk that the Peanut ward is not suitable for paediatric care)	**TE**	**8 May 2025**	May 2025: TE gave the following update at the May Board meeting. A working group chaired by the Chief medical officer has been established to develop the future model for the care of children at QVH building on the QVH strategy. An evaluation of estate opportunity to support improvements in clinical services is underway led by the Chief nursing officer. Mitigations are in place and actively managed to ensure risks are minimised within the current estate available for paediatric care.	**CLOSED**
3	March 2025	135-25	EPRR report	Confirm whether Fit test numbers have increased and provide an update regarding technology testing	**KT**	**8 May 2025**	March 2025: update on technology testing provided outside of meeting incuding cyber security, server infrastructure, network infrastructure, date centres and business continuity May 2025: KT gave the following update at the May Board meeting. She explained that fit testing had improved from 4.7% to 53.3% and recently dropped down to 51.2%. She acknowledged that this requires improvement and the Board endorsed the continued follow up described to ensure that the position improves.	**CLOSED**

4	May 2025	7-25*	Company secretary's report	Provide ongoing updates about progress on actions to improve compliance with Governing documents to the Board for monitoring	**LM, AJ**	**September 2025***	July 2025: Governing documents have been reviewed and updated to ensure they are accessible to staff. These will be presented to the Board for approval at its meeting in July 2025. Material updates have been made to the Scheme of Delegation. Both the Contract management policy and Procurement policies have been updated. Communication plan related to individual responsibilities for staff is underway and development of the Governance handbook will commence in Q2.	**PENDING**
5	May 2025	10-25*	Annual business plan 2025/26	Provide the Board with an update on the trajectory and phasing of the cost improvement plan	**SM**	**July 2025***	July 2025: Key finance risks including cost improvement plans (CIP), income and cash flow are set out within the CEO's report and a paper to the Private Board meeting . The trajectory and phasing of our CIP is shown within our annual plan. Our actual progress and forecast against this trajectory will be presented monthly at F&P from Month 3.	**PENDING**

Report cover-page					
References					
Meeting title:	Board of Directors				
Meeting date:	10/07/2025	**Agenda reference:**	**38-25**		
Report title:	Chair's report				
Sponsor:	Jackie Smith, Trust Chair				
Author:	Jackie Smith, Trust Chair				
Appendices:	None				
Executive summary					
Purpose of report:	To update the Board of Directors on Chair, non-executive director and governor activities since the last meeting.				
Summary of key issues	• At the beginning of July 2025, Chris Barham stepped down as our lead governor. I would like to extend my enormous thanks and thanks on behalf of the Board and the Council of Governors to Chris for all that he has done during his time in the role. Janet Hall (public governor) has taken up the role of lead governor and John Harold (public governor) has taken up the role of deputy lead governor • Work has commenced to develop an option appraisal to consider strategic partnership options to enable the longer term sustainability of the Trust's services in the new NHS environment. This is the Board's key priority • The Board are considering the future arrangements for the Strategic development committee and will consider the establishment of a Strategy and culture committee at its meeting in July 2025. Key elements of the People committee and Strategic development committee will be combined into one committee focussed on current challenges and priorities • The NHS ten year plan was published on 3 July 2025				
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:** ***To deliver outstanding care***	**KSO2:** ***To innovate and improve***	**KSO3:** ***To be an excellent employer***	**KSO4:** ***To deliver sustainable services***	**KSO5:** ***To collaborate with others***
Implications					
Board assurance framework:	None				
Organisational 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:	38-25
Date of meeting:	10 July 2025
Report from:	Jackie Smith, Trust Chair
Report author:	Jackie Smith, Trust Chair
Date of report:	3 July 2025
Appendices:	None

Chair's report

Council of Governors

At the beginning of July 2025, Chris Barham stepped down as our lead governor. I would like to extend my enormous thanks and thanks on behalf of the Board and the Council of Governors to Chris for all that he has done during his time in the role. Janet Hall (public governor) has taken up the role of lead governor and John Harold (public governor) has taken up the role of deputy lead governor. I am looking forward to working with Janet and John in their new roles.

I am pleased to say that Bob Lanzer has been appointed for a further term of three years as our stakeholder governor for West Sussex County Council.

During June, governor working groups were be held with the Finance and Performance, Quality and safety committee and Audit and risk committee Chairs, executive leads and governors.

I have met with our new lead governor and deputy lead governor and will meet with them regularly to discuss key issues.

Board of Directors

Work has commenced to develop an option appraisal to consider strategic partnership options to enable the longer term sustainability of the Trust's services in the new NHS environment. This is the Board's key priority. The Board remains focussed on the Trust's challenging financial position and cost improvement plans for 2025/26.

The Board are considering the future arrangements for the Strategic development committee and will consider the establishment of a Strategy and culture committee at its meeting in July 2025. Key elements of the People committee and Strategic development committee will be combined into one committee focussed on current challenges and priorities. Its key functions will be:

- To provider oversight and direction of the development of the Trust's strategic and sustainable future model and the delivery of the QVH Strategy 2025-2030 in the national context
- Assist the Board in its oversight of the delivery of people, culture and organisational development strategies

At its extraordinary meeting on 24 June 2025, the Board approved the Annual report and accounts 2024/25 and our Quality Account for 2024/25. These documents are testament to the hard work of all of our staff during the year, clinical and non-clinical, for the benefit of patients and service users. The Annual report and accounts

2024/25 will be shared with governors and our members at our Annual members meeting which is being held at 6pm on 23 September 2025.

Other activities
I continue to meet regularly with the Chair of NHS Sussex and engage with NHSE as well as Chair's and Chief executive officers from other providers within and outside of the system to explore collaborative working opportunities. Stephen Lightfoot will step down as Chair of NHS Sussex from September 2025.

Since the last Board meeting, non-executive colleagues have visited the histopathology, burns and breast departments. I am pleased to say that governors are increasingly taking up the offer to join Non-executive directors on service visits.

Government policy for the NHS
The NHS ten year plan was published on 3 July 2025. It states that 'By 2035, our ambition is that every NHS provider should be an FT with freedoms including the ability to retain surpluses and reinvest them, and borrowing for capital investment. FTs will use these freedoms and flexibilities to improve population health, not just increase activity…We will remove the requirement for FTs to have governors. While governors have provided helpful advice and oversight for some FTs, we expect the next generation of NHS FTs to put in place more dynamic arrangements to take account of patient, staff and stakeholder insight. This should include systematic measures of patient reported experiences and outcomes'.

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

Report cover-page					
References					
Meeting title:	Board of Directors				
Meeting date:	10/07/2025	**Agenda reference:**	**39-25**		
Report title:	Chief Executive Officer (CEO) report				
Sponsor:	Abigail Jago, Acting Chief Executive Officer				
Author:	Diane Talbot, Business Manager to CEO, Michelle Baillie, Associate Director of Communications, Engagement and Charity, Leonora May, Company Secretary				
Appendices:	None				
Executive summary					
Purpose of report:	This report outlines the main developments since the last public Board meeting to bring to the Board's attention.				
Summary of key issues	• The Trust continues to have a challenging financial outlook for the year ahead with the need to deliver significant savings in order to achieve the breakeven plan in 2025/26. • The NHS 10 year plan, Fit for the Future, has been published based on extensive consultation. • Ongoing change continues at a local and national level with the announcement of the abolishment of further bodies. • The NHSE Oversight Framework has been published and providers assigned a segment score. • Work has commenced to develop an option appraisal to consider strategic partnership opportunities to enable the longer term sustainability of services in the new NHS environment. • In May the Care Quality Commission's 2024 Children and Young People's Patient Experience survey results were published with QVH the only hospital categorised as achieving 'much better than expected' results. • The financial challenge is our greatest organisational risk.				
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:	All				
Organisational risk register:	None				
Regulation:	None				
Legal:	None				
Resources:	Resource impact as identified within the report.				
Assurance route					

Report to:	Board Directors
Agenda item:	39-25
Date of meeting:	10 July 2025
Report from:	Abigail Jago, Acting Chief Executive Officer
Report author:	Diane Talbot, Business manager to CEO
Date of report:	July 2025
Appendices:	None

Chief executive officer (CEO) report

Alert

- The Trust continues to have a challenging financial outlook for the year ahead with the need to deliver significant savings in order to achieve the breakeven plan in 2025/26.
- There continues to be significant change at a national level in terms of organisational structure with the announcement of the abolishment of further bodies including commissioning support units (CSUs), Healthwatch (national patient voice body and c.150 local branches) and the National Guardian's Office. Some functions will move into the Department of Health and Social Care.
- Key risks for the organisation relate to the financial position, ongoing estates challenges and ongoing delivery of our performance standards.

Assure

- The 2024/2025 year end position has been confirmed as a £16k surplus following audit completion.
- Work has commenced to develop an option appraisal to consider strategic partnership opportunities to enable the longer term sustainability of services in the new NHS environment.
- In May the Care Quality Commission's 2024 Children and Young People's Patient Experience survey results were published with QVH the only hospital categorised as achieving 'much better than expected' results.
- The East Grinstead Community Diagnostic Centre (CDC) Business Case has been approved. A build contractor has been appointed and build planning is underway. Work continues with the planning of the Bognor CDC.

Advise

- The NHS 10 year plan, Fit for the Future, has been published. The plan aims to bring the NHS closer to home with Neighbourhood Health Services. The plan progresses three shifts, hospital to community, analogue to digital and sickness to prevention. The plan has been built on extensive consultation.
- NHSE have approved the proposal for NHS Sussex and NHS Surrey Heartlands Integrated Care Boards (ICBs) to collaborate.
- Key Strategic Objectives (KSO) for 2025/26 have been developed which set out the year 1 priorities for the QVH Strategy 2025-30.
- Work is underway to implement the trust Behaviour Framework as a key priority for cultural development.
- The NHS Oversight Framework has now been published and providers assigned a segment score.
- The Electronic Patient Record business case has been approved taking into account key changes to the programme.

National and Local Updates

NHS Oversight Framework

The NHS Oversight Framework 2025/6 has now been published. The 1 year framework sets out how the NHS will assess providers and ICBs alongside a framework of promoting improvement whilst helping the identification of organisations requiring support. NHS England will use the performance assessment process to measure delivery against an agreed set of metrics. This will determine the segment score for each provider and identify where improvement is required. 1 is the highest performing and 5 the lowest. A focused set of metrics contributes to the segment score.

The assessment includes an organisational delivery score and financial override. The override means that all organisations in deficit or in receipt of deficit support funding will be limited to organisational delivery score of no greater than 3. QVH has been placed in segment 3.

Where providers are part of a provider collaborative or group model they will be measured as a trust and not as a wider group. The effectiveness with which providers are collaborating and supporting system working will form part of the provider collaborative assessment.

Leadership Changes

Change continues at a national level with the ongoing planning of the new operating model.

Samantha Jones has been appointed Permanent Secretary at DHSC – to support government's Plan for Change.

Adam Doyle has returned to his role as CEO for NHS Sussex following a period within a national role.

Mark Smith moves from Interim CEO to lead the transition to a new Integrated Care Board for Sussex and Surrey.

Stephen Lightfoot will step down as Chair of NHS Sussex in September.

Angela Stevenson, CEO for Surrey and Sussex NHS Trust retires in August. Andrew Hines, currently Executive Director for Group Development at Barts Health NHS Trust has been appointed to the role and is due to start in the Autumn.

NHS Operating Model

In line with the national intention to move from 42 ICBs to 26 NHS have approved the proposal for NHS Sussex to work collaboratively with NHS Surrey Heartlands. This includes the Surrey Heath and Farnham areas coming back into the Surrey health system (from the Frimley system). Preparation work is now underway to formally develop the change programme across both organisations.

There have been further announcements that a number of bodies have been dissolved including Healthwatch and the Guardian Service.

System Collaboration

We recognise collaborative working is more important than ever, QVH continues to be an active Committee in Common member, supporting the delivery of the Sussex wide Improving Lives together strategy. The Trust is also an active member of the Provider Collaborative which is now multi sector. Key priorities have been agreed for the

collaborative and these include integrated neighbourhood teams and exploring corporate opportunities.

NHS 10 year plan

The 10 Year Health Plan for England – Fit for the Future was published on 3rd July. It sets out a bold and ambitious course for the NHS that aims to ensure sustainability for generations to come.

It has been built upon an extensive engagement exercise including members of the public and the health and care workforce. One of the key themes of the plan is to 'take the best of the NHS to the rest of the NHS'. The key themes include: getting the care you need, when you need it; making healthcare seamless, fixing the basics and making the NHS a great place to work. This plan is to be delivered though 3 shifts:

- **From hospital to community**; transforming healthcare with easier GP appointments, extended neighbourhood health centres, better dental care, quicker specialist referrals, convenient prescriptions, and round-the-clock mental health support - all designed to bring quality care closer to home.

- **From analogue to digital;** creating a seamless healthcare experience through digital innovation, with a unified patient record eliminating repetition, AI-enhanced doctor services and specialist self-referrals via the NHS app, a digital red book for children's health information, and online booking that ensures equitable NHS access nationwide.

- **From sickness to prevention;** shifting to preventative healthcare by making healthy choices easier—banning energy drinks for under-16s, offering new weight loss services, introducing home screening kits, and providing financial support to low-income families

It is a clear aim of this plan is to make the NHS the very best place to work – setting new standards for flexible, modern NHS employment, expanding training opportunities and reducing the administrative burden. The plan includes:

- A new set of Staff Standards for employment in the NHS.
- The time staff need to spend on statutory mandatory training will be substantially reduced by April 2026.
- Single sign-on for NHS software will be introduced to reduce the administrative burden.
- From 2027, the roll out of validated AI diagnostic tools and AI administrative tools.
- New advanced practice models will be developed for nurses, midwives and allied health professionals.
- Streamlined NHS operating model through the reduction in organisations and simplified decision-making.
- Support to a quality focus through the clinical development of 'Modern Service Frameworks' to accelerate progress in conditions where there is potential for rapid and significant improvements in quality of care and productivity.

The plan also sets out a system of value based healthcare where spending and incentives are aligned to what delivers the best outcomes. This includes improving productivity and reducing waste, transparent financial regime.

Finance and Performance

The financial outlook continues to be very challenging with the need to deliver significant savings in order to achieve the breakeven plan in 2025/26. The Trust reported an Income and Expenditure position in line with planned deficit of £0.7m for month 2 and had a cash balance of £5.1m. Pay was £81k above plan, although both bank and agency usage was lower than plan and within the targets laid out by NHSE. Non-Pay compensated for the pay overspend, with clinical supplies in particular being underspent.

Whilst the position is positive for M1 and M2, there will need to be a significant acceleration of delivery to assure the planned break even position for 2025/26, with the main risk area being delivery of best value schemes of £7.5m (6%) for the year. To date £7.6 million of schemes are in progress. Our risk adjusted current forecast indicates confidence in the delivery of £3.9m with further improvement expected to £4.5m next month. The £3.9m assured to date includes £2m of pay (including £0.7m of corporate post reductions), £1.2m of non-pay and £0.7m of income contributions. Actual delivery to month 2 was £0.9m of which £0.5m was pay, £0.3m was non pay and the balance was via income contributions.

Immediate work is planned to look at additional mitigations and on driving further productivity opportunities across outpatients and nursing, through wider procurement opportunities and from medical staffing.

The level of recurrent cost reduction is the highest the Trust has delivered to date. Delivery of the full £7.5 million remains exceptionally challenging and given our relative economies of scale, collaboration will be key in order to realise the ongoing savings required.

It is key to note that our focus is on the current arrangements and moving forward there are even greater future financial pressures in terms of the withdrawal of top up arrangements and moving back to a tariff only system. Planning work for that will be undertaken over the summer.

The Trust met its planned Month 1 performance against the 2025/26 operational targets for Urgent and Emergency Care, Referral to Treatment and Cancer. For month 2 there were challenges in regard to MIU due to staffing challenges and the Faster Diagnosis standard due to consultant vacancy in Head and Neck. There is also an increase in skin cancer referrals which may impact cancer performance moving forwards. In month 2, 44 patients waited greater than 65 weeks against a forecast of 50. Work continues to reduce long waits further including recruitment and insourcing.

Income from activity was on plan, and CDC activity increased, yet was behind plan from an income perspective given underperformance in some modalities. Work is in place to understand and address constraints to activity delivery.

Theatre productivity continued to achieve the GIRFT recommended performance. The Trust has begun its outpatient transformation programme, with focussed work within sleep services, standardisation of clinical templates and optimising the use of digital dictation.

Temporary staffing use has decreased in M1, with substantive roles being filled and turnover decreasing. This has resulted in a lower vacancy rate in M1 (5.3%).

Quality and Safety

Children and Young People's Patient Experience Survey

In May the Care Quality Commission's 2024 Children and Young People's Patient Experience survey results were published with QVH the only hospital categorised as achieving 'much better than expected' results. The national survey asked children and young people across England about their hospital treatment.

QVH achieved high scores from children aged 8-15 years old relating to being able to ask questions, feeling staff explained operations or procedures, and being given privacy when receiving care and treatment. For parents responding to the survey on behalf of their children aged 0 to 7 years they rated the helpfulness of staff; felt their child was looked after in hospital; the ward was suitable for the child's age group; felt they could be with their child as much as they wanted; were listened to by staff; had confidence in staff; and knew who to contact if they had worries when they went home. Overall, 95% of parents would give their child's experience of QVH a 7 out of 10 or above.

These results are testament to the hard work of our colleagues so thank you to everyone supporting our patients, and to the young people and parents who took the time to provide us with this valuable feedback.

Environmental Health Inspection

Following a visit from environmental health, the Trust has been issued with two hygiene improvement notices. An action plan which is monitored daily is in place. A continuous improvement approach has been taken to ensure that the root causes are addressed and robust processes are developed and embedded.

Continuous improvement

The QVH Way programme remains on track having moved into year two of the programme. We have fifteen areas of the Trust undertaking regular Improvement Huddles with over 100 'improvement tickets' now completed. Our training programme continues, with 44 staff from all areas of the Trust completing their Yellow Belt training with our most recent celebration event taking place on 5 June 2025. This event celebrated staff completing their 90-day improvement projects using the *QVH Way* methodology. Our first cohort of Green Belts all passed their examinations following an eight-day programme, all now undertaking their 6 month strategically aligned improvement projects ranging from review of our Local Anaesthetic Unit activity to supporting our Outpatient Transformation Programme and development of our Professional Nurse Advocate framework.

Development of our new Trust's Key Strategic Objectives (2025/26) and associated metrics is also nearing Trust wide deployment. Benefits of the programme are being recorded via a database where all projects and improvement are monitored against a key list of benefit domains including clinical effectiveness, financial benefits, patient experience, patient safety and reducing delays. These will be regularly presented to both the Strategy and Engagement Sub- Committee and the Quality and Safety Committee demonstrating the impact of continuous improvement across QVH.

Trust Strategy and Strategic Projects

Year 1 strategy implementation and Key Strategic Objectives (KSOs)

The new KSO were approved by the Board as part of the QVH Strategy 2025-30 in November 2024. Year 1 / 2025-26 priorities have been considered and developed by the senior leadership team and supported by the Board in a Board Seminar. The KSOs have been developed taking into account national planning guidance expectations, system priorities, QVH strategy 2025/30 and agreed quality priorities. The key strategic objectives are monitored and overseen through the Integrated Quality Performance framework.

	KSO1: To deliver outstanding care	**KSO2: To innovate and improve**	**KSO3: To be an excellent employer**	**KSO4: To deliver sustainable services**	**KSO5: To collaborate with others**
Key strategic objective detail	Quality and access at the **centre** of what we are and do for patients, families and communities	Research, innovation and continuous improvement underpinning all that we do	People are our greatest asset and we need to work hard to develop and deliver our workforce for the future	Deliver best value, support a sustainable environment and future digital pathways and literacy	Develop partnership ambition - anchor, NHS, academic and commercial activities for the future
Annual objective (inc. major projects)	Deliver Access Targets - RTT, Cancer, Urgent Emergency Care *Quality Priority /Health Inequalities: Meet the individual needs of patients including communication and data* Development of children's model phase 1 NHSE Burns Service review recommendations	Research & Innovation: Governance, Collaborative Framework & Research Centre *Quality Priority: Evidence through measurable Outcome Measures* Embed Continuous Improvement	Embed Values / Behavioural Framework Deliver Equality Diversity and Inclusion Priorities	Deliver trust costs by £7.5 million (6%) including £2.1 million in corporate cost Electronic Patient Record (EPR) implementation Phase 1 reconfiguration of estates / critical infrastructure System Major project: Pathology and imaging network delivery	Development of strategic partnerships to deliver corporate sustainability QVH Local - Community Diagnostic Centres Contribution to Sussex Major Service Review

Strategic collaboration

Given the significant change in national context (including the clear directive of the NHS to live within its means, changes to the elective funding regime and specific requirement to reduce corporate costs), the future funding challenges for the local health systems and the related QVH financial outlook work is underway to identify strategic partnerships. This is key in order to ensure the sustainability of the QVH services and delivery of the key ambitions within the QVH Strategy 2025-30.

The models of specialist hospitals set out in the Federation of Specialist Hospitals *Power of Specialism in the Future (2025) have* been reviewed and the linked model approach is being considered. An engagement plan has been developed and option appraisal is in progress.

Community Diagnostic Centre (CDC) / QVH and Bognor
A building contractor has been selected for the QVH CDC following a tender process. Governance arrangements have been updated with a new framework, work-streams and terms of reference. We are hosting 2 events on 22nd July for local residents and other interested parties to talk about the practicalities of the build.

The Bognor CDC programme is continuing connecting with the University of Chichester and NHS Sussex.

Electronic Patient Record (EPR)
The Electronic Patient Record business case has been approved taking into account key changes to the programme.

Preparations for a consolidated go live (including theatre & MIU modules) and EPMA (digital pharmacy) is on track. Further work will be required following this to optimise and enhance core functionalities, and planning to support this is being progressed.

Where components are not included in the consolidated go live, reallocation of agreed spend in the full business case to meet organisational priorities is being considered.

The clinical safety case and Oct/Nov cutover plans are in draft and consultation will follow finalisation to minimise identified risks in transition.

Risk

The delivery of our cost improvement programme for 2025/26 is our biggest organisational risk, however, we are also carrying a number of estates risks with limited capital resource to manage our critical infrastructure this year.

Celebrating QVH Team

Recognising outstanding patient experience
Each year we have the pleasure of recognising colleagues who have made a lasting impact on our patients through our Outstanding Patient Experience Award. It is presented at our annual Star Awards which, thanks to support from our QVH Charity, we will be holding again this year. It is an opportunity for us to hear directly from our patients – whether it is the person who helped book their appointment, or served them in the canteen, through to the nurse, therapist or doctor. Nominations can be made through the QVH website.

Values in Practice (VIP) award winners
Our Values in Practice award programme, recognising colleagues who demonstrate our updated Trust values, continues to be popular, with nominations received from across our organisation. Our winner in April was Emily Ford, Volunteer Coordinator, nominated for being caring and inclusive (over all else) for being always there to advise and help all the volunteers. She is described as being very calm, continuously helpful with a smile on her face, is always there for volunteers to turn to, and makes people feel cared for. Our May winner was Edline Madzivanyika, Senior Management Accountant, for being supportive and challenging (over staying comfortable). Edline was recognised for going above and beyond for the wider finance team, providing support to functions outside of her role and covering staff absence. Her nomination says it would not be an understatement to say that she's kept

this part of the Trust going whilst still delivering all that is required from her own job.

Recommendation

The Board is asked to:

- **NOTE** the contents of the report
- **RATIFY** the 2025-26 strategic priorities

Report cover-page					
References					
Meeting title:	Board of Directors				
Meeting date:	10/07/2025	**Agenda reference:**	**40-25**		
Report title:	Freedom to Speak Up Annual Report				
Sponsor:	Edmund Tabay – Chief nursing officer				
Author:	Jackie Doherty – The Guardian Service				
Appendices:	The Guardian Service Annual Report 01 May 2024 – 31 May 2025				
Executive summary					
Purpose of report:	Provide an annual update to the Board, from the Guardian Service, relating to Freedom to Speak Up.				
Summary of key issues	• The report covers a 13 month period from 1 May 2024 to 31 May25. • Total number of cases raised to FTSU Guardian is 40 • The main themes being; management issue (35%) System and Process (25%) and Bullying or harassment (22.5%) • 62% of the cases raised wanted it kept confidential within Guardian Service remit • There was one red concern regarding patient safety, in relation to missing patient referrals. This was escalated to the Chief Medical Officer and responded to in line with the agreed RAG timescales • 40% of the cases reported were from Corporate Support Services • 45% of cases were from admin and clerical staff • 48% of cases were reported to the Guardian Service due to the impartial support • There has been no detriment reported in this period due to speaking up • Good support has been received from the Executive team and senior leaders in the Trust • There is more to be done to promote an open and honest culture where staff members feel safe and empowered to raise any concerns				
Recommendation:	The Board are asked to note the contents of the report and support the recommendations to encourage staff to speak up.				
Action required	Approval	**Information**	Discussion	Assurance	Review
Link to key strategic objectives (KSOs):	KSO1: *To deliver outstanding care*	KSO2: *To innovate and improve*	**KSO3:** ***To be an excellent employer***	KSO4: *To deliver sustainable services*	KSO5: *To collaborate with others*
Implications					
Board assurance framework:	None				
Corporate risk register:	None				
Regulation:	None				
Legal:	None				
Resources:	None				
Assurance route					
Previously considered by:	N/A				
	Date:		Decision:		

Next steps:	

Queen Victoria Hospital
NHS Foundation Trust

The Guardian Service
Here to listen

Annual Report
1 May 2024 to 31 May 2025

Circulation:

Main point of contact
Edmund Tabay
Chief Nursing Officer

Prepared by:
Jackie Doherty
Guardian
The Guardian Service Ltd.

Date: 25th June 2025

The Guardian Service
Here to listen

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14. **Detriment** 8
15. **Action taken to improve the Freedom to Speak Up Culture** 8
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17. **Comments & Recommendations** 9

1. Executive summary

The Guardian Service was introduced as the independent provider for Freedom to Speak Up in QVH on 1st May 2024, and this report covers from this date until 31st May 2025, a period of 13 months.

Forty concerns have been raised, of which thirty six were raised in the first 12-month period. The main three themes have been: Management issue (35%), System and Process (25%) and Bullying or harassment (22.5%). Further information is detailed throughout the report.

The Guardian Service has been well supported by the Executive team and Senior leaders within the Trust, and this has helped to increase usage of this channel for Speaking Up.

Staff raising concerns have stated that they have raised a concern previously and nothing has been done (22%), or they are fearful to raise a concern in the first instance due to a fear of reprisal (28%). There needs to be more encouragement and support to foster an open and honest culture where staff members feel safe and empowered to raise any concerns.

Following positive experiences from staff members who have used the Freedom to Speak Up Service they have shared their experience with colleagues, which has resulted in new cases from staff members who the service has been recommended to.

Promotion of Speaking Up from all leaders and managers in the Trust and demonstrating that all concerns are dealt with in a timely, appropriate and fair manner will contribute to staff believing speaking up is the right thing to do.

There are a number of recommendations detailed at the end of this report that the Trust is asked to consider.

2. Purpose of the paper

The main purpose of this report is to give an insight into the data arising from cases, themes and issues raised through the Freedom to Speak Up Guardian from 1st May 2024 to 31 May 2025. The report follows the guidance from the National Guardian Office (NGO) on the content FTSU Guardians should include when reporting to their Board which include Assessment of cases, Action taken to improve speaking-up culture and Recommendations.

3. Background to Freedom to Speak Up

Following the Francis Inquiry[1] 2013 and 2015, the NHS launched 'Freedom to Speak Up' (FTSU). The aim of this initiative was to foster an open and responsive environment and culture throughout the NHS enabling staff to feel confident to speak up when things go or may go wrong; a key element to ensure a safe and effective working environment.

4. The Guardian Service

The Guardian Service Limited (GSL) is an independent and confidential staff liaison service. It was established in 2013 by the National NHS Patient Champion in response to The Francis Report. The Guardian Service provides staff with an independent, confidential 24/7 service to raise concerns, worries or risks in

[1] https://www.gov.uk/government/publications/report-of-the-mid-staffordshire-nhs-foundation-trust-public-inquiry

their workplace. It covers patient care and safety, whistleblowing, bullying, harassment, and work grievances. We work closely with the National Guardian Office (NGO) and attend the FTSU workshops, regional network meetings and FTSU conferences. The Guardian Service is advertised throughout the Trust as an independent organisation. This encourages staff to speak up freely and without fear of reprisal. Freedom to Speak Up is part of the well led agenda of the CQC inspection regime. The Guardian Service supports the Trust's Board to promote and comply with the NGO national reporting requirements.

The Guardian Service Ltd (GSL) was implemented in Queen Victoria Hospital NHS Trust on 01 May 2024.

Communication and marketing have been achieved by meeting with senior staff members, joining team meetings, site visits, the Intranet and the distribution of flyers and posters across the organisation. All new staff will become aware of the Guardian Service when undertaking the organisational induction programme.

5. Access and Independence

Being available and responsive to staff are key factors in the operation of the service. Many staff members, when speaking to a Guardian, have emphasised that a deciding factor in their decision to speak up and contacting GSL was that the Guardians are not NHS employees and are external to the Trust.

6. Categorisation of Calls and Agreed Escalation Timescales

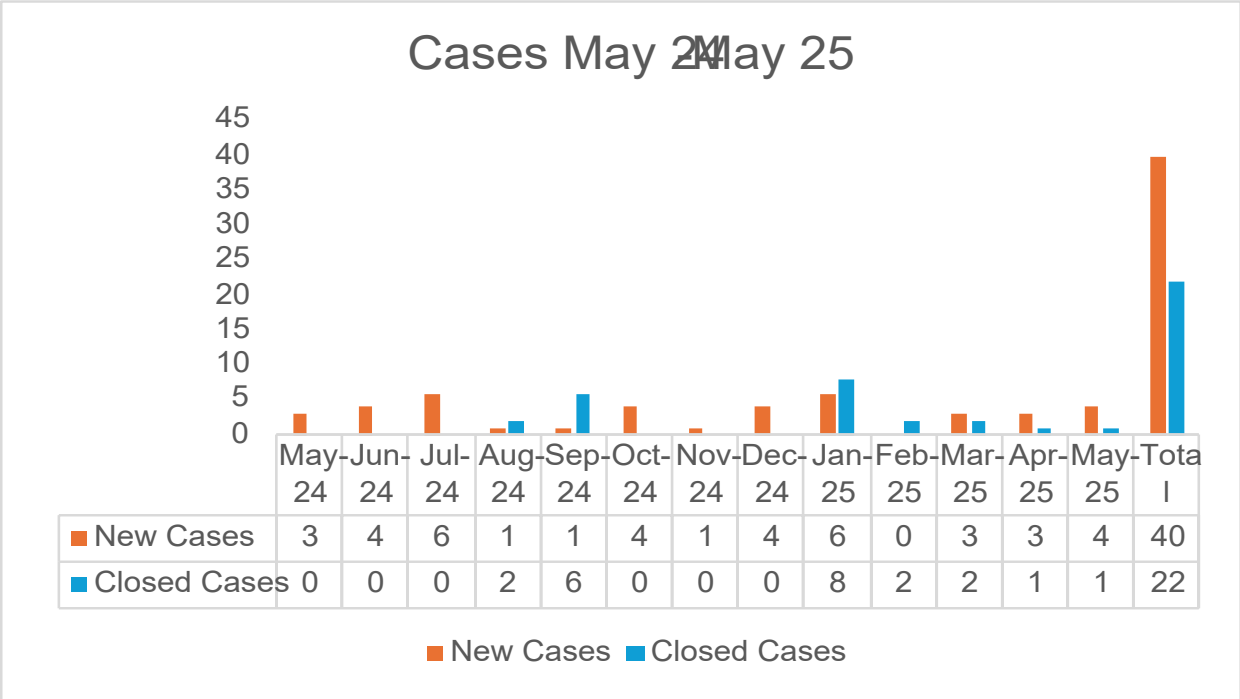
The following timescales have been agreed and form part of the Service Level Agreement.

Call Type	Description	Agreed Escalation Timescales
Red	Includes patient and staff safety, safeguarding, danger to an individual including self-harm.	Response required within 12 hours
Amber	Includes bullying, harassment, and staff safety.	Response required within 48 hours
Green	General grievances e.g. a change in work conditions.	Response required within 72 hours
White	No discernible risk to organisation.	No organisational response required

Open cases are continually monitored and regular contact is maintained by the Guardian with members of staff who have raised a concern to establish where ongoing support continues to be required. This can be via follow up phone calls and/or face to face meetings with staff who are in a situation where they feel they cannot escalate an issue for fear of reprisal. Guardians will also maintain contact until the situation is resolved or the staff member is satisfied that no further action is required. Where there is a particular complex case, setbacks or avoidable delays in the progress of cases that have been escalated, these would be raised with the organisational lead for the Guardian Service at regular monthly meetings.

Escalated cases are cases which are referred to an appropriate manager, at the request of the employee, to ensure that appropriate action can be taken. As not all employees want their manager to know they have contacted the GSL, they either progress the matter themselves or take no further action. There are circumstances where cases are escalated at a later date by the Guardian. A staff member may take time to consider options and decide a course of action that is right for them. A Guardian will keep a case open and continue to support staff in such cases. In a few situations contact with the Guardian is not maintained by the staff member.

7. Number of concerns raised



	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Total
New Cases	3	4	6	1	1	4	1	4	6	0	3	3	4	40
Closed Cases	0	0	0	2	6	0	0	0	8	2	2	1	1	22

Data from 2024/2025 'Speaking Up Data' spreadsheet published by the National Guardians Office has been used to provide comparison for this report. This offers a useful contextual benchmark to help identify patterns and identify where QVH figures may differ from national trends. However, any differences should be interpreted with caution as individual nuances of each organisation and its context may account for variation.

For this reporting year, 01st April 2024 to 31st March 2025 there were 33 cases raised at QVH (and logged on the national returns to the National Guardians Office) with 54 themes logged in total.

- According to the data from the National Guardians Office, 17.8% of cases raised included an element of patient safety/quality, a drop in cases compared to 2023/24 (18.7%). There was 1 case at QVH that had an element patient safety/quality recorded
- 1 case had an element of worker wellbeing or safety, nationally the rate is higher with almost 1 in every 3 cases raised (38.8%) having an element of worker safety or wellbeing
- 61% of cases recorded had an element of other inappropriate attitudes and behaviours. When we analyse trends across all clients within the GSL alliance we see that 50% of the cases included this element compared to lower national rate of 40%
- Nationally 18% of cases reported included an element of bullying or harassment. QVH falls below the national average, with 11% of cases recorded as having an element of bullying or harassment
- The percentage of cases which were raised anonymously at the Trust is 5%, the percentage case raised anonymously nationally is higher at 12%

8. Confidentiality

Confidentiality	No. of concerns	Percentage
Keep it confidential within Guardian Service remit	25	62%
Permission to escalate with name	7	18%
Permission to escalate without name	8	20%
Total	**40**	**100%**

9. Themes

Concerns raised are broken down into the following categories;

Theme	Total
A Patient and Service User Safety / Quality	1
B Management Issue	14
C System Process	10
D Bullying and Harassment	9
E Discrimination / Inequality	1
F Behavioural / Relationship	4
G Other (Describe)	0
H Worker Safety	1
Grand Total	**40**

10. Trends in Cases

The Guardian Service went live in QVH NHS Trust in May 2024 and between then and 31st May 2025 there have been a total of 40 cases. The peak months for cases raised were July 2024 and January 2025 with 6 cases each. This is an average of 3 cases per month and before the Guardian Service was introduced the number of cases reported by the internal FTSU Guardian to the National Guardian's Office was an average of 2 per quarter.

11. Assessment of Cases

There was one red concern regarding patient safety, in relation to missing patient referrals. This was escalated to the Chief Medical Officer for investigation and the Trust responded in line with the agreed RAG timescales to the Guardian Service, with the concern being dealt with at the service level.

The majority of cases raised to the Freedom to Speak Up Guardian come under the following themes:

Management issue

This theme accounted for 35% of cases raised and some examples of this are:

- Managers making decisions and not explaining these or communicating to the team
- Staff members feeling unsupported by their manager
- Managers favouring staff members in relation to promotion and extra shifts
- Managers not following Trust values or behaviour framework

System and Process

This area was the second highest, accounting for 25% and some examples of this are:

- Unfair allocation of shifts, including bank and overtime
- Not feeling supported whilst on long term sick and on return to work
- Recruitment process not being followed correctly
- Allocation of senior positions within the Trust

Bullying and Harassment

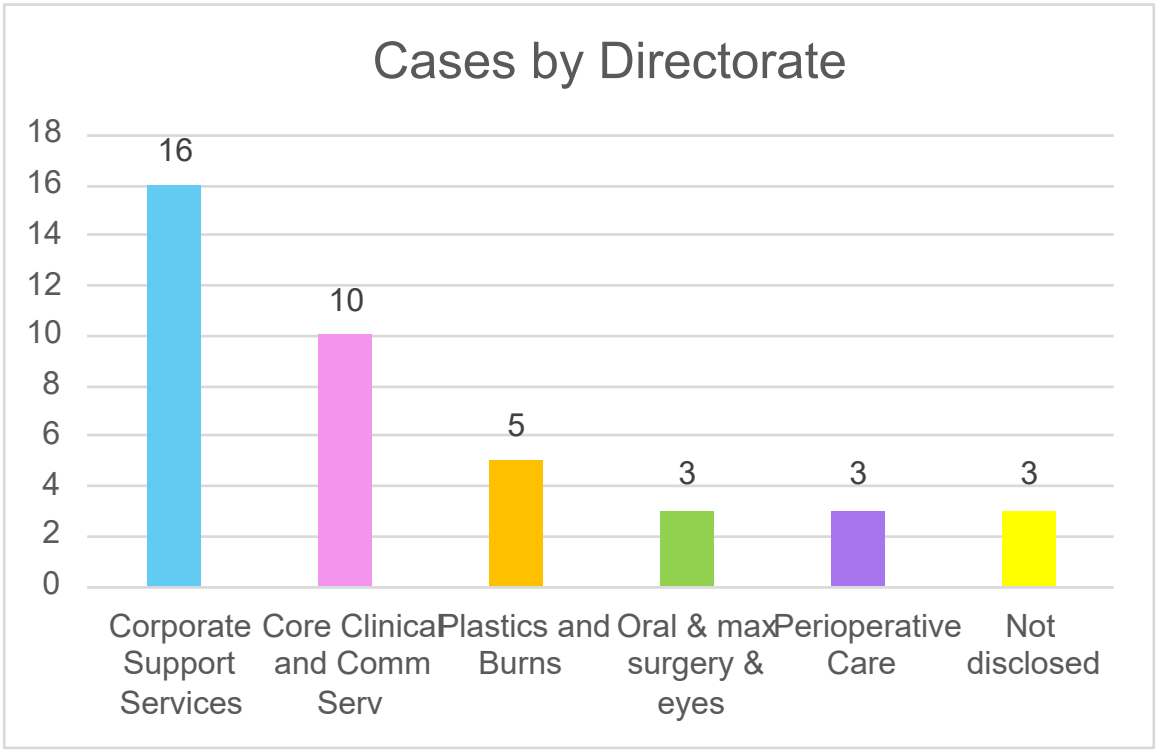
This area was responsible for 22.5% of concerns raised and some examples of this are:

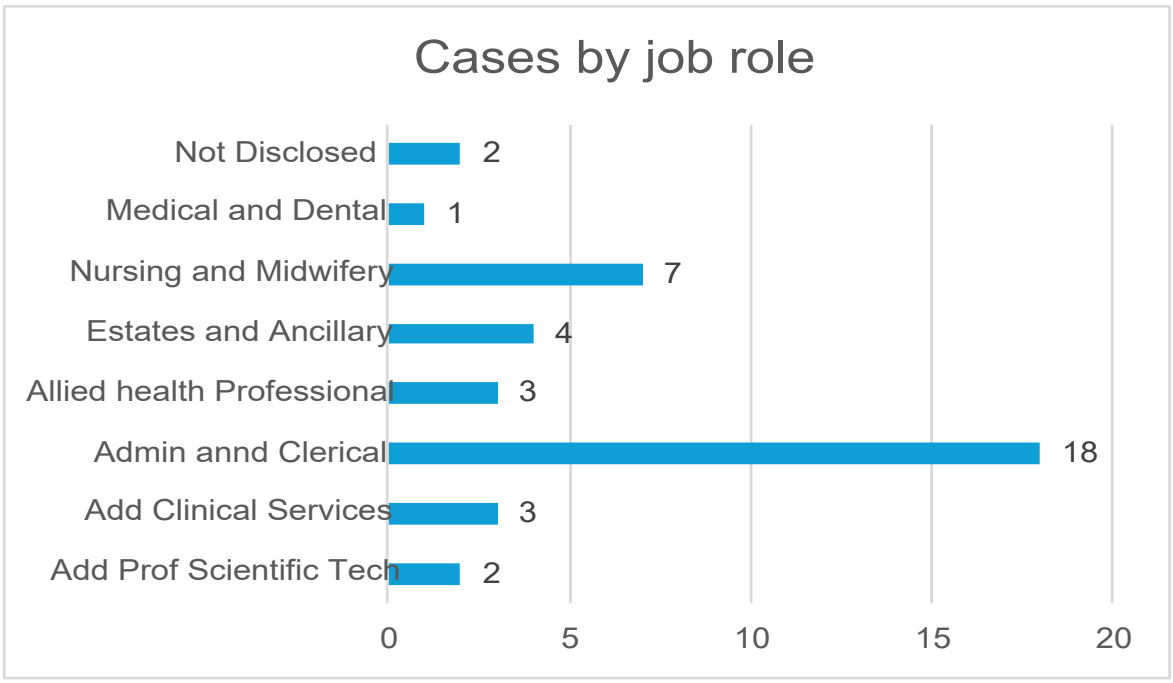
- Feeling bullied and isolated in the team
- Believing there is a bullying culture in the team
- Feeling bullied and belittled by senior staff members
- Believing they are being bullied and discriminated against in their department due to age and gender

Some examples of other concerns were:

- Feeling unsupported in the organisation.
- Concerned about how the Trust is changing and the impact that cost saving measures may have on staff and patient care.
- Perceived unacceptable and unprofessional behaviours being accepted from staff members

12. Statistical Graphs





13. Why do staff use The Guardian Service?

Staff who use the Guardian Service are routinely asked why they chose this option to raise their concern, and the answers are shown in the table below:

Reason for using Guardian Service	Number	Percentage
Impartial Support	19	48%
Have raised concern before but not been listened to	9	22%
Believe they will not be listened to	1	2%
Fear of reprisal	11	28%
Other	0	0%

14. Detriment

There has been no reported detriment in this period. The Guardian Service encourages staff to speak up whilst maintaining that they will not suffer any detriment. The FTSU Guardian spends a great deal of time with staff members creating a psychologically safe space for them to be able to share their experiences openly, reassuring them that if they do feel they have suffered detriment they must report this to the FTSU Guardian immediately. This is part of the process and gives staff confidence they will continue to be supported. Detriment is a major concern that is associated with speaking up and has a huge influence on FTSU culture.

15. Action taken to improve the Freedom to Speak Up Culture

- Regular promotions from FTSUG including drop-in sessions, walkarounds, staff handovers, team meetings, regular attendance at Corporate Trust inductions.
- Monthly meeting with Execurive Director to discuss activity report which includes themes and outcomes of cases-no identifying details are shared, therefore maintaining staff members' confidentiality.
- Quarterly meeting held with Non-Executive Director to discuss activity, and any emerging themes and support required.
- Monthly meetings being held with the Chief Executive Officer to share any themes or concerns, particularly while Trust is undergoing restructuring due to cost savings.
- Regular attendance on Team Talk by FTSUG to promote the service

16. Learning and Improvements

Staff chose to speak up to the Guardian because they want impartial support, they have raised a concern before and not been listened to, or they were afraid of reprisal. Confidence in Speaking Up can be raised through promoting positive experiences and outcomes of speaking up through all available channels.

There have been cases where staff members have not wanted issues escalating after speaking to the Guardian. Reasons for this are more complex than they initially appear as each person has a different reason for speaking to the Guardian. Conversations with some staff members indicate that the Trust could engage with staff to try and understand why employees feel they cannot escalate an issue internally and what the organisation can do to remove these barriers.

17. Comments & Recommendations

There appears to be a fear of Speaking Up in a number of the cases bought to the Guardian Service and this is reflected in the fact that only in 18% of cases has the staff member agreed to escalation with their name. To support a Freedom to Speak Up culture in QVH, leaders at every level need to role-model the speaking up principles. This will help workers to feel safe, valued and confident to speak up and workers are likely to emulate the values and behaviours they see in their senior colleagues.

Continued high visibility and approachability of the Executive Team in all areas of the Trust will encourage staff to feel comfortable to Speak Up to senior leaders.

All managers and leaders to encourage staff to speak up however they feel most comfortable, and consider aftercare, including regular check-ins with staff following the outcomes of both formal and informal processes.

Consideration to be given to training for managers regarding Speaking Up. Listen Up training is available for mangers as e-learning from NHS England.

Staff to be made aware the Guardian Service offers a 24-hours a day, 365 days a year service to ensure all staff have the option to contact a Guardian at a time that suits them.

Report cover-page					
References					
Meeting title:	Board of Directors				
Meeting date:	10/07/2025	**Agenda reference:**	**41-25**		
Report title:	Standing orders (SOs), Scheme of delegation & reservation of powers (SoD RoP) and Standing financial instructions (SFIs)				
Sponsor:	Leonora May, Company secretary Simon Marshall, interim Chief finance officer				
Author:	Leonora May, Company secretary Simon Marshall, interim Chief finance officer Jonathan Wharton, deputy Chief finance officer Charles Kirabo, Head of procurement				
Appendices:	Appendix one- Standing orders Appendix two- Scheme of delegation and reservation of powers Appendix three- Standing financial instructions				
Executive summary					
Purpose of report:	To present the revised governing documents to the Board for approval.				

Summary of key issues	• Minimal amendments have been made to the Standing orders
	• The SoD RoP has been reformatted to support accessibility for staff
	• The limits for approvals of business cases and service developments have been updated to:
	  ○ Up to £250k Chief finance officer (as previously
	  ○ £250k-£500k Chief finance officer and Chief executive officer (previously up to £1m)
	  ○ £500k-£1m Executive leadership team (previously Chief finance officer and Chief executive officer)
	  ○ £1m-£2m Finance and performance committee (previously Trust Board)
	  ○ Over £2m Trust Board (increased from £1m)
	• The limits for quotes, tenders and selection of suppliers have been updated to:
	  ○ Up to £20k one written quote (previously £10k)
	  ○ £20k-£75k three written quotes (previously £10k-£50k)
	  ○ £75k and above competitive tender exercise (previously £50k and above)
	• The Audit and risk committee reviewed the documents at its meeting in June 2025 and agreed to recommend them to the Board for approval				

Recommendation:	The Board is asked to approve the revisions to the SOs, SoD RoP and SFIs.				
Action required	**Approval**	Information	Discussion	Assurance	Review
Link to key strategic objectives (KSOs):	**KSO1:** ***To deliver outstanding care***	**KSO2:** ***To innovate and improve***	**KSO3:** ***To be an excellent employer***	**KSO4:** ***To deliver sustainable services***	**KSO5:** ***To collaborate with others***
Implications					
Board assurance framework:	BAF5- compliance				
Organisational risk register:	Organisational risk related to non-compliance with governing documents- this review is key action				

Regulation:	Constitution CQC well led			
Legal:	None			
Resources:	None			
Assurance route				
Previously considered by:	Audit and risk committee			
	Date:	June 2025	Decision:	Approved
Next steps:	Documents to take effect immediately			

Report to: Board Directors
Agenda item: 41-25
Date of meeting: 10 July 2025
Report from: Leonora May, Company secretary, Simon Marshall, interim Chief finance officer

Report author: Leonora May, Company secretary, Simon Marshall, interim Chief finance officer, Jonathan Wharton, deputy Chief finance officer, Charles Kirabo, Head of procurement

Date of report: 3 July 2025
Appendices: Appendix one- Standing orders, Appendix two- Scheme of delegation and reservation of powers, Appendix three- Standing financial instructions

Standing orders (SOs), Scheme of delegation & reservation of powers (SoD RoP) and Standing financial instructions (SFIs)

Introduction

The Board are required to review the Trust's Governing documents (SOs, SoD RoP and SFIs) annually.

The SOs together with the RoP SoD and SFIs provide a framework for the functions of the Trust. The RoP SoD and SFIs have effect as if they were incorporated into the SOs.

A review of the documents has been undertaken by the Company secretary and Chief finance officer. Proposed amendments to the documents are summarised below. The full documents are included as appendices to this report.

The Audit and risk committee reviewed these documents at its meeting in June 2025 and agreed to recommend them to the Board for approval. Since review by the Audit and risk committee, references to 'NHS protect' have been updated to 'NHS Counter Fraud Authority (CFA)'.

Standing orders

Minimal amendments have been made to the Standing orders as below:

- Job titles have been updated (ie Medical director to Chief medical officer)

- Caldicott guardian responsibilities moved from the Chief nursing officer to the Chief medical officer as per executive responsibility
- Reference to Strategic development committee updated to Strategy and culture committee (subject to agreement by the Board in July 2025)

Scheme of delegation and reservation of powers
The SoD RoP has been reformatted to support accessibility for staff. As the document has been reformatted, the tracked change version is not included and the key proposed amendments are set out below:

- A contents has been added to support navigation of the document
- Definition and interpretations have been updated to ensure clarity
- A paragraph regarding non-compliance has been included and states that non-compliance with the document may result in disciplinary action and that details of non-compliance must be reported to the next formal Audit and risk committee meeting
- Extracts from sub-committee terms of reference have been removed and instead staff are referred to the current terms of reference for each sub-committee (to prevent duplication and inconsistency as the ToR are updated)
- Additional guidance regarding business cases incl. appropriate approval processes and escalation has been included
- The limits for approvals of business cases and service developments have been updated to:
    - Up to £250k Chief finance officer (as previously)
    - £250k-£500k Chief finance officer and Chief executive officer (previously up to £1m)
    - £500k-£1m Executive leadership team (previously Chief finance officer and Chief executive officer)
    - £1m-£2m Finance and performance committee (previously Trust Board)
    - Over £2m Trust Board (increased from £1m)
- The limits for quotes, tenders and selection of suppliers have been updated to:
    - Up to £20k one written quote (previously £10k)
    - £20k-£75k three written quotes (previously £10k-£50k)
    - £75k and above competitive tender exercise (previously £50k and above)

Standing financial instructions
Minimal amendments have been made to the Standing orders as below:

- Addition of definition of director in line with the definition in the RoP SoD
- WTO GPA references updated to UK procurement financial thresholds
- References to Audit committee updated to Audit and risk committee
- References to ‘he’ changed to ‘they’ in line with inclusion standards
- Guidance related to quotation limits, disposal limits and awarding of contracts referred to as in the SoD RoP to prevent duplication

Communication
Communication to staff will take place through team meetings and budget holder training. Communication to key teams such as estates and procurement will be targeted first. Staff will be briefed on individual responsibility during corporate induction and the governance handbook will be developed during Q2 of 2025/26- this will bring together key parts of the governing documents for staff with process charts.

Recommendation
The Board is asked to **approve** the revisions to the SOs, SoD RoP and SFIs.

Queen Victoria Hospital NHS Foundation Trust

Standing orders for the Board of Directors

Approved by the Board of Directors at its meeting on 10 July 2025

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Introduction

Statutory framework

Queen Victoria Hospital NHS Foundation Trust ("**the Foundation Trust**"), became a Public Benefit Corporation on 1 July 2004 following the approval by the Regulator. The Foundation Trust is governed by the National Health Service Act 2006 ("**the 2006 Act**"), the Constitution and the Licence granted by the Regulator ("**the Regulatory Framework**"). The functions of the Foundation Trust are conferred by the Regulatory Framework. The Regulatory Framework requires the Board of Directors to adopt Standing Orders for the Board of Directors for the regulation of its proceedings and business. The Foundation Trust must also adopt Standing Financial Instructions which set out various responsibilities of individuals.

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

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

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

1 Interpretations and definitions

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

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

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

1.4 In these SOs:

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

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

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

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

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

Chief Executive means the Chief Executive of the Foundation Trust;

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

Committee means a committee appointed by the Board of Directors;

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

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

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

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

Director means a member of the Board of Directors;

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

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

Foundation Trust means the Queen Victoria Hospital NHS Foundation Trust;

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

2 The Foundation Trust Board of Directors

Composition of the Board of Directors

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

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

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

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

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

Appointment and powers of the Deputy Chair

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

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

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

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

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

Appointment of a Senior Independent Director

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

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

3 Role of members of the Board of Directors

Corporate role of the Board of Directors

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

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

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

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

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

Chief Executive

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

Chief Finance Officer

3.7 The Chief Finance Officer shall be responsible for the provision of financial advice to the Foundation Trust and to members of the Board of Directors and for the supervision of financial control and accounting systems. The Chief Finance Officer shall be responsible along with the Chief Executive for ensuring the discharge of obligations under applicable financial directions and the regulator's guidance.

~~Medical director~~Chief Medical Officer

3.8 The ~~medical director~~chief medical officer shall be responsible for effective professional leadership and management of medical staff of the Foundation Trust and shall be the responsible officer for NHS medical revalidation and the Caldicott Guardian. The chief medical ~~director~~ officer shall provide advice to the Chief Executive and the Board of Directors on key strategic medical efficacy issues and matters relating to the medical workforce of the Foundation Trust.

Chief Nursing Officere

3.9 The Chief Nursing officere shall be responsible for effective professional leadership and management of nursing staff of the Foundation Trust ~~and is the Caldicott guardian~~. The

Chief Nursing officere shall provide advice to the Chief Executive and the Board of Directors on key strategic care quality issues and matters relating to the nursing workforce of the Foundation Trust.

Non-Executive Directors

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

Chair

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

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

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

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

Corporate role of the Council of Governors

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

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

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

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

4 Meetings of the Board of Directors

Calling meetings

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

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

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

Notice of meetings and the business to be transacted

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

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

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

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

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

Setting the agenda

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

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

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

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

Agenda and supporting papers

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

Petitions

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

Notice of motion

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

Withdrawal of motion or amendments

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

Motion to rescind a resolution

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

Emergency motions

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

Motions: procedure at and during a meeting

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

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

4.19.1 an amendment to the motion; or

4.19.2 the adjournment of the discussion or the meeting; or

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

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

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

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

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

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

Written motions

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

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

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

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

Chair of meeting

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

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

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

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

Chair's ruling

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

Quorum

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

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

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

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

Voting

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

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

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

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

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

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

Suspension of Standing Orders

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

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

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

4.42 The audit and risk committee shall review every decision to suspend Standing Orders.

Variation and amendment of Standing Orders

4.43 These Standing Orders may be amended only if:

1. a notice of motion under Standing Orders 4.14 has been given;

2. upon a recommendation of the Chair or Chief Executive included on the agenda for the meeting of the Board of Directors;

3. at least two-thirds of the member of the Board of Directors are present at the meeting where the variation is being discussed;

4. at least half of the Non-Executive Directors vote in favour of the amendment; and

5. the variation proposed does not contravene a statutory provision, direction or guidance or best practice advice issued by the Regulator, or the terms of the Foundation Trust's Constitution.

Minutes

4.44 The names of the Chair and members of the Board of Directors present shall be recorded in the minutes of the meeting.

4.45 The minutes of the proceedings of a meeting of the Board of Directors will be drawn up by the Secretary and submitted for agreement at the next ensuing meeting of the Board of Directors, to be signed by the person presiding at it.

4.46 No discussion will take place upon the minutes except upon their accuracy or where the Chair considers discussion appropriate. Any amendments to the minutes shall be agreed and recorded at the next meeting.

Admission of the public and the press

4.47 The public and representatives of the press shall be afforded facilities to attend all formal meetings of the Board of Directors but shall be required to withdraw upon the board resolving as follows:

"*That representatives of the press, and other members of the public, be excluded from the remainder of this meeting having regard to the confidential nature of the business to be transacted, publicity on which would be prejudicial to the public interest*".

4.48 The Chair or person presiding over the meeting of the Board of Directors will give such directions as he/she thinks fit with regard to the arrangements for meetings and accommodation of the public and representatives of the press such as to ensure that the Board of Directors' business can be conducted without interruption and disruption and, without prejudice to the power to exclude on grounds of the confidential nature of the business to be transacted, the public and representatives of the press will be required to withdraw upon the Board of Directors resolving as follows:

"*That in the interests of public order the meeting adjourn for (the period to be specified) to enable the Board of Directors to complete its business without the presence of the public or press".*

4.49 Matters to be dealt with by the Board of Directors following the exclusion of representatives of the press, and other members of the public, shall be confidential to the members of the Board of Directors, nominated officers, officers and/or others in attendance at the request of the Chair shall not reveal or disclose the content of papers or reports presented, or any discussion on these generally, which take place while the public and press are excluded, without the express permission of the Chair.

Use of equipment for recording or transmission of meetings

4.50 Nothing in these Standing Orders shall require the Board of Directors to allow members of the public or representatives of the press to record proceedings in any manner whatsoever, other than writing, or to make any oral report of proceedings as they take place, without the prior agreement of the Board of Directors.

Observers

4.51 The Board of Directors will decide what arrangements and terms and conditions it feels are appropriate to offer in extending an invitation to observers to attend and address any meetings of the Board of Directors and may change, alter or vary these terms and conditions as it deems fit.

5 Committees

5.1 Subject to the Regulatory Framework and such guidance issued by the Regulator, the Board of Directors may and, if directed by the Regulator shall, appoint Committees of the Trust, consisting wholly or partly of members of the Board of Directors of the Trust. The Board of Directors may only delegate its powers to such a Committee if that Committee consists entirely of Directors of the Trust.

5.2 A committee or joint committee appointed under this Standing Order 5 may, subject to the Regulatory Framework and such guidance and/or best practice advice as may be issued by the Regulator or the Board of Directors or other Health Service Bodies in question, appoint sub-committees consisting wholly or partly of members of the Committee (whether or not they are members of the Board of Directors); or wholly of persons who are not members of the Board of Directors subject to the same proviso as in this Standing Order 6.3 to 6.5 relating to membership of the Committee and delegation of powers.

5.3 The Standing Orders, as far as they are applicable, shall apply with appropriate alteration to meetings of any Committees or sub-committees established by the Board of Directors. In such a case the term "Chair" is to be read as a reference to the Chair of the Committee or sub-committee as the context permits, and the term "Director" is to be read as a reference to a member of the Committee also as the context permits. (There is no requirement to hold meetings of Committees or sub-committees established by the Foundation Trust in public.)

5.4 The Board of Directors shall approve the appointments to each of the Committees, which it has formally constituted. Where the Board of Directors determines and regulations permit that persons, who are neither Directors nor officers, shall be appointed to a Committee the terms of such appointment shall be determined by the Board of Directors as defined by the Regulatory Framework. The Board of Directors shall define the powers of such appointees and shall agree allowances, including reimbursement for loss of earnings, and/or expenses in accordance where appropriate with its Constitution. The Board of Directors may elect to change the committees, sub-committees and joint-committees of the Board of Directors, as necessary, without requirement to amend these Standing Orders.

5.5 The Board of Directors shall also determine the terms of reference of Committees and sub-committees and shall, if it requires to, receive and consider reports of such Committees

5.6 The Committees established by the Board of Directors are:

1. Audit and Risk Committee (also in accordance with paragraph 47 of the Constitution)

2. Nomination and Remuneration Committee (also in accordance with paragraphs 37.3 and 37.4 of the Constitution)

5.7 In addition, the Board of Directors shall establish and maintain the following Committees:

1. Finance and Performance Committee

2. Quality and Safety Committee

3. Strategy and culture~~ic Development~~ Committee

5.8 The Board of Directors may also establish such Committees as it requires to discharge the Foundation Trust's responsibilities.

5.9 Terms of reference for Committees established by the Board of Directors will be reviewed annually, approved by the Board of Directors and published on the Foundation Trust's website.

Appointments for statutory functions

5.10 Where the Board of Directors is required to appoint persons to a Committee and/or to undertake statutory functions as required by the Regulator, and where such appointments are to operate independently of the Board of Directors, such appointment shall be made in accordance with the regulations and directions issued by the Regulator.

Joint committees[1]

5.11 Joint committees may be appointed by the Board of Directors, by joining together with one or more bodies consisting of, wholly or partly of the Chair and Directors of the Foundation Trust or other bodies, or wholly of persons who are not Directors of the Trust or other bodies in question.

5.12 Any Committee or joint committee appointed under this Standing Order may, subject to such directions or guidance as may be issued by the Regulator or the Foundation Trust, appoint sub-committees consisting wholly or partly of members of the Committee(s) or joint committee(s) or wholly of other persons provided that the Foundation Trust is always represented by an Executive Director on such Committees, joint committees or sub-committees.

Terms of reference

5.13 Each such Committee and sub-committee shall have such terms of reference and powers and be subject to such conditions (as to reporting to the Board of Directors) as the Board of Directors shall decide and shall be in accordance with any legislation and/or guidance and/or best practice issued by the Regulator. Such terms of reference shall have effect as if incorporated in the Standing Orders. Where Committees are authorised to establish sub-committees they may not delegate executive powers to sub-committee unless expressly authorised by the Board of Directors.

Delegation of powers

5.14 Where committees are authorised to establish sub-committees they may not delegate executive powers to the sub-committee unless expressly authorised by the Board of Directors.

5.15 In the event of an urgent decision required by the Board of Directors or a sub-committee, such a decision can be considered by a Committee by email or other electronic correspondence. This is subject to the quorum of the Board of Directors or sub-committee endorsing the required decision.

Confidentiality

5.16 A member of a committee, sub-committee or joint committee shall not disclose a matter dealt with, by, or brought before, the committee without its permission until the Committee, sub-committee or joint committee (as appropriate) shall have reported to the Board of Directors or shall otherwise have concluded on that matter.

[1] Please note that all decisions of the joint committee will need to be ratified by the Board of Directors

5.17 A Director or a member of a committee, sub-committee or joint committee shall not disclose any matter reported to the Board of Directors or otherwise dealt with by the committee, sub-committee or joint committee, notwithstanding that the matter has been reported or action has been concluded, if the Board of Directors or committee, sub-committee or joint committee shall resolve that it is confidential.

6 Arrangements for the exercise of board functions by delegation

6.1 Subject to the Regulatory Framework and such guidance or best practice as may be issued by the Regulator, the Board of Directors may make arrangements for the exercise of any of its functions by a committee or sub-committee or by a Director or an officer of the Foundation Trust in each case subject to such restrictions and conditions as the Board of Directors considers appropriate.

Emergency powers

6.2 The powers which the Board of Directors has reserved to itself within these Standing Orders may in emergency be exercised by the Chief Executive and the Chair after having consulted at least two Non-Executive Directors. The exercise of such powers by the Chief Executive and Chair shall be reported to the next formal meeting of the Board of Directors in public session for formal ratification (unless for reasons of the nature of the information for example it is privileged, not disclosable or of commercial sensitivity when it will need to go to the confidential session). The Board of Directors may also instruct the Chair to take certain actions and report back to a subsequent meeting.

Delegation to Committees

6.3 The Board of Directors shall agree from time to time to the delegation of executive powers to be exercised by Committees, or sub-committees, or joint committees, which it has formally constituted in accordance with the Constitution. The Constitution and the terms of reference of these Committees, or sub-committees, or joint committees, and their specific executive powers shall be approved by the Board of Directors.

6.4 When the Board of Directors is not meeting as the Foundation Trust in public session it shall operate as a Committee and may only exercise such powers as may have been delegated to it by the Foundation Trust in public session.

Delegation to Officers

6.5 Those functions of the Foundation Trust which have not been retained as reserved by the Board of Directors or delegated to a Committee or sub-committee or joint committee shall be exercised on behalf of the Foundation Trust by the Chief Executive. The Chief Executive shall determine which functions they will perform personally and shall nominate officers to undertake the remaining functions for which they will still retain accountability to the Foundation Trust.

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

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

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

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

Duty to report non-compliance with Standing Order

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

7 Declaration of interests

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

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

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

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

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

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

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

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

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

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

Interests of officers in contracts

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

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

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

Fit and proper person test

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

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

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

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

Duty of candour

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

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

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

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

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

Canvassing of and recommendations by Directors in relation to appointments

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

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

Relatives of Directors or Officers

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

7.22 The Chair and every Director and officer of the Foundation Trust shall disclose to the Chief Executive any relationship between themself and a candidate of whose candidature that Director or officer is aware. It shall be the duty of the Chief Executive to report to the Board of Directors on any such disclosure made.

7.23 Prior to acceptance of any appointment, Executive Directors should disclose to the Chief Executive whether they are related to any other Director or holder of any office under the Foundation Trust.

7.24 On appointment, Directors should disclose to the Board of Directors whether they are related to any other Director or holder of any office under the Foundation Trust.

7.25 Where the relationship to a Director of the Foundation Trust is disclosed, Standing Orders in respect to the 'Disability of Chair and Directors in proceedings on account of pecuniary interest' shall apply.

8 Standards of business conduct policy

8.1 Directors and officers should comply with the Foundation Trust's standards of business conduct policy and relevant codes of conduct.

8.2 Members of the Board of Directors must also comply with the Foundation Trust's annual declarations by Directors process.

9 Overlap with other policy statements, procedures, regulations and standing financial instructions

Policy statements: general principles

9.1 The Board of Director, Committees, sub-committees and joint committees will from time to time agree and approve policy statements and procedures which will apply to all or specific groups of officers of the Foundation Trust. The decisions to approve such policies and procedures will be recorded in an appropriate meeting minutes and will be deemed where appropriate to be an integral part of the Foundation Trust's Standing Orders and Standing Financial Instructions.

Specific policy statements

9.2 These Standing Orders and the Standing Financial Instructions should be read in conjunction with the following policy statements:

1. Standards of business conduct policy
2. Disciplinary policy and procedure
3. Appeals policy and procedure
4. Raising concerns (whistleblowing) policy

all of which shall have effect as if incorporated in these Standing Orders.

Specific guidance

9.3 These Standing Orders and the Standing Financial Instructions must be read in conjunction with current legislation and guidance and any other relevant guidance issued by the Regulator.

10 Custody of seal and sealing of documents

Custody of seal

10.1 The Secretary shall keep the seal of the Foundation Trust in a secure place.

Sealing of Documents

10.2 Documents can only be sealed once they have been authorised by a resolution of the Board of Directors or of a committee thereof, or where the Board of Directors has delegated its powers.

10.3 Building, engineering, property or capital documents do not require authorisation by Board of Directors or a committee thereof, but before presenting for seal these documents do require the approval and signature of the Chief Finance Officer (or an officer nominated by them) and the authorisation and countersignature of the Chief Executive (or an officer nominated by them who shall not be within the originating directorate).

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

Register of sealing

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

11 Signature of documents

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

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

12 Miscellaneous

Standing Orders to be given to Directors and Officers

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

Documents having the standing of Standing Orders

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

Review of Standing Orders

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

Joint finance arrangements

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

NHS
Queen Victoria Hospital
NHS Foundation Trust

Queen Victoria Hospital NHS Foundation Trust

Reservation of Powers and Scheme of Delegation

Effective from 10 July 2025

Approved by the Board of Directors at its meeting on 10 July 2025

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Introduction

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.

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.

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 Officer. The scheme of delegation identifies those functions, which the Chief Executive Officer shall perform personally and those which are delegated to other Directors and Officers. All powers delegated by the Chief Executive Officer can be re-assumed by him/her should the need arise.

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 in line with the Standing orders.

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.

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 Officer.

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.

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.

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.

The Reservation of powers and scheme of delegation should be read in conjunction with the Trust's Standing Orders and Standing Financial Instructions.

Caution over the use of delegated powers
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
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
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.

In circumstances where the Chief Executive Officer 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 Officer in his/her absence.

Definition and interpretations
Words importing the singular shall import the plural and vice-versa in each case. In this document:

> **Budget manager** means a member of staff 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 Officer** means that, as Accounting Officer, the Chief Executive Officer is accountable for the funds entrusted to the Trust. The Chief Executive Officer 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 Officer should also ensure that he/she complies with the NHS foundation trust accounting officer memorandum.
>
> **Director** means a formally appointed voting or non-voting director of the Trust Board and unless otherwise specified does not include other personnel who carry the word 'Director' or 'Chief' as part of their title.
>
> **Executive leadership team** means the formally appointed voting and non-voting executive directors of the Trust Board and the clinical directors meeting as the executive leadership team.
>
> **Level 2 manager** means staff in the following posts, in relation to their own area of the Trust only:
> - General managers
> - Heads of Nursing
> - Deputies to members of the executive leadership team
> - Heads of functions directly reporting to members of the executive leadership team

Unless specified otherwise, all amounts set out in this document exclude Value Added Tax (VAT).

Non-compliance

Failure to comply with the Trust's Reservation of powers and Scheme of delegations may result in disciplinary action in accordance with the relevant disciplinary policy and procedure at that time.

If for any reason the reservation of powers or delegations detailed in this document are not complied with, including the exercise of powers without proper authority, full details of the non-compliance and any justification for non-compliance shall be reported to the next formal meeting of the Audit & Risk committee for determining or ratifying action.

Notwithstanding the above, all members of the Board and all employees must report any instance of non-compliance to the Chief Financial Officer, Chief Executive Officer or Company Secretary immediately when they become aware of it.

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

Reservation of Powers to the Board of Directors

The matters below are reserved to the Board for decision making and will not be delegated.

General enabling provision
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.
Regulation and control
• 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. • Approve a Scheme of Delegation of powers from the Board of Directors to Officers which has been prepared by the Chief Executive Officer under SO 6.5 (Delegation to Officers) of the SOs. • 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. • 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. • Approve arrangements for dealing with complaints. • Approve disciplinary procedure for Officers of the Trust. • 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 Officer who may delegate this function as appropriate. • Ratify any urgent or emergency decisions taken by the Chair and Chief Executive Officer in accordance with SO 3.4 (Emergency Powers) of the SOs. • Approve arrangements relating to the discharge of the Trust’s responsibilities as a corporate trustee for funds held on trust. • Approve arrangements relating to the discharge of the Trust's Responsibilities as a bailee for patients' property. • Approve proposals of the Nomination and Remuneration Committee regarding Board members and senior Officers and those of the Chief Executive Officer not covered by the Nomination and Remuneration Committee. • Discipline Executive Directors who are in breach of statutory requirements or the SOs.

- Subject to the provisions set out in the Standing Orders, the authorisation of the use of the Seal.
- Suspension of the Standing Orders.
- Amendment of the Constitution, in accordance with the Constitution (amendments are subject to approval from the Council of Governors).
- Approval and authorisation of institutions in which cash surpluses may be held.

Committees

- Appoint and dismiss committees of the Trust that are directly responsible to the Board of Directors.
- Establish terms of reference and reporting arrangements for all committees of the Board.
- 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.
- 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.
- Confirm the recommendations of the Trust's committees where the committees do have executive powers.

Strategy, business plans and budgets

- Define the strategic aims and objectives of the Trust.
- Approve the Trust's forward plan and budget in respect of each financial year setting out the application of available financial resources.
- Approve and monitor the Trust’s policies and procedures for the management of risk. Approve key strategic risks.
- 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.
- 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.
- Approve proposals for ensuring equality and diversity in both employment and the delivery of services.
- Approve the Trust’s investment policy and authorise institutions with which cash surpluses may be held.
- Approve the Trust’s borrowing policy, which will include other long term financing arrangements such as leases.

- Authorise any necessary variations to total budget spend of capital schemes of more than 10% or £50,000, whichever is the greater. Authorise any increase in the total capital programme excluding increases resulting from additional Public Dividend Capital (PDC) allocations to the Trust.

- Approve the Trust's banking arrangements.

- Approve the Trust's Annual Business Plan.

- 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 in line with the Trust's Constitution.

- Consider a significant transaction as defined in the Constitution in line with the Constitution.

Monitoring

- 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.

- Consider and approve the Trust's Annual Report and Annual Accounts, prior to submission to the Council of Governors and the Regulator.

- Receive and approve the Annual Report and Accounts for funds held on trust.

- Receive reports from the Chief Finance Officer on financial performance against budget and the annual business plan.

- All monitoring returns required by the Department of Health and the Charity Commission shall be reported, at least in summary, to the Board.

Audit arrangements

- Receive reports of Audit and Risk Committee meetings and take appropriate action.

- Receive the annual management letter from the external auditor and agree action on the recommendations where appropriate of the Audit and Risk Committee.

- 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).

Committee Delegation

The Board of Directors may determine that certain powers shall be exercised by committees of the Board of Directors and these shall be set out within the committee terms of reference. The composition and terms of reference of such committees shall be determined by the Board of Directors taking into account the reservation of powers as agreed by the Board and 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 Standing Orders, 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
- People Committee
- Strategic development Committee

A list of committees, along with their terms of reference, shall be maintained by the Company Secretary and are available on the Trust's website: https://www.qvh.nhs.uk/about-us/board-of-directors/

Board Member Responsibilities

Chief Executive Officer
Accounting Officer to Parliament for stewardship of Trust resources including ensuring the propriety and regularity of the public finances for which they are responsible, the keeping of proper accounts, prudent and economical administration in line with the principles set out in the governments 'managing public money' publication, the avoidance of waste and extravagance and the efficient and effective use of all the resources in their charge Sign the accounts on behalf of the Board of Directors. Ensure effective internal controls that safeguard public funds and assist the Chair to implement requirements of corporate governance including ensuring managers: • Have a clear view of their objectives and the means to assess achievements in relation to those objectives • Be assigned well defined responsibilities for making best use of resources • Have the information, training and access to the expert advice they need to exercise their responsibilities effectively.
Chief Executive Officer and Chief Finance Officer
Ensure the accounts of the Trust are prepared under principles and in a format directed by the regulator. Accounts must disclose a true and fair view of the Trust's income and expenditure and its state of affairs.
Chair
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. Ensuring the provision of accurate, timely and clear information to the Directors and the Council of Governors. Ensuring effective communication with Officers, patients and the public. Arranging the regular evaluation of the performance of the Board of Directors, its Committees and individual Directors. Facilitating the effective contribution of Non-Executive Directors and ensuring constructive relations between Executive and Non-Executive Directors.
Board of Directors
Meet regularly and to retain full and effective control over the Trust Collective responsibility for adding value to the Trust, for promoting the success of the Trust by directing and supervising the Trust's affairs Provide active leadership of the Trust within a framework of prudent and effective controls which enable risk to be assessed and managed

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

Set the Trust's values and standards and ensure that its obligations to patients, the local community and the Regulator are understood and met.

All members of the Board of Directors

Share corporate responsibility for all decisions of the voting members of the Board of Directors.

Non-executive Directors

To bring independent judgement to bear on issues of strategy, performance, key appointments and accountability by:

- Constructively challenge and contribute to the development of strategy
- Scrutinise the performance of management in meeting agreed goals and objectives and monitor the reporting of performance
- Satisfy themselves that financial information is accurate and that financial controls and systems of risk management are robust and defensible
- Determine appropriate levels of remuneration of executive directors and have prime role in appointing and where necessary , removing senior management and in succession planning
- 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.

Sitting on Committees of the Board of Directors.

Financial Limit Delegations

Approval of business case and service developments
Applies to all business cases and service developments. Does not include setting of pay and non-pay budgets as part of annual planning process.

A business case is a document that provides the rationale for why the Trust should agree to fund a particular project.

This delegation has application when a business case requesting funding is required to be prepared and approved. Note: delegations relating to procurement or the signing of a contract are outlined separately *(see section on signature of legally binding contracts)*.

A business case is required in the following situations:

- When funding is requested in excess of allocated budget OR
- A significant change to the model of service delivery or model of care is proposed OR
- An increase to the workforce establishment is proposed.

The Business Case Review Group is required to scrutinise all business cases requesting new budget from the contingency prior to the case going to the Trust's Executive Leadership Team and the Capital Investment Group (where relevant) for endorsement, and then the Finance and performance committee of the Trust Board or Trust Board (dependent on the financial value) for final approval.

Determining the appropriate approval process
The appropriate approval process for a business case is determined by the value of the business case. The following principles should be applied to calculate the value of the business case:

- For non-pay or capital expenditure business cases, the value of the business case should be calculated on the basis of the total cost over 5 years
- For pay expenditure business cases, the value of the business case should be calculated based on the annual cost, and
- For business cases combining non-pay, capital and pay expenditure, the value of the business case should be calculated on the basis of the total cost over 5 years.
- New revenue budgets can only be funded from the Trust reserves or within existing revenue budgets; additional capital budgets can only be funded from within the approved capital plan or from an additional allocation of PDC to the Trust

Escalating the business case approval process
There will be situations where a business case is relatively low value but of strategic importance to the Trust. Accordingly, any Executive Director has the right to override these delegations to escalate approval up the approval process. Example situations include:

- Politically or commercially sensitive, novel or contentious
- Outsourcing of a service with implications on staffing
- Deemed of strategic importance and intrinsically linked to the Trust's strategic direction and priorities, or
- Where the Directorate is not meeting its budget control total.

An Executive Director cannot override these delegations to de-escalate approval down the approval process.

Revenue expenditure (5 year value)	
Up to £250,000	Chief Finance Officer
£250,001 to £500,000	Chief Finance Officer AND Chief Executive Officer
£500,001 to £1,000,000	Executive Leadership Team
£1,000,001 to £2,000,000	Finance & Performance committee
Over £2,000,001	Board of Directors
Capital expenditure and disposals	
Up to £250,000	Chief Finance Officer
£250,001 to £500,000	Chief Finance Officer AND Chief Executive Officer
£500,001 to £1,000,000	Executive Leadership Team
£1.000,001 to £2,000,000	Finance & Performance committee
Over £2,000,001	Board of Directors
Virements (reallocation of budgets)	
Within a Business Unit/Directorate	Level 2 Managers responsible for cost centres
Between Business Units/Directorates	Directors responsible for the relevant cost centres
Trust wide virements (e.g. Pay award adjustments)	Chief Finance Officer AND Chief Executive Officer

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.

All thresholds apply to the aggregate value of orders, which may be across different areas of the Trust. All staff 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.

UK procurement financial thresholds are limits set that define which specific procurement rules apply during a procurement episode. As these thresholds regularly change and the Public Procurement Regulations are periodically updated, all staff 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.

Capital/revenue expenditure	Minimum requirements
Up to £20,000	1 Written quote (Authorised by Budget Manager)
£20,001 to £75,000	3 Written quotes (Authorised by Budget Manager)
£75,001 to UK procurement financial Threshold (contact procurement department for current value)	Competitive Tender Exercise (Level 2 Manager AND Chief Finance Officer)
Over UK procurement financial threshold (see note above – threshold is different for works and non-works)	UK procurement financial threshold (Relevant Director AND Chief Finance Officer)
Quotation and tenders process waivers	
Waiving of tender and quotation for items where estimates expenditure is less than £30,000 but greater than £20,000 (less than £20,000 requires only 1 quote)	Deputy Chief Finance Officer
Waiving of tender and quotation for items where estimated expenditure is less than £250,000 but greater than £30,000	Chief Finance Officer, or Chief Executive Officer (when Chief Finance Officer has commissioned the item or where there is a conflict)
Waiving of tender and quotation for items where estimated expenditure is less than £1,000,000 but greater than £250,000.	Chief Executive Officer AND Chief Finance Officer
Waiving of tender and quotation for items where estimated expenditure is greater than £1,000,000	Board of Directors
Opening tenders	
Electronic tenders received through on line e-Tendering tool.	Head of Procurement or Deputy Chief Finance Officer / Chief Finance Officer (in absence of Head of Procurement)
Committing expenditure	
Revenue and non-capital works expenditure and invoice requests within approved financial plans or business plans	
Up to £20,000	Budget Holder
Up to £50,000	Level 2 Manager
Up to £100,000	Director
Up to £250,000	Chief Finance Officer OR Chief Operating Officer
Up to £500,000	Chief Finance Officer AND Chief Operating Officer
Over £500,000	Chief Finance Officer AND Chief Executive Officer

Approval of Capital invoices Where a significant contract is approved by the Trust Board, the Chief Finance Officer will have the delegation to raise and approve any purchase orders required related to the approved contract. Evidence of Board approval must be provided with the requisition.	
Up to £20,000	Capital Scheme Budget Manager
Up to £50,000	Level 2 Manager
Up to £100,000	Director
Up to £250,000	Chief Finance Officer OR Chief Operating Officer
Up to £1,000,000	Chief Finance Officer AND Chief Operating Officer
Over £1,000,001	Chief Finance Officer AND Chief Executive Officer
Granting and termination of equipment leases and credit finance	
Trust's employee lease car scheme	Chief Finance Officer
Leases/arrangements up to £250,000	Chief Finance Officer
Leases/ arrangements £250,001 to £1,000,000	Chief Finance Officer AND Chief Executive Officer
Leases / arrangements £1,000,001-£2,000,000	Finance & Performance committee
Leases / arrangements over £2,000,001	Board of Directors
Agreements and licences Letting or licencing of premises to or from other organisations (see also section below on signature of legally binding contracts for guidance on who can sign these agreements)	
Up to £250,000	Chief Finance Officer
£250,000 to £1,000,000 and signing of Landlord and Tenant Act notices relating to the acquisition or granting of leases	Chief Finance Officer AND Chief Executive Officer
£1,000,001 to £2,000,000	Finance & Performance committee
Over £2,000,001	Board of Directors
Condemning and disposal Items obsolete, obsolescent, redundant, irreparable or unable to be repaired cost effectively	
Up to £5,000 (carrying value)	Director or Deputy Chief Finance Officer
Over £5,000 (carrying value)	Chief Finance Officer (may be delegated in specific cases in writing, but no lower than to a level 2 manager)
Transfer or sale of assets to another organisation	Chief Finance Officer

Losses, write-offs and compensation Note: 'novel, contentious or repercussive cases' should be deferred to the Department of Health for approval	
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	Deputy Chief Finance Officer
Up to £50,000	Chief Finance Officer
Over £50,001	Audit & Risk committee
Fruitless Payments (including abandoned capital schemes)	
Up to £10,000	Deputy Chief Finance Officer
Up to £50,000	Chief Finance Officer
Over £50,001	Audit & Risk committee
Ex-Gratia payments to patients and Officers for loss of personal effects. Police report required for losses over £100.	
Up to £10,000	Deputy Chief Finance Officer
Up to £50,000	Chief Finance Officer
Over £50,001	Approval noted by Audit & Risk committee
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	Chief Finance Officer
£50,001 to £100,000	Chief Executive Officer AND Chief Finance Officer
Over £100,000	Audit & Risk Committee
Reimbursement of patients monies	
Chief Finance Officer or Chief Operating Officer	
Removal expenses, excess rent and house purchase expenses	
Chief People Officer	
Contractual and non-contractual severance payments and all non-contractual payments, excluding Directors.	
Up to £20,000	Chief People Officer
Over £20,000	Chief Finance Officer AND Chief Executive Officer

Expenditure from charitable funds	
Up to £2,000	Director or Trust Charity Lead
Up to £30,000	QVH Charity Committee
Over £30,000	Corporate Trustee
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.	
Signature to approve invoices or otherwise commit expenditure (e.g. engagement letter), without any further legally binding obligations.	See 'Committing Expenditure' above
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).	To be signed in line with the Trust's Standing Orders
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 and facilities
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 £100,000	Director
Up to £250,000	Chief Finance Officer
Over £250,001	Chief Finance Officer AND Chief Executive Officer

Setting of fees, charges and income	
Private patient, overseas visitors, income generation and other patient related services	Associate Director Business Development
Price of NHS contracts	
Setting fees and charges for contracts up to £50,000 per annum	Director
Setting fees and charges for contracts over £50,000 per annum	Chief Finance Officer
Authorisation of income credit notes	
Up to £20,000	Budget holders
Up to £50,000	Level 2 managers, Financial Services Manager and Associate Director Business Development
Up to £100,000	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
Department of Health Interim Revenue Support Where the Trust is trading at a deficit and there is 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.	
£0 - £1,000,000	Chief Finance Officer
£1000,001 - £2,000,000	Chief Finance Officer AND Chief Executive Officer
Above £2,000,000	Board of Directors
Approval to align with NHSE guidance if that differs from the above approval limits.	

Scheme of Delegation of Powers from Standing Orders

Duties delegated	SO ref
Chair	
Final authority on the interpretation of the SOs.	1.2
Responsible for the operation of the Board of Directors.	3.11
Chair all meetings of the Board of Directors and associated responsibilities.	3.11
Call meetings of the Board of Directors.	4.2
Sign notices of meetings of the Board of Directors.	4.4
Give final ruling to permit late requests for items to be included on the agenda for meetings of the Board of Directors.	4.11
Chair all meetings of the Board of Directors.	4.25
Give final ruling in questions of order, relevancy and regularity of meetings.	4.28
Have a second or casting vote.	4.33
Sign minutes of the proceedings of meetings of the Board of Directors.	4.45
Issue directions regarding arrangements for meetings of the Board of Directors and accommodation of the public and press.	4.48
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.	3.6
The Chief Executive shall prepare a Scheme of Delegation identifying his/her proposals which shall be considered and approved by the Board of Directors	6.6
Ensure that existing Directors and Officers and all new appointees are notified of and understand their responsibilities within the SOs and SFIs.	12.1
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 Officer and the Chair after having consulted at least two Non-Executive Directors. The exercise of such powers by the Chief Executive Officer and Chair shall be reported to the next formal meeting of the Board of Directors in public session for formal ratification.	6.2
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.	3.7

Duties delegated	SO ref
Chief Finance Officer and Chief Executive Officer	
Approve and sign any building, engineering, property or capital document.	10.3
Secretary	
Advise the Chair on the interpretation of the SOs.	1.2
Include any petition received by the Trust on the agenda for the next meeting of the Board of Directors.	4.13
Prepare minutes of the proceedings of the meetings of the Board of Directors and submit minutes for agreement at the next meeting of the Board of Directors.	4.45
A register of interests shall be established and maintained.	7.6
Keep the Trust's Seal in a secure place.	10.1
Secretary / Chair	
Where a Director has any doubt about the relevance of an interest, this should be discussed with them.	7.4
Directors	
Duty not to solicit for any person any appointment under the Trust or recommend any person for such appointment, and disclose informal discussions outside appointment panels or committees to the panel or committee.	7.20
On appointment, disclose to the Board of Directors whether you are related to any other Director or holder of any officer under the Trust.	7.24
Executive Directors	
Prior to acceptance of any appointment, disclose to the Chief Executive Officer whether you are related to any other Director or holder of any officer under the Trust.	7.23
Chief Executive Officer / nominated Executive Director	
Approve and sign all documents which will be necessary in legal proceedings.	11.1
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.	11.2

Scheme of Delegation of Powers from Standing Financial Instructions

Responsibilities and delegation	SFI ref
Chair	
Final authority on interpretation of the SFIs.	1.2.1
Chief Executive Officer	
The Chief Executive Officer is the trust's accounting officer.	2.4.1
To ensure all existing officers and new appointees are notified of their responsibilities within the SFIs.	2.4.4
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.	2.4.6
Determine whether powers devolved under the SFIs and the scheme of delegation be taken back to a more senior level.	2.4.7
To ensure that the trust provides an annual forward plan to the regulator each year.	2.4.8
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.	2.4.5
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	2.5.1
Chief Executive Officer / Chief Finance Officer	
Advise the Chair on the interpretation of the SFIs.	1.2.1
Audit	**SFI ref**
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;	3.2.1

• 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.	
To ensure that external audit is providing a cost effective service that meets the prevailing requirements of the regulator and other regulatory bodies.	3.5.1
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.	3.2.3
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 and Counter Fraud Authority (CFA) requirements; • 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 CFA; and • Deciding at what stage to involve police in cases of misappropriation or other irregularities.	3.3.1
Responsible for the promotion of counter fraud measure within the trust and ensure that the trust co-operate with NHS CFA in relation to the prevention, detection and investigation of fraud in the NHS.	3.6.2
Ensure the trust's local counter fraud specialist receives appropriate training in connection with counter fraud measures.	3.6.4
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.	3.6.5
Prepare a 'fraud response plan' that sets out the action to be taken in connection with suspected fraud.	3.6.11
Inform police if theft or arson is involved.	3.6.12
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.	3.6.13
To establish procedures for the management of expense claims submitted by officers.	3.7.1
Chief Finance Officer / designated auditors	
Entitled to require and receiver without prior notice:	3.3.2

• 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.	
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.	3.4.2
To assess the process in place to ensure the assurance frameworks are in accordance with current guidance from the regulator.	3.4.3
To notify the Chief Finance Officer should any matter arise which involves, or is thought to involve, irregularities concerning cash, stores or other property.	3.4.4
Lead internal auditor	
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 Officer of the trust.	3.4.5
Chief Executive Officer and Chief Finance Officer	
Monitor and ensure compliance with guidance issued by the regulator or NHS CFA on fraud and corruption in the NHS.	3.6.1
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.	3.6.7
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.	3.8.1
To record in writing, notification of any gift, hospitality or sponsorship accepted (or refused) by officers on behalf of the trust.	3.8.2
Council of Governors	
Appoint external auditor to the trust.	3.5.1
Annual planning, budgets, budgetary control and monitoring	**SFI ref**
Chief Executive Officer	
Compile and submit to the board of directors and the regulator, strategic and operational plans.	4.1.1
Chief Finance Officer	
Prepare and submit the operational plan to the financial and performance committee, the Board of Directors and the regulator	4.1.2

Compile and submit financial estimates and forecasts for both revenue and capital to the Board of Directors	4.1.3
Ensure adequate training is delivered on an ongoing basis to enable the Chief Executive Officer and other Officers to carry out their budgetary responsibilities.	4.2.4
Finance and performance committee	
Submit budgets to the board of directors for approval.	4.2.1
All directors	
To meet their financial targets as agreed in the annual plan approved by the board of directors.	4.2.4
Annual accounts and reports	**SFI ref**
Chief Executive Officer	
Certify annual accounts.	5.2
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.	5.1
Prepare annual account. Submit annual accounts and any report of auditor on them to the regulator.	5.2
Bank accounts	**SFI ref**
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.	6.1–6.6
Financial systems and transaction processing	**SFI ref**
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.	7.1-7.8
Approve arrangements for making disbursements from cash received.	7.12
Contracts for provision of services to customers	**SFI ref**
Chief Finance Officer	
Negotiating contracts with commissioners for the provision of services to patients in accordance with the annual plan.	8.1
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.	8.4

Contracts, tenders and healthcare service agreements	SFI ref
Chief Executive Officer	
Ensure that best value for money can be demonstrated for all services provided under contract or in-house.	9.1.2
Nominate officers to commission service agreements with providers of healthcare.	9.12.2
Nominate an officer who shall oversee and manage each contract on behalf of the trust.	9.13.3
Ensure that best value for money can be demonstrated for all services provided on an in-house basis.	9.1.2
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.	9.1.3
Establish procedures to carry out financial appraisals and shall instruct the appropriate requisitioning officer to provide evidence of technical competence.	9.4.1
Enquiries concerning the financial standing and financial suitability of approved contractors.	9.7.1
Chief Executive Officer/ Chief Finance Officer	
Approval of awarding of contracts for which tendering is deemed not strictly competitive.	9.5.15
Where one tender is received will assess for value for money and fair price.	9.6.16
Terms of service, officer appointments and payments	**SFI ref**
Chief Executive Officer	
Present to the board of directors procedures for determination of commencing pay rates, conditions of service etc. for Officers.	10.2.3
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.	10.4.1
Issue detailed procedures covering payments to officers.	10.4.3
Chief Finance Officer and Chief People Officer	
Approve advances of pay.	10.5.1
Non-pay expenditure	**SFI ref**
Chief Executive Officer	
Determine the level of delegation to budget managers.	11.1.1

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.	11.1.2
Set out procedures on the seeking of professional advice regarding the supply of goods and services.	11.1.4
Chief Finance Officer	
Responsible for the prompt payment of accounts and claims.	11.2.3
• 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.	11.3.1
Approve proposed prepayment arrangements	11.5.1
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.	11.6.6
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.	11.1.3
Equity investments, external borrowing, public dividend capital and mergers and acquisitions	**SFI ref**
Chief Finance Officer	
Produce an investment policy in accordance with any guidance received from the regulator.	12.1.1
Prepare detailed procedural instructions on the operation of investment accounts and on the records to be maintained.	12.1.3
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.	12.2.1
Applications for a loan or overdraft.	12.2.2
Prepare detailed procedural instructions concerning applications for loans and overdrafts.	12.2.3

Approval of short terms borrowing requirements.	12.2.4
Capital investment and assets	**SFI ref**
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.	13.1.1-13.1.3
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.	13.2.1
Implement procedures to comply with guidance on valuation contained within the treasury's guidance.	13.2.2
Establish procedures covering the identification and recording of capital additions.	13.2.3
Develop procedures covering the physical verification of assets on a periodic basis.	13.2.4
Develop policies and procedures for the management and documentation of asset disposals.	13.2.5
Stores and receipts of goods	**SFI ref**
Chief Executive Officer	
Delegate overall responsibility for the control of stores.	14.1.1
Identify those officers authorised to requisition and accept goods from the NHS supply chain.	14.2.1
Chief Finance Officer	
Responsible for systems of control.	14.1.1
Set out procedures and systems to regulate the stores including records for receipt of goods, issues and returned to stores and losses.	14.1.5
Agreed stocktaking arrangements.	14.1.6
Approval of alternative arrangements where a complete system of stores control is not justified.	14.1.7
Pharmaceutical officer	
Responsible for the control of any pharmaceutical stocks.	14.1.3
Disposals and condemnations, losses and special payments	**SFI ref**
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.	15.1.1
Approve form to in which to record the condemning of unserviceable assets and provide a list of officers to countersign entries.	15.2.1
Prepare procedural instructions on the recording of and accounting for condemnations, losses and special payments.	15.3.1
Immediately inform the police if theft or arson is involved in a suspected criminal offence.	15.3.3
Inform the trust's local counter fraud specialist (LCFS) and NHS CFA in cases of fraud or corruption.	15.3.4
Notify the audit and risk committee, LCFS and the external auditors of all frauds.	15.3.5
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.	15.3.6
Take steps to safeguard the trust's interest in bankruptcies and company liquidations. Consider whether any insurance claim can be made for any losses incurred by the trust.	15.3.8
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.	15.3.9
Head of department	
Advise the Chief Finance Officer of the estimated market value of the item to be disposed of.	15.1.2
Condemning officers	
Report evidence of negligence in use of assets to the Chief Finance Officer.	15.2.3
Managers	
Report discovered or suspected losses of any kind to the Chief Executive Officer and Chief Finance Officer	15.3.2
Information technology	**SFI ref**
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	16.1

• Publish and maintain a freedom of information (FOI) publication scheme.	
Ensure that contracts for computer services for financial applications clearly define the responsibility of all parties and ensure rights of access for audit purposes.	16.2.1
Periodically seek assurances that adequate controls are in operation.	16.2.2
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.	16.3.1
• 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.	16.4.1
Patients' property	**SFI ref**
Chief Executive Officer	
Responsible for ensuring patients and guardians are informed about patients' money and property procedures on admission.	17.3
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.	17.4
Senior officers	
Inform officers, on appointment, their responsibilities and duties for the administration of the property of patients.	17.5
Retention of records	**SFI ref**
Chief Executive Officer	
Maintain archives for all documents required to be retained in accordance with the regulator and/or secretary of state guidelines.	18.1
Produce a records lifecycle policy, detailing the secure storage, retention periods and destruction of records to be retained.	18.2
Risk management and insurance	**SFI ref**
Chief Executive Officer	
Ensure that the trust has a programme of risk management which shall be approved and monitored by the board of directors.	19.1
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.	19.3
Chief Finance Officer	

Ensure that insurance arrangements exist in accordance with the trust's risk management policy.	19.4
Funds held on trust (charitable funds)	**SFI ref**
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.	20.5

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 ~~May~~ July~~ne~~ 202~~5~~4

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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 (or~~f~~ 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;

"Director" means a formally appointed voting or non-voting director of the Trust Board and unless otherwise specified does not include other personnel who carry the word 'Director' or 'Chief' as part of their title

"**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~~**UK procurement financial thresholds**" are limits set that define which specific procurement rules apply during a procurement episode~~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 and Risk Committee

3.2.1 In accordance with Standing Orders for the Board of Directors, the Board of Directors shall formally establish an Audit and Risk 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 and Risk Committee shall be considered as forming part of these SFIs.

3.2.3 Where the Audit and Risk Committee feel there is evidence of ultra vires transactions, evidence of improper acts, or if there are other important matters that the Audit and Risk Committee wish to raise, the Chair of the Audit and Risk 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 and Counter Fraud Authority (CFA) requirements;

(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 and Risk 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 and Risk 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 and Risk 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 and Risk Committee, who must ensure that external audit is providing a cost effective service that meets the prevailing requirements of the regulator and other regulatory bodies.

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

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

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

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

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

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

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

3.6 Fraud and corruption

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

3.6.2 The Chief Finance Officer is responsible for the promotion of counter fraud measures within the Trust and, in that capacity, theyhe 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~~they are 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~~ their functions effectively and efficiently and, in particular, that ~~he~~ they will be able to devote sufficient time to the Trust.

3.6.6 The local counter fraud specialist shall report directly to the Chief Finance Officer and 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 and Risk 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~~a Director.

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 and Risk 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 and Chief Finance Officer.

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 auditor report ~~of auditor~~ on them, to the regulator.

5.3 The Trust's annual accounts must be audited by an external 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 and submitted to parliament.

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 should be sought in line with the SoD. ~~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 £10,000~~	~~Best value, supported by 1 written quote~~
	~~£10,001 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 SoD~~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 but should be undertaken and approved in line with the SoD., ~~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 relevant ~~following~~ Officers as set out within the SoD.~~:~~

~~(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~~SoD value threshold for a competitive tender has not been met~~.~~;

(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 GP~~UK PROCUREMENT FINANCIAL THRESHOLDS 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~~UK PROCUREMENT FINANCIAL THRESHOLDS ~~limits. Waivers over these limits will only be signed once approval has been made by the Executive Management~~ Leadership Team and Audit Committee ~~following a submitted report by the stakeholder.~~ is subject to the thresholds set out in the SoDs.

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 Most Health care services fall~~s~~ within the Health Care Services (Provider Selection Regime) Regulations 2023. Healthcare services that do not fall within the scope of the PSR will continue to be regulated by ~~within~~ the 'Light Touch Regime' (LTR) of the Procurement Act 2023. ~~Procurement Regulations 2015.~~ Any tendering for

these services should be discussed with the Hhead of Pprocurement to identify the suitableility 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 dealt 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 the Trust's Constitution, Standing Orders and the Code of Governance for NHS provider trusts, 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~~deputy Chief Finance Officer, the Chief People Officer and/or the Deputy ~~Director of Workforce~~Chief People Officer.

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.

Report cover-page					
References					
Meeting title:	Board of Directors				
Meeting date:	10/07/2025		**Agenda reference:**	42-25	
Report title:	Strategy and culture committee				
Sponsor:	Leonora May, Company secretary				
Author:	Leonora May, Company secretary				
Appendices:	Appendix one- Draft terms of reference for Strategy and culture committee				
Executive summary					
Purpose of report:	To seek approval to establish a Strategy and culture committee in place of the People committee and Strategic development committee.				
Summary of key issues	It is proposed that there is one Board sub-committee focussed on key strategic priorities to ensure enhanced Board oversight and input into strategic partnership options and organisational culture. A pragmatic approach is proposed, combining key elements of both the People committee (culture) and the Strategic development committee into one committee focussed on key current challenges and priorities. The key functions of the committee are proposed to be: • Provide oversight and direction regarding the development of the Trust's strategic and sustainable future model • Provide oversight and direction regarding the delivery of the QVH strategy 2025-2030, clinical ambitions and key enablers in the national context. • Assist the Board in its oversight and delivery of people, culture and organisational development strategies which support the delivery of The QVH strategy 2025-2030 and ensure a sustainable future				
Recommendation:	The Board is asked to **approve** the establishment of the Strategy and culture committee in place of the People committee and Strategic development committee, including the terms of reference.				
Action required	**Approval**	Information	Discussion	Assurance	Review
Link to key strategic objectives (KSOs):	**KSO1:** ***To deliver outstanding care***	**KSO2:** ***To innovate and improve***	**KSO3:** ***To be an excellent employer***	**KSO4:** ***To deliver sustainable services***	**KSO5:** ***To collaborate with others***
Implications					
Board assurance framework:	Risks to key strategic objectives to be considered by the committee				
Organisational risk register:	Organisational risk regarding the delivery of the QVH Strategy 2025-2030. This committee will support oversight of that risk				
Regulation:	CQC well led				
Legal:	None				
Resources:	The combination of the committees is a pragmatic solution to support the best use of resources available				
Assurance route					
Previously considered by:	ELT				

	Date:	June 2025	Decision:	Approved
Next steps:	As set out within report			

Report to: Board Directors
Agenda item: 42-25
Date of meeting: 10 July 2025
Report from: Leonora May, Company secretary
Report author: Leonora May, Company secretary
Date of report: 27 June 2025
Appendices: Appendix one- Draft terms of reference for Strategy and culture committee

Strategy and culture committee

Introduction

This report seeks approval of the establishment of a Strategy and culture committee as a sub-committee of the Trust Board including its terms of reference.

Proposal

The national position and QVH's financial outlook means that the Trust must collaborate in order to support the delivery of the QVH Strategy 2025-2030 and continued provision of specialist services for patients. The Trust is exploring a range of partnership options to achieve this and it is proposed that there is one Board sub-committee focussed on key strategic priorities to ensure enhanced Board oversight and input into strategic partnership options and organisational culture.

A pragmatic approach is proposed, combining key elements of both the People committee (culture) and the Strategic development committee into one committee focussed on key current challenges and priorities.

The key functions of the committee are proposed to be:

- Provide oversight and direction regarding the development of the Trust's strategic and sustainable future model
- Provide oversight and direction regarding the delivery of the QVH strategy 2025-2030, clinical ambitions and key enablers in the national context.
- Assist the Board in its oversight and delivery of people, culture and organisational development strategies which support the delivery of The QVH strategy 2025-2030 and ensure a sustainable future

Governance

The committee will regularly report to the Board and provide assurance on all areas within the committee's remit. The committee will create Board bandwidth and support increased Non-executive input and oversight of sustainability, QVH Strategy and culture. There will also be a Governor working group aligned to the Board sub-committee.

It is proposed that the committee will meet monthly until a Board decision is made regarding strategic partnerships, and that the frequency will be reviewed thereafter.

The core membership will comprise of:

- Non-executive Chair (Russell Hobby)
- Two other Non-executive members
- Chief Executive Officer
- Chief Medical Officer
- Chief People Officer

The deputy Chief Strategy Officer and an Associate Non-executive director will attend the meetings. Other shall be invited to meetings in all or part as and when required for specific items.

Next steps

If there is agreement to establish the committee, then:

- The first meeting of the committee will be scheduled
- A work plan will be drafted based on current priorities and the terms of reference

Recommendation
The Board is asked to **approve** the establishment of the Strategy and culture committee in place of the People committee and Strategic development committee, including the terms of reference.

Terms of reference

Name of governance body

Strategy and Culture Committee

Constitution

The Strategy and Culture 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 oversight of organisational culture.

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 oversight and direction regarding the development of the Trust's strategic and sustainable future model
- Provide oversight and direction regarding the delivery of the QVH strategy 2025-2030, clinical ambitions and key enablers in the national context.
- Assist the Board in its oversight and delivery of people, culture and organisational development strategies which support the delivery of The QVH strategy 2025-2030 and ensure a sustainable future

To fulfil its purpose, the Committee will:

- Maintain oversight of the effective management of organisational risks appropriate to the committee's remit
- Identify the key strategic issues, risks and opportunities requiring discussion or decision by the Board of Directors
- Advise on appropriate mitigating actions

Duties and responsibilities

Duties

Sustainability

- Detailed oversight of the development of the Trust's strategic sustainable future model
- Inform proposals related to partnerships and strategic collaborations and making recommendations to the Board
- Influence proposals related to leadership and governance models and making recommendations to the Board
- Oversight of key strategic engagement activities related to organisational sustainability

- Oversight of how the organisation is embedding national priorities and direction in its strategic and sustainable future model

Strategy

- Oversight and direction of the QVH strategy 2025-2030 and provide assurance to the Board regarding its delivery
- Oversight and direction of the delivery of the Trust's strategic clinical ambitions
- Oversight and direction of the delivery of the Trust's key strategic enabling strategies - research & innovation and digital
- Monitor and provide assurance to the Board that the Trust's strategic direction is in alignment with national priorities and direction
- Oversight of key engagement related to organisational strategy
- Identify information needed by the Board for strategic decision making and ensure that the Board is sighted on key strategic risks, issues and opportunities

Culture

- Oversight of the development of the Trust's organisational culture and the delivery of people, culture and organisational development strategies
- Monitor and assure the Board on the development of an organisational culture which:
  - supports the delivery of a strategic sustainable future
  - is aligned with the Trust's values and behaviour framework
- Support the Board with its annual assessment of organisational culture

Risks and opportunities

- Maintain oversight of the effective management of organisational risks appropriate to the committee's remit

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

- Preparation of the draft agenda for agreement with the chair.
- Organisation of meeting arrangements, facilities and attendance.
- Collation and distribution of meeting papers.

- Taking the minutes of meetings and keeping a record of matters arising and issues to be carried forward.

Membership

Members

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

- Three non-executive directors (one of which will be Chair)
- Chief Executive Officer
- Chief Medical Officer
- Chief People Officer

Attendees

- The secretary to the committee
- Deputy Chief Strategy Officer
- Associate Non-executive director

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:

- Deputy Chief Executive Officer
- Chief Finance Officer
- Chief Nursing Officer
- Chief Operating Officer
- 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 Non-executive directors and one executive director 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 June 2026 in anticipation of approval by the Board of Directors at its meeting in July 2026.
***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:	10/07/2025	**Agenda reference:**	**43-25**		
Report title:	Organisational risk register				
Sponsor:	Executive risk owners				
Author:	Leonora May, Company secretary				
Appendices:	Appendix one- Organisational risk register				
Executive summary					
Purpose of report:	The Organisational risk register as at 3 July 2025 is presented to the Board for review.				
Summary of key issues	• Currently the highest scoring open risk is risk 148 (delivery of the cost improvement plan (CIP)) which has a current score of 20. Other high scoring risks (current score of 15) include risks related to dire dampers, heating and hot water, the Trust's boiler, electrical fire and the delivery of the QVH Strategy 2025-2030. • There is a new high scoring risk to be added to the organisational risk register. Risk 161 is in relation to the Trust's cash balance reducing to zero or falling below the level that the Trust aims to keep in reserve and has an initial score of 16 (see new risks below) • The current score for risk 16 (mental capacity act) has been reduced from a 16 to a 12 due to mitigating actions being put in place including the establishment of a task and finish group, appointments letters being updated as well as the forms and schedulers highlighting patients at risk				
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:** ***To deliver outstanding care***	**KSO2:** ***To innovate and improve***	**KSO3:** ***To be an excellent employer***	**KSO4:** ***To deliver sustainable services***	**KSO5:** ***To collaborate with others***
Implications					
Board assurance framework:	Organisational risks to be linked to the BAF BAF risks being updated				
Organisational risk register:	Appendix one				
Regulation:	CQC well led Risk management framework				
Legal:	None				
Resources:	None				
Assurance route					
Previously considered by:	ECQR, Quality and safety and Finance and performance committees				
	Date:	June/ July 2025	Decision:		
Next steps:	NA				

Report to:	Board of Directors
Agenda item:	43-25
Date of meeting:	10 July 2025
Report from:	Executive risk owners
Report author:	Leonora May, Company secretary
Date of report:	3 July 2025
Appendices:	Appendix one- Organisational risk register

Organisational risk register

Introduction and background

The organisational risk register as at 3 July 2025 is presented for information. The full register is included with this report as appendix one.

Organisational risks are either risks which score more than 15 or those that require organisational wide oversight due to organisation wide action required, significant spend on controls or where there is requirement to aggregate multiple local risks.

The Executive committee for quality and risk (ECQR) reviews the Organisational risk register monthly and approves risks for inclusion or removal from the Organisational risk register.

The relevant organisational risks have been reviewed by the Finance and performance committee and Quality and safety committee at recent meetings.

Risks

- Currently the highest scoring open risk is risk 148 (delivery of the cost improvement plan (CIP)) which has a current score of 20. Other high scoring risks (current score of 15) include risks related to dire dampers, heating and hot water, the Trust's boiler, electrical fire and the delivery of the QVH Strategy 2025-2030.
- There is a new high scoring risk to be added to the organisational risk register. Risk 161 is in relation to the Trust's cash balance reducing to zero or falling below the level that the Trust aims to keep in reserve and has an initial score of 16 (see new risks below)

<u>Changes to risk scores during the period</u>

- The current score for risk 73 (Emergency planning response and resilience (EPRR)) has reduced from a 12 to a 9 due to there not being an EPRR lead in post previously and resource discussions taking place to ensure that the Trust can implement the actions from the previous annual assurance review
- The current score for risk 16 (mental capacity act) has been reduced from a 16 to a 12 due to mitigating actions being put in place including the establishment of a task and finish group, appointments letters being updated as well as the forms and schedulers highlighting patients at risk
- The current score for risk 115 (breakeven position for 2024/25) has been reduced from a 12 to an 8 as the position remains breakeven with no

significant issues raised by the auditors. This risk will be closed as the audit work for 2024/25 has been completed
- The current score for risk 133 (recruitment to certain roles) has reduced from a 9 to a 6. Controls in place include apprenticeships and system networks for hard to recruit to roles

New risks added to the register during the period

- Risk 153 (spread of fire due to lack of fire compartmentalisation) has been added to the register during the period following review at the June ECQR meeting. Since review by the Finance and performance committee, the current score has been reduced from a 12 to a 15 due to the fact that we would be alerted to a fire at its early stage by the alarm system and appropriate action would be taken to mitigate it spreading
- Risk 147 (critical failure of Cone Beam CT equipment) was added to the register during the period. This risk was then closed as the new equipment has been installed, however it should be noted that this has had an impact on the waiting list

Risks closed during the period

- Risk 137 (the Trust may not be able to submit a breakeven plan for 2025/26) has been closed during the period due to the plan being submitted as a breakeven position
- Risk 147 (critical failure of CBCT equipment) was added to the register during the period. This risk was then closed as the new equipment has been installed, however it should be noted that this has had an impact on the waiting list

Heat map

Likelihood	*Consequence*				
	Negligible	**Minor**	**Moderate**	**Major**	**Catastrophic**
Almost certain					
Likely			**125** **16**	***161**	**148**
Possible			**73** **48**	**14** **47** **144** **149** **17** **38** **117** **121** **88** **153**	**49** **53** **54** **132** **139**
Unlikely			**77** **133**	**11** **115**	**138**
Rare					

*new risks to be added to the organisational risk register

New risks to be added to the organisational risk register

The following risks will be presented for approval to go onto the organisational risk register at the next Executive committee for quality and risk meeting and if approved will be included in the register submitted to the next meeting:

Risk ID	Risk Stage	Risk Description - Cause	Risk Description - Risk	Risk Description - Effect	Risk Register Type	Initial Consequence	Initial Likelihood	Initial Rating
Risk 00000161	Approval	Due to overspending, shortfall of CIPs, late collection of income and un-forecast cash requirements.	There is a risk that the Trust cash balance will reduce to zero or fall to a level lower than the Trust aims to keep in reserve (£1m)	Which may result in delays/difficulties in paying suppliers or capital.	Organisational	4	4	16

Recommendation

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

Risk Register ORGANISATIONAL

Queen Victoria Hospital
NHS Foundation Trust

Risk ID	Risk Stage	Risk Description - Cause	Risk Description - Risk	Risk Description - Effect	Risk Register Type	Initial Consequence	Initial Likelihood	Initial Rating	Current Consequence	Current Likelihood	Current Rating	Target Consequence	Target Likelihood	Target Rating	Target Date	Owner	Handler	Child Controls	Actions	Actions completed	Actions Outstanding	Latest Update Comments	Risk type	Risk Substype
Risk 00000011	Open	Due to ineffective communication or a breakdown in trust	There is a risk that there may be a breakdown in the effective working relationship between the Board and the Council of Governors	Which may result in further formal regulatory action impacting on the reputation and sustainability of the Trust	Organisational	5	3	15	4	2	8	4	2	8	31/03/2025	Leonora May	Leonora May	Code of conduct for governors Code of governance for NHS provider trusts Development of Trust strategy People Relationship building between Board and Council of Governors				Score reduced from 12 to 8 given results of most recent Council of Governors effectiveness review and feedback on relationships. Risk to remain on risk register for continued monitoring	Regulatory and Compliance	External regulatory standards
Risk 00000014	Open	Due to a culture of non-compliance with processes and procedures	There is a risk of a non-compliant event involving SFIs or scheme of delegation and reservation of powers	Which may result in regulatory action including fines, adverse publicity or impact to reputation	Organisational	4	3	12	4	3	12	4	2	8	31/07/2025	Leonora May	Leonora May	Audit and risk committee Scheme of delegation and reservation of powers Standing financial instructions	Board level review of Scheme of delegation and reservation of powers Longer term actions to address wider cultural issues	0	2	Score reduced from 16 to 12 given work completed to address weaknesses in value for money arrangements including work to minimise single tender waivers, the development of a reliable contracts database and additional process and oversight by governance and finance teams	Regulatory and Compliance	External regulatory standards
Risk 00000016	Open	Due to the structure and timeframes of the patient pathway	There is a risk that mental capacity assessments are not being routinely undertaken when required	This may result in either absence of valid consent for procedures that are undertaken or procedures being declined without patient having capacity to do so, which may result in patients being unable to continue with treatment or procedure being completed without full compliance with the MCA	Organisational	4	5	20	3	4	12	3	1	3	28/11/2025	Edmund Tabay	Ian Cruickshank	Awareness training MCA compliance audit MCA lead MCA training for consultants	Repeat the Audit of compliance Set up task and finish group to review processes nd patient pathways to identify opportunities MCA training	0	3	MCA T&F group working through issues. Appointment letter changed, Evolve form being adapted, schedulers highlighting patients at risk. Date for completion altered to reflect Board discussion and 6 month time frame for task and finish group Risk reviewed. No change with the scores. Task and finish group meeting scheduled in April 2025 to support addressing the issue. Reviewed Risk and residual score after mitigations. Reduced to 16. Policy updated and changes to training. Audit data presented to clinical teams. MCA policy approved, awaiting new MCA document sign off.	Patient safety, outcomes and experience	Clinical safety/quality of care
Risk 00000017	Open	Due to the potential for individuals not feeling safe to speak up	There is a risk that staff may not speak up with concerns	Which may result in concerns not being addressed leading to patient safety issues, staff safety issues, reputational damage	Organisational	4	4	16	4	3	12	4	1	4	18/12/2025	Edmund Tabay	Edmund Tabay	Cultural transformation steering group External FTSU Guardian FTSU engagement FTSU policy Monitoring of FTSU referrals	Implement FTSU engagement plan Board engagement plan Organisational culture assessment	0	3	Risk reviewed and the scores remain the same Risk reviewed. Scores remain the same currently. Controls have been implemented and there is a regular update of FTSU that goes to the Executive Leadership Team and the Trust Board. Controls have been implemented but will require information to determine if these are working. The external service has only been implemented for about 12 months.	Regulatory and Compliance	External regulatory standards
Risk 00000038	Open	Due to insufficient and inadequate space on Peanut ward to meet the individual care needs of both children who are inpatients and those who need to be seen in an outpatient setting for surgical assessment.	There is a risk that the environment on Peanut ward is not appropriate for children or their families, particularly those with additional needs. There is a further risk that due to limitations in Peanut space that children are alternatively cared for in areas which are not adequately set up for paediatric care and do not have sufficient staff clinically skilled to support the holistic care of children.	Which may result in children's care being compromised by limitations in the physical estate available to support them. This may lead to limitations in access to appropriately trained paediatric staff in an outpatient setting which may compromise individualised care and privacy for children and their families and, potentially impact on safeguarding processes.	Organisational	4	4	16	4	3	12	3	2	6	16/10/2025	Tamara Everington	Rosie Lindley	Monitoring throughput within ward Process for paediatric admission, stay and discharge Risks to paeditatric	Review provision for Paediatrics across QVH (strategic priority for year one)	0	1	Task & Finish group established to address the children's model for care chaired by the CMO. Group developing the clinical service model estate requirements led by the Dep CNO Reviewed by Jane Dickson and Tamara Everington. Included risks from Peanut Ward care for inpatients as well as the outpatient risk. Owner changed to TE. Discussed risk and is a cross-directorate risk, therefore more appropriate to add to Organisational Risk Register for organisational oversight. Scheduled for approval at next ECQR on 18/11/24	Estates infrastructure and environment	Property maintenance and management
Risk 00000047	Open	Due to the age and construction of existing electrical cabelling and infrastructure on site	There is a risk of multiple failures of the site electrical systems	Which may result in loss of electrics, increased costs for repairs, potential injury to staff due to wiring faults	Organisational	4	4	16	4	3	12	3	2	6	31/12/2025	Claire Lowe	Claire Lowe	47 Fixed wire	Specification for works to be written	0	1	The estates team have engaged with specialist contractors and consultants and have inspected the electrical infrastructure in more detail, this has enabled the Estates team to upgrade the power availability from the utility company UKPN to 700kva from 400kva at DSS1. Further works are required to upgrade the sub mains switch rooms and cupboards across the site to lower the risk further. Electrical inspections and replacement infrastructure electrical equipment currently being tendered Electrical inspections currently being tendered	Estates infrastructure and environment	Property maintenance and management
Risk 00000048	Open	Due to the lack of a L1 fire alarm system across all areas of the site, faults with existing fire alarm cabling and fire alarm panels	There is a risk that a fire could occur and the fire alarm system may not alert the area(s) appropriately	Which may result in risks to those on site, switchboard not being notified of a fire activation, fire enforcement action, damage to the estate	Organisational	3	3	9	3	3	9	2	2	4	30/09/2025	Claire Lowe	Claire Lowe	48 Fire alarm system	Fire alarm panels and communication system to be replaced	0	1	Next phase of fire alarm works to progress within 2025, this will include priority ward areas Chubb have undertaken significant works on the network cabling that have removed the faults on the fire alarm system, with the sounder circuits working correctly across site at this time of writing Chubb Fire are currently undertaking the installation of a new network cabling system and panel replacement project, this will reduce the risk of fire alarm system failure. The Trust are also undertaking the acceleration of the remaining areas across site to be upgraded to an L1 fire alarm system, with Rowntree being started within January 20205. Upgraded to Organisational Register due to risk score increase Issues with fire alarm system identified on 22/11/24. Current risk score therefore increased and risk slightly re-worded to add in issues with cabling and panels Fire alarm works underway, estimated completion Feb 25	Estates infrastructure and environment	Property maintenance and management

Risk 00000049	Open	Due to the incorrect installation of the fire damper system, areas without current coverage, lack of previous maintenance	There is a risk that fire dampers may fail to operate in the event of a fire	Which may result in fire spreading, harm to individuals, loss of services and resulting impacts	Organisational	5	3	15	5	3	15	3	2	6	30/09/2025	Claire Lowe	Claire Lowe	49 Dampers	Replace and repair dampers	0	1	The estates team have engaged an external professional team due to the lack of an in house fire officer, this is required to provide technical design and formal strategy around the installation of the new fire damper systems needed across site. Surveys complete. Awaiting programme of works	Estates infrastructure and environment	Property maintenance and management
Risk 00000053	Open	Due to the heating and hot water systems running on gas only (no dual fuel capability)	There is a risk that the site suffers a loss of heating and hot water systems in the event of a gas outage	Which may result in the inability to continue to delivery services, financial and reputational impact	Organisational	5	3	15	5	3	15	5	1	5	31/03/2026	Claire Lowe	Claire Lowe	53 Energy centre	Establish funding for energy centre	0	1	The estates team have designs and plans in action to install new electric heaters through out the hospital, this will include new electric waters heaters also, this will reduce the reliance on GAS heating only, this also feeds into the NHS Green Plan in terms of decarbonisataion. Energy centre required to remove risk	Estates infrastructure and environment	Property maintenance and management
Risk 00000054	Open	Due to the age and condition of some boilers on site, and inability to obtain replacement parts	There is a risk that a boiler might fail and require full boiler replacement	Which may result in financial impact, impact to services and resulting impacts	Organisational	5	5	25	5	3	15	2	2	4	31/03/2026	Claire Lowe	Claire Lowe	54 Energy Centre 54 Temporary boilers	Seek funding for new energy centre (£4.5m)	0	1	We currently have a 2 year contract for the temporary boiler system, this started 1st April 2025. The proposed new energy centre will need significant design input from a professional design team within 2025 to be able to make the scheme feasible within the 2 year time scale we currently have. The estates team are waiting budget allocation / funding for a new energy centre, this will fully upgrade the current GAS boiler systems across site. We have installed a 2MW temporary boiler and pipe work system to reduce the risk of failure Temporary boilers being installed in areas where boilers have failed completely	Estates infrastructure and environment	Property maintenance and management
Risk 00000073	Open	Due to limited dedicated EPRR resources and skills and experience of trust staff	There is a risk that the trust may not be able to maintain full compliance rating for EPRR.	Which may result in reputational damage to the trust.	Organisational	4	3	12	3	3	9	3	2	6	28/08/2025	Kirsten Timmins	Ashley Hunt	EPRR exercising schedule EPRR policy and procedures in place EPRR resources On call rota TNA	Recruitment of substantive EPRR officer Internal resources EPRR resource update	0	3	Risk has not increased given we did not have a specific EPRR lead previously. Resource conversations are taking place to ensure the trust is implementing the actions from the previous annual assurance review. Upgrading risk given decision not to go out for recruitment for an EPRR lead. Conversations will need to follow about internal resourcing this work. Risk approved for escalation to the Organisational Risk Register at the ECQR 16/12/24 No changes to current risk score, although JD is currently with HR for evaluation.	Regulatory and Compliance	External regulatory standards
Risk 00000077	Open	Due to a larger overall patient waiting list following the pandemic and the increased complexity of patient treatments, fluctuating demand and capacity	There is a risk that patients may come to harm whilst waiting for treatment	Which may result in delayed patient treatment, potential patient harm, reputational impact	Organisational	5	3	15	3	2	6	2	2	4	31/03/2026	Kirsten Timmins	Victoria Worrell	Cancer plan Waiting list management action plan Weekly access meeting Weekly RTT PTL meeting	Weekly update to COO and CMO Harm review	0	2	Risk approved for escalation to the Organisational Risk Register at the ECQR 16/12/24	Patient safety, outcomes and experience	Clinical safety/quality of care
Risk 00000088	Open	Due to challenges in performance resulting from internal and external factors	There is a risk we fail to deliver compliance with operational and NHS constitutional standards in relation to performance	Which may result in a negative impact in patient outcomes/experience, reputational impact, financial impact	Organisational	4	4	16	4	3	12	3	3	9	31/03/2026	Kirsten Timmins	Victoria Worrell	88 Policy and training 88 Referral to Treatment monitoring 88 Reporting of data to Sussex ICB 88 Reporting to clinical governance meetings (Plastics) 88 Reporting to weekly system DMO1 and sleep planning meeting Improved operational governance Internal Audit	Cancer Action Plan Waiting List Action Plan Delivery in 2024/25	1	2	The trust has met key targets for UEC, cancer, DM01. 65ww has been a key focus for 2025/26, and the trust has delivered The trust has met key targets for UEC, cancer, DM01. 65ww has been a key focus for 2025/26, and the trust has delivered Risk approved for escalation to the Organisational Risk Register at the ECQR 16/12/24	Governance and sustainability	Organisational sustainability
Risk 00000115	Open	Due to the additional unexpected costs, NHS financial/activity pressures or inability to deliver the activity plan.	There is a risk that the Trust will fail to deliver a breakeven or better position for 2024/25	Which may result in additional financial restrictions and controls being implemented by the ICB or NHSE.	Organisational	4	3	12	4	2	8	4	2	8	30/05/2025	Simon Marshall	Jonathan Wharton	Nationally allocated funding Q4 Cost improvement programme	Complete national funding evaluation Evaluation of cost improvement plans	0	2	Audit has not raised any issues at the moment but the audit is not yet complete. The position remains looking like break even. Initial draft accounts have been submitted and are break even. Finalisation of numbers and Audit are still required but draft significantly reduces the risk	Finance	Budgetary control
Risk 00000117	Open	Due to the lack of a strategic overview of medical devices across the trust (age, condition etc.) and the lack of a capital replacement plan for Medical Device replacement	There is a risk that our Medical devices may fail to the point where we cannot repair due to age and unavailability of the parts of the device	Which may result in service delivery disruption to our patients	Organisational	4	4	16	4	3	12	3	2	6	30/07/2025	Edmund Tabay	Jan Somera	117 Finance capital replacement plan 117 Finance planning 117 Medical Devices register	Reinstigated the medical devices under the leadership of the Interim CNO Pull together a tender specification for the medical devices contract Engaging with the current contract supplier to improve service level Working with contract supplier (Avensys) to ensure that asset register is up to date	3	1	MTS commenced as the EBME services provider at QVH on 2 June 2025. As part of their role, they will undertake a full assessment and review of all existing medical and clinical equipment across the Trust. At present, the risk rating score remains unchanged , as the capital funding allocated for medical and clinical devices in 2025/26 is limited, reserved for emergency needs only. We will continue to monitor the situation closely and prioritise equipment replacement based on risk and clinical necessity. MTS commenced as the EBME services provider at QVH on 2 June 2025. As part of their role, they will undertake a full assessment and review of all existing medical and clinical equipment across the Trust. At present, the risk rating score remains unchanged , as the capital funding allocated for medical and clinical devices in 2025/26 is limited, reserved for emergency needs only. We will continue to monitor the situation closely and prioritise equipment replacement based on risk and clinical necessity. The score remains the same. There are clinical and medical devices that have already been purchased in the last financial year capital fund but recognising that there are still devices that require replacement. Medical and clinical devices group meeting in place. Due to the capital spending for clinical and medical devices this year, the risk score is reduced	Patient safety, outcomes and experience	Clinical safety/quality of care
Risk 00000121	Open	Due to end of life contract for supplier of Paging system infrastructure and no availability of parts, if the system fails there is no guarantee of repair	There is a risk that the paging system fails, Business continuity response will be instigated. A new supplier has been sourced and a contract signed for new pagers which will be implemented in 2025/26.	Emergency page not received by Resuscitation team	Organisational	4	3	12	4	3	12	4	2	8	30/09/2025	Kirsten Timmins	Bill Gordon	Ashley Hunt	Scope to understand number of pagers required for emeregency response teams Identify alternative supplier for pager solution and place order Scope and agree alternative solution for those not on Resuscitation team Replacement bleep system Contract in place	2	3	Kick off meeting with supplier on 9th May. Expected lead time to start project in 2 weeks. Plan to go live in Sept 2025 Order has been place and received (5 year contract) A company has been identified and a contract signed for new pagers to be delivered in early 2025/26. Replacement of bleep system on priority one for purchase by the financial year end	Patient safety, outcomes and experience	Clinical safety/quality of care

Risk 00000125	Open	Due to lack of an SLA with a mental health provider	There is a risk that patients suffering a mental health crisis or requiring mental health support whilst undergoing an inpatient stay may not get the help they need	Which may result in inappropriate transfers of care or inability to provide targeted interventions that improve the patient's recovery and rehabilitation	Organisational	3	4	12	3	4	12	2	3	6	01/10/2025	Tamara Everington	Tamara Everington	Access to agency RMNs Psychology services input for patients with MH difficulties SLA with SPFT for mental health liaison	SLA with SPFT	0	1	Target date of 01/04/2025 for achieving this has not been met due to the complexity involved in rebuilding and developing an SLA with the mental health provider, as well as financial challenges. A revised target date has now been set. Rebuilding SLA is a cost pressure that needs to be balanced against other priorities with potential benefits.	Patient safety, outcomes and experience	Clinical safety/quality of care
Risk 00000132	Open	Due to competing internal and external priorities, such as internal organisational priorities, financial resources, adherence to planning guidance priorities	There is a risk that the implementation of the QVH strategy is delayed or unable to progress	Which may result in failure to deliver the QVH strategy, reputational impact, uncertainty for the future direction or financial impact	Organisational	5	3	15	5	3	15	4	2	8	30/09/2025	Abigail Jago	Kathy Brasier	132 Accountability and ownership 132 Driving performance through strategy 132 External engagement 132 Financial sustainability 132 Internal engagement 132 Priority development	Operational Plan Stress test of approved organisational strategy 2025-30	0	2		Governance and sustainability	Organisational sustainability
Risk 00000133	Open	Due to the impact of national shortages of specific roles (eg radiology, sonography, histopathology, sleep physiologist).	There is a risk that if these roles become vacant we may not be able to recruit to them in a timely manner.	Which may result in increased waiting times for patients, cancellation of clinics / appointments. Increase in temporary staffing costs to cover the roles.	Organisational	3	3	9	3	2	6	2	2	4	31/03/2026	Helen Edmunds	Helen Edmunds	Apprenticeships to support growing our own System networks for hard to recruit roles	Undertake succession planning across directorates	0	1		Workforce	Recruitment and retention
Risk 00000138	Open	Due to various internal and external factors around the delivery of the EPR programme (e.g. funding, medical engagement, benefits realisation)	There is a risk of failure to deliver the EPR programme	Which may result in impact to patient care, reputational impact, impact on strategy, challenges with partnership working, lack of data driven culture, digital maturity, staff recruitment/retention, legacy software challenges	Organisational	5	3	15	5	2	10	5	1	5	30/11/2025	Tamara Everington	Bill Gordon	138 External assurance 138 Governance and reporting 138 Programme plan and risk register 138 Programme resource	Revised Business Case summary	0	1	Autumn go live now approved by Trust Board	Information technology and digital	Digital transformation and innovation
Risk 00000139	Open	Due to the age and design of the electrical cabling and switch room equipment within the American Wing radiology department	There is a risk of an electrical fire	Which may result in loss of life and property	Organisational	5	3	15	5	3	15	5	1	5	04/12/2025	Claire Lowe	Peter Boag					Weekly inspection still being carried out. Fire detection within room and adjacent rooms. Weekly visual inspection by estates management team to confirm no damage to electrical equipment within room has been put on the PPM system The cabling is red and black cables which high light the need for a full rewire of the space, currently the electrical equipment is also over 50 years old and poses a considerable risk of fire	Estates infrastructure and environment	Estates development
Risk 00000144	Open	Due to the NHS financial pressures, the significant level of savings required within the QVH plan and the uncertainty of ERF funding.	There is a risk that the Trust will fail to deliver a break even position in 2025/26	Which may result in additional financial restrictions and controls being implemented by the ICB or NHSE, critical cash pressures, reduced access to capital and loss of deficit funding c£1.2m	Organisational	4	3	12	4	3	12	4	2	8	01/09/2025	Simon Marshall	Jonathan Wharton	Monthly Monitoring	Contract agreements	0	1		Finance	Budgetary control
Risk 00000148	Open	Due to the significant level of the CIP programme in 2025/26 and the required phasing of the programme	There is a risk that the Trust will be unable to deliver the full value of CIP or that a significant proportion will be non-recurrent	Which may result in failure to deliver the Trust break even plan which would lead to additional external financial controls on the Trust, critical cash issues, restriction in capital and an increase in the underlying run rate.	Organisational	5	4	20	5	4	20	4	3	12	31/12/2025	Simon Marshall	Jonathan Wharton	Efficiency steering group					Finance	Budgetary control
Risk 00000149	Open	Due to uncertainty regarding the contractual arrangements for ERF funding and the ICB financial positions	There is a risk that the current assumptions for ERF funding in the Trust plan are not agreed	Which may result in failure to deliver the break even position, to meet performance targets and fund unavoidable cost pressures.	Organisational	4	4	16	4	3	12	4	2	8	31/07/2025	Simon Marshall	Jonathan Wharton		ERF Contract sign off	0	1	Sussex agreed and Kent updating the base ERF along with the contract to pay on delivery of activity rating has been updated. Sussex ICB have agreed. Other ICBs not agreed yet.	Finance	Revenue generation
Risk 00000153	Open	Due to lack of fire compartmentalisation within the plant room above theatres.	There is a risk fire would spread quickly to other larger parts of the plant room above theatres.	Which may result in catastrophic loss of property and life	Organisational	5	3	15	4	3	12	3	3	9	22/03/2026	Claire Lowe	Peter Boag	Fire alarm system Fire damper system	External company to inspect and advise regarding course of action	0	1	Current score updated to 12 on the basis that we would be alerted to a fire an its early stage by the alarm system. Appropriate action would be taken to mitigate it spreading. The score will remain 12 until the external contractor has completed the survey and remedial works is finished. The theatre complex was built in 2012, and due to value engineering the roof plant room fire compartmentalisation was omitted. Unfortunately this has left the Trust at risk since 2012. We now need this element of remedial works to be completed urgently to remove this risk.	Estates infrastructure and environment	Property maintenance and management

Report cover-page			
References			
Meeting title:	Board of Directors		
Meeting date:	10/07/2025	**Agenda reference:**	**44-25**
Report title:	Integrated Quality and Performance Report Month 1		
Sponsor:	Kirsten Timmins, Chief Operating Officer		
Author:	Allison Hunter, Strategy & Improvement Project Support Officer		
Appendices:	Appendix – Integrated Quality and Performance Report (IQ&PR) M1 slide pack		
Executive summary			
Purpose of report:	To discuss the Month 1 Integrated Quality and Performance Report and highlights from M2 where significant.		
Summary of key issues	**KSO1** - The Friends and Family Test recommendation rate remains high. In M2 a quality incident regarding a small number of ultrasounds was identified. Work is in place to contact patients and further information will be included in M2 reporting. A never event occurred in M2 regarding a wrong site block. This has been reported externally and improvements made as a result. Work has commenced on the children's model and the trust contributed to the London and South East Burns Review with the final report due in June 2025. The Trust met its planned Month 1 performance against the 2025/26 operational targets for Urgent and Emergency Care, Referral to Treatment and Cancer. Income from activity was on plan, and CDC activity increased, yet was behind plan from an income perspective given underperformance in some modalities. Work is in place to understand constraints to activity delivery. Theatre productivity continued to achieve the GIRFT recommended performance. The Trust has begun its outpatient transformation programme, with focussed work within sleep services. **KSO 2** – There is additional support in place for the for research and innovation team. The annual audit report for 2024/25 has completed and is informing audit planning for 2025/26 with directorates. The Clinical Learning Forum has started with the first meeting offering the opportunity to share learning from patient safety investigations. **KSO 3** – Temporary staffing use has decreased in M1, with substantive roles being filled and turnover decreasing. This has resulted in a lower vacancy rate in M1 (5.3%). Support programmes for change management are now available. April was stress awareness month. QVH hosted several 'unwind spaces' to support employees health and wellbeing. Positive feedback was received from staff. A staff wellbeing survey is being promoted to understand how staff are feeling and what additional support can be provided. The trust will be delivering behavioural framework/toolkit workshops from June to September to provide and understanding of how to apply and embed the framework throughout areas of responsibility. **KSO 4** – The Trust reported an Income and Expenditure position broadly in line with planned deficit of £0.4m and had a cash balance of £6.9m. Whilst the position is positive for M1, there will need to be a significant improvement in Trust contribution to deliver the planned break even position for 25/26, with the main risk area being delivery of best value schemes of £7.5m (6%) for the year. **KSO 5** – QVH will be adopting a phased approach to the Local Offer outlined in the Trust strategy. The team are working collaboratively with primary care and the wider primary care network to enhance and further develop partnership working.		

	Two areas have been prioritised for further work as part of the Major Services Review - 'Core Urgent and Emergency Care' and 'Rehabilitation and Intermediate Care'. QVH attended the first of these groups on 13 May 2025. **Major Projects** **Community Diagnostic Centre:** Full business case approved for East Grinstead by Trust Board in May. Ongoing conversations with University of Chichester regarding the Bognor programme. **Sussex Pathology Network (SPN) Programme:** Project continuing in line with the plan that was submitted to NHSE and the ICB. **Electronic Patient Records Programme:** Formal sign-off of business case by Trust Board in May, go-live scheduled for late Autumn 2025.				
Recommendation:	The Board is requested to note the Integrated Quality and Performance 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:	BAF 4- long term sustainability (the IAF supports the delivery of the Trust's strategy BAF5- compliance (addresses the well led review recommendations, supports the implementation of continuous improvement methodology				
Corporate risk register:	CRR – organisational risk register in development				
Regulation:	ICS, NHS England, CQC				
Legal:	None				
Resources:	None				
Assurance route					
Previously considered by:	This has been reviewed by ELT, Finance and Performance Committee, Quality and Safety Committee				
	Date:	02/06/25, 30/06/25, 01/07/25	Decision:	N/A	
Next steps:	Continue to embed the monthly reporting processes				

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Integrated Quality and Performance Report

Month 1: April 2025

BALANCED SCORECARD

Queen Victoria Hospital
NHS Foundation Trust

Priority Metrics	M12 target	Latest month	Planned trajectory in month	Actual performance in month	Previous Month	Summary	Confidence in delivery (RAG)
Breakeven YTD	£0.0m	Apr-25	-£0.43m	-£0.42m	£0.0m	Achieved M1 plan by £0.01m.	
RTT> 52 weeks as a proportion of waiting list	1%	Apr-25	2.3%	2.2%	2%	Achieved M1 plan by 0.1%. Common cause variation -no significant change.	
Cancer 62 days	75%	Mar-25	77.6%	80.3%	77.6%	Achieving target. Common cause variation -no significant change.	
% Overall FFT Recommendation Rate	90%	Apr-25	90%	95.0%	94.9%	Achieving target. Common cause variation -no significant change.	
Trust vacancy rate (excluding bank and agency	8%	Apr-25	7%	5.3%	7.0%	Improved position in month. Common cause variation -no significant change.	

Major Project	This Month	Overall Status	Last Month	Summary
To deliver the Community Diagnostic Centre programme at East Grinstead and Bognor (respectively)		On track (East Grinstead) Off track (Bognor)		Full Business case for East Grinstead CDC approved by Trust Board at the end of May. Engagement continues with University of Chichester regarding next steps for the Bognor site.
To deliver the Sussex Pathology Network Programme		Off track but mitigations in place		Progress has been made across delayed LIMS, Order Comms and Managed Service Contract however still potential cost implications for 2025/26.
To implement year one of the Electronic Records Programme		On track		Business case summary signed off at Trust Board on 8th May. Due to complexity of programme, programme status deemed Green/Amber.

CEO SUMMARY

Queen Victoria Hospital
NHS Foundation Trust

The Trust is committed to improving elective recovery, especially in critical areas including cancer treatment, diagnostics, improving waiting times and supporting system partners to reduce long waits across the wider system. The delivery of the priorities are against a challenging financial position for the trust to achieve breakeven for 2025/26.

Alert

- The trust has a challenging financial outlook for 2025/26 with a significant savings programme required to deliver breakeven and requirement for a significant reduction in corporate costs.
- Key risks relate to the financial position, estate challenges and meeting our performance targets.

Assure

- The trust achieved the planned performance metrics for Urgent and Emergency Care, RTT, and Cancer for M1 (M12 2024/25 for Cancer).

Advise

- QVH Strategy 2025-2030 has been reviewed in the new financial climate. Year 1 objectives and performance key metrics have been developed supporting the trust to deliver in line with planning and operational guidance.
- The Trust's Income and Expenditure position was in line with the planned deficit of £0.4m and had a cash balance of £6.9m. While this is a positive start to the financial year, the main risk is the delivery of best value schemes of £7.5m (6%) for the year.
- Change management support is in place to support colleagues through the ongoing change across the NHS.
- Organisational culture continues to be a key priory for the Trust. Work continues to triangulate information from the people pulse survey, freedom to speak up concerns, employee relations cases, listening sessions and Datix to understand micro-cultures and where we need to align our values and behaviours framework.
- The East Grinstead Community Diagnostics Centre (CDC) business case has been approved by the Board. Work continues with stakeholders to progress the Bognor CDC planning.

Abigail Jago
Acting Chief Executive Officer

KEY STRATEGIC OBJECTIVES – SUMMARY

Queen Victoria Hospital
NHS Foundation Trust

KSO1

- The Friends and Family Test recommendation rate remains high for the Trust.
- The Trust delivered against plan for activity (including CDC activity) and achieved the planned performance metrics for RTT, Cancer, and Urgent and Emergency Care.
- In April, the Trust set up a task and finish group to begin work on the children's model as outlined in the Trust strategy.
- The Trust has contributed to the London and South-East Burns Network Review and is awaiting the final report due in June 2025.

KSO2

- Work is underway to strengthen the research and innovation team and ensure alignment with the continuous improvement work across the trust.
- The annual audit report for 2024/25 has completed and is informing audit planning for 2025/26 with directorates
- The Clinical Learning Forum has started with the first meeting offering the opportunity to share learning from patient safety investigations

KSO3

- Substantive roles are being filled in M1, leaning to a reduction in temporary staffing and turnover.
- Change management support is available via the organisational development / wellbeing team to support colleagues through the ongoing change across the NHS.
- The Trust has submitted to NHSE its terms of reference for the mandatory Learning Oversight Group – this is a mandated working group to manage an assurance process for locally mandated learning in response to the national programme of delivery.
- The trust is delivering behavioural framework/toolkit workshops from June to September to provide and understanding of how to apply and embed the framework throughout areas of responsibility.

KSO4

- At the close of April 2025, the Trust reported an Income and Expenditure position broadly in line with planned deficit of £0.4m and had a cash balance of £6.9m. Whilst a planned position is positive for M1, there will need to be a significant improvement in Trust contribution to deliver the planned break even position for 2025/26, with the main risk area being delivery of best value schemes of £7.5m (6%) for the year

KSO5

- Full Business case including build costs for the East Grinstead CDC approved by the Finance and Performance Committee and will be submitted to Trust Board for approval at the end of May.

Queen Victoria Hospital
NHS Foundation Trust

KSO1

To deliver outstanding care

Ambition

Quality at the centre of what we are and do for patients, families and communities

Board Assurance Framework

01 Patient services
02 Workforce strategy
03 Physical infrastructure
04 Long term sustainability
06 Financial sustainability
07 Information assets
08 Partner organisations

2025/26 Annual Objectives (TBC following Board approval)

1. Deliver Access Targets (RTT, Cancer, Urgent and Emergency Care)
2. Quality Priority/Health Inequalities: Ensure that patient outcomes are positive and consistent, and that they meet both clinical expectations and the expectations of people themselves including communication, advice and data.
3. Development of children's model phase 1
4. Address outputs of London and South-East Burns Review.

2025/26 Annual goals

1. RTT- By March 2026, 1% of waiting list over 52 weeks, First appointment <18 weeks 75.3%, RTT 18 week performance 62.3%. Cancer- By March 2026 FDS performance 80%, 62 day treatment performance 75%. UEC performance delivery in line with previous years.
2. 90% complaints effectively responded to within 30 days, directorates deliver on Directorate identified priority for the year by end Q4.
3. Staff are consistently trained in how to apply the Mental Capacity Act so patients who may lack capacity are supported in decision making in keeping with their wishes and preferences.
4. Improve ethnicity data recording to 95%.
5. Children’s operating model design completed by end Q3.
6. Outputs of London and South-East Burns Review addressed by end of Q3.

Queen Victoria Hospital
NHS Foundation Trust

KSO1 EXECUTIVE SUMMARY

The Trust had a strong start to the new financial year in terms of operational performance and quality.

The Friends and Family Test recommendation rate remains high for the Trust in M1. In April, the Trust set up a task and finish group to begin work on the children's model as outlined in the Trust strategy. The Trust has contributed to the London and South East Burns Review and is awaiting the final report due in June 2025. Tackling health inequalities remains a key priority for the trust and a Health Inequalities Steering Group is in place focussing on improving ethnicity data recording. In addition, a Task and Finish is focused on ensuring staff are consistently trained in how to apply the Mental Capacity Act so patients who may lack capacity are supported in decision making in keeping with their wishes and preferences.

The Trust met its planned Month 1 performance against the 2025/26 operational performance targets for Urgent and Emergency Care, Referral to Treatment and Cancer. The Trust had 37 patients waiting over 65 weeks in April, lower than the forecast position of 45. The Trust will continue to have patients waiting more than 65 weeks within plastic surgery and is recruiting an additional consultant and using an insourcing provider to treat patients sooner. The Trust is part of the national Referral to Treatment (RTT) waiting list validation sprint and has had focussed effort on improving validation performance. The Trust continues to provide mutual aid to patients across Sussex to treat patients sooner than if they continued at an alternative trust.

Income from activity was on plan for M1 and Community Diagnostic Centre (CDC) activity overall achieved 110%, although there was variation at a modality level and CDC income was below plan in month. Work is underway at a modality level to review activity and work through constraints to delivery. Theatre productivity continued to achieve the GIRFT recommended performance. The Trust has begun its outpatient transformation programme, with focussed work within sleep services.

Kirsten Timmins
Chief Operating Officer

Edmund Tabay
Chief Nursing Officer

KSO1 BALANCED SCORECARDS

NHS
Queen Victoria Hospital
NHS Foundation Trust

QUALITY & SAFETY METRICS

Metric	Latest Month	Target	Variation	Assurance	Actual	Actual Previous Month	Mean	LCL	UCL	Summary
Ethnicity recording	Apr-25	95%			79.7%	79.8%	79.03%	76.25%	81.82%	Special Cause - improving variation
Smoking Status	Apr-25	95%			99.3%	99.2%	98.98%	97.66%	100.30%	Common cause - no signficant change
Falls per 1,000 Occupied Bed Days	Apr-25	7			1.3	4.0	4.04	-4.27	12.35	Common cause - no signficant change
Hospital Aquired PU Per 1,000 Occupied Bed Days	Apr-25	0			2.6	4.0	0.76	-1.85	3.37	Common cause - no signficant change
% Complaints Responded On Time	Apr-25	70%			100.0%	100.0%	95.35%	73.01%	117.70%	Common cause - no signficant change
Safer Staffing Compliance	Apr-25	90%			99.7%	97.9%	99.62%	98.43%	100.80%	Common cause - no signficant change
% Overall FFT Recommendation Rate	Apr-25	90%			95.0%	94.9%	95.49%	94.50%	96.48%	Common cause - no signficant change
Overall FFT Response Rate	Apr-25	25%			21.3%	22.2%	20.75%	16.75%	24.74%	Common cause - no signficant change
FFT Recommendation Rate - Inpatients	Apr-25	90%			100.0%	99.3%	99.71%	98.03%	101.39%	Common cause - no signficant change
FFT Response Rate - Inpatients	Apr-25	25%			47.4%	36.5%	40.90%	22.24%	59.55%	Common cause - no signficant change
FFT Recommendation Rate - Inpatients Children	Apr-25	90%			100.0%	100.0%	99.44%	97.47%	101.41%	Special Cause - improving variation
FFT Response Rate - Inpatients Children	Apr-25	25%			24.2%	19.7%	20.89%	-1.65%	43.43%	Common cause - no signficant change
FFT Recommendation Rate - MIU	Apr-25	90%			93.9%	90.6%	93.09%	88.59%	97.60%	Common cause - no signficant change
FFT Response Rate - MIU	Apr-25	25%			19.2%	21.9%	19.33%	12.43%	26.23%	Common cause - no signficant change
FFT Recommendation Rate - Outpatients	Apr-25	90%			94.5%	94.9%	95.21%	94.24%	96.18%	Common cause - no signficant change
FFT Response Rate - Outpatients	Apr-25	25%			17.8%	18.9%	17.57%	14.95%	20.18%	Common cause - no signficant change
Readmissions< 30 Days	Apr-25	2%			1.5%	2.6%	2.21%	0.74%	3.67%	Common cause - no signficant change
VTE Risk Assessment	Apr-25	95%			99.2%	97.7%	97.60%	94.31%	100.89%	Common cause - no signficant change

KSO1 BALANCED SCORECARDS

Queen Victoria Hospital
NHS Foundation Trust

QUALITY & SAFETY METRICS

Metric	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25
Number of Complaints	24	6	3	9	3	5	7	4	5	8	7	4	6
Number of Open CAS Alerts	2	2	2	3	2	2	1	0	1	0	0	0	0
Number of Patient Falls Incidents	2	3	0	4	6	6	4	1	1	5	2	4	1
Number of QVH Acquired Pressure Ulcers Cat. 2 and above	0	0	0	0	0	1	0	2	0	0	0	4	2
Never Events declared	0	0	0	0	0	0	0	0	0	0	0	1	0
Medication Incidents (No and low harm)	0	0	0	16	19	27	33	18	7	4	8	12	9
Medication Incidents (Moderate harm or above)	0	0	0	0	0	0	0	0	0	0	0	0	0
Internal Investigation declared	1	0	1	1	0	0	0	0	0	0	1	0	0
Patient safety incident investigations declared	0	0	0	0	0	0	0	0	0	0	0	0	0
Mortalities	0	0	0	0	0	0	0	0	0	1	0	1	1
Hospital Acquired CDI, MRSA, E.Coli, MSSA	0	1	0	0	0	0	1	1	2	0	1	1	0
Occupied Bed Days	934	891	836	899	797	828	908	939	755	803	893	991	781
Oliver McGowan Training Compliance	87.5%	89.4%	90.5%	91.9%	92.5%	92.8%	92.2%	92.1%	92.2%	92.4%	92.3%	91.8%	91.9%

KSO1 BALANCED SCORECARDS

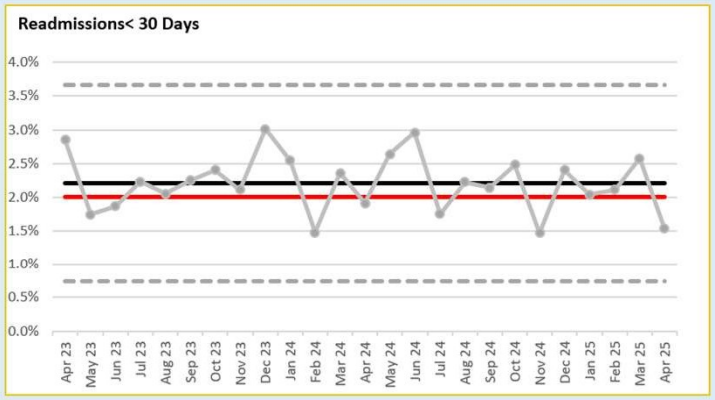
Queen Victoria Hospital
NHS Foundation Trust

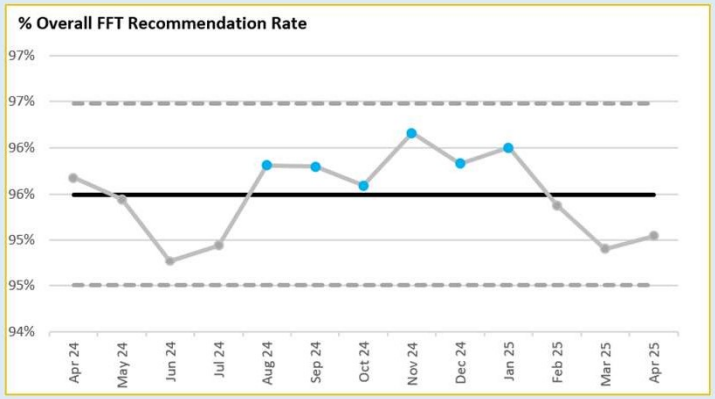
OPERATIONAL PERFORMANCE METRICS

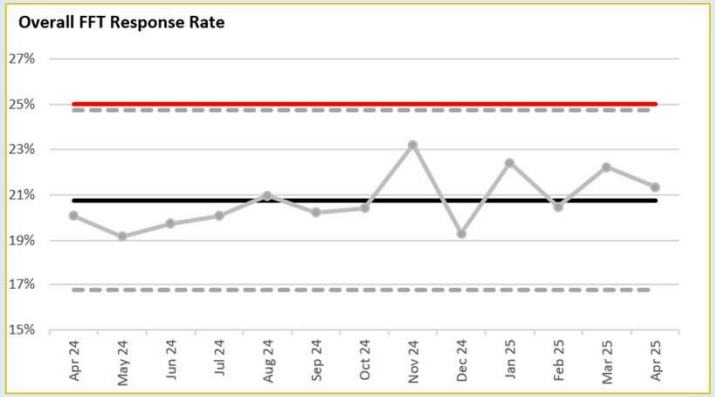
Metric	Latest Month	Target	Variation	Assurance	Actual	Actual Previous Month	Mean	LCL	UCL	Summary
RTT 18 week wait performance - first appointment	Apr-25	75.32%			71.6%	69.6%	70.95%	66.97%	74.92%	Common cause - no signficant change
RTT 18 Week Wait Performance	Apr-25	62.35%			58.9%	56.5%	59.56%	56.93%	62.19%	Special Cause - concerning variation
RTT Waiting List	Apr-25	-			18,115	18,187	18168.36	17530.40	18806.32	Common cause - no signficant change
RTT >52 Weeks	Apr-25	-			397	362	418.76	336.97	500.56	Common cause - no signficant change
RTT >52 Weeks as a proportion of Waiting List	Apr-25	1.00%			2.2%	2.0%	2.30%	1.91%	2.70%	Common cause - no signficant change
CDC activity vs plan	Apr-25	100.00%			110.5%		110.48%			
% Income Vs Plan	Apr-25	100.00%			100.2%	106.7%	99.42%	88.48%	110.36%	Common cause - no signficant change
Cancer 28 Day FDS	Mar-25	80.00%			87.3%	85.4%	82.92%	72.78%	93.07%	Common cause - no signficant change
Cancer 62 Days	Mar-25	75.00%			79.7%	77.3%	78.25%	65.69%	90.81%	Common cause - no signficant change
Outpatient Productivity - Patient Initiated Follow Ups (PIFU)	Apr-25	2.00%			1.9%	1.9%	1.78%	1.18%	2.38%	Special Cause - improving variation
Outpatient Productivity - Missed Appointment Rate	Apr-25	4.00%			5.0%	5.2%	5.34%	4.86%	5.82%	Common cause - no signficant change
Diagnostics 6 Week Wait Performance	Apr-25	95.00%			81.2%	86.2%	87.42%	80.05%	94.78%	Common cause - no signficant change
UEC 4 Hour Performance	Apr-25	98.00%			98.97%	98.95%	99.42%	98.39%	100.46%	Common cause - no signficant change
Theatre Productivity - % of Cancellations on the Day	Apr-25	5.00%			5.1%	5.0%	5.04%	0.22%	9.86%	Common cause - no signficant change
Theatre Elective Utilisation - QVH Site (Capped)	Apr-25	85.00%			85.7%	86.1%	82.68%	77.53%	87.82%	Common cause - no signficant change
NHS App appointments available	Apr-25	70.00%			78.4%	77.4%	78.85%	76.32%	81.38%	Common cause - no signficant change

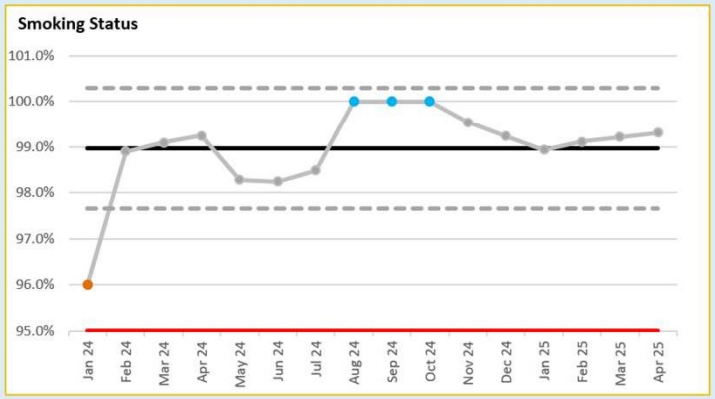
QUALITY & SAFETY METRICS

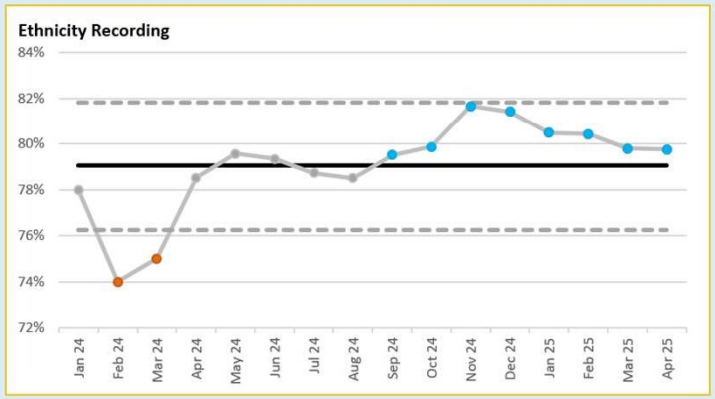
Queen Victoria Hospital
NHS Foundation Trust

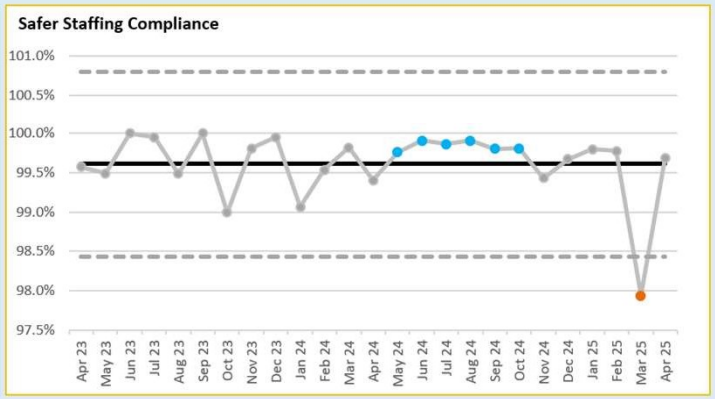












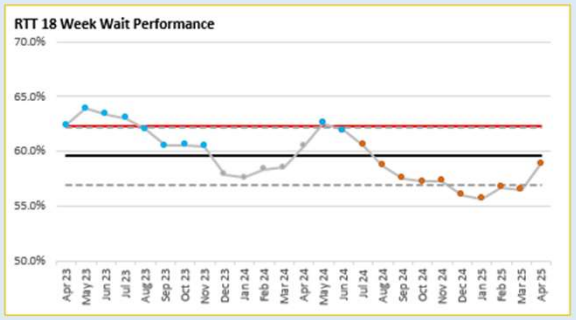
For M2, safer staffing compliance will be reported for day and night

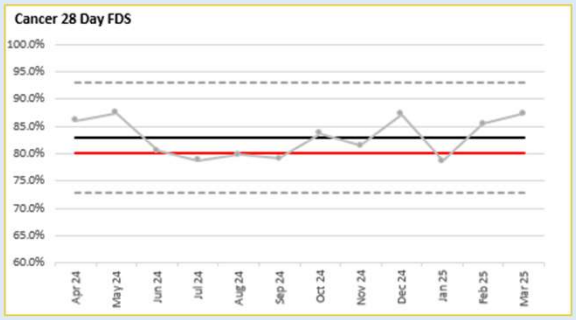
Slide 10

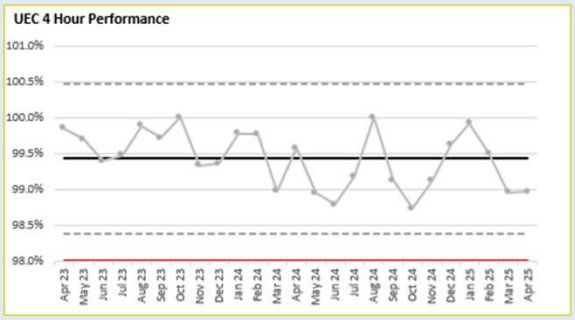
TK2 Timmins Kirsten, 03/06/2025

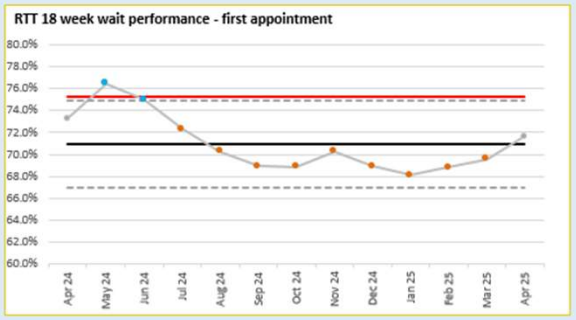
OPERATIONAL PERFORMANCE METRICS

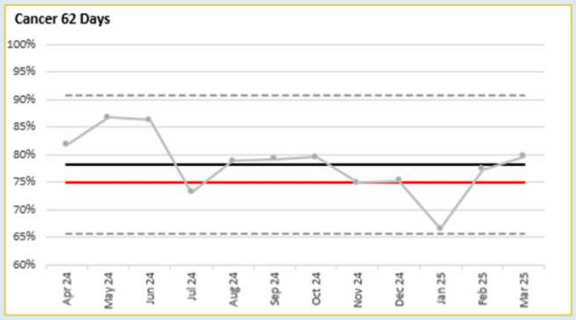
Queen Victoria Hospital
NHS Foundation Trust

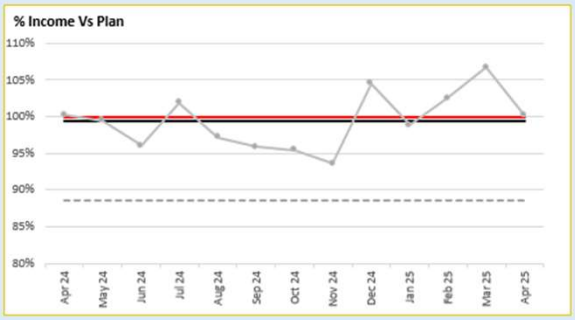


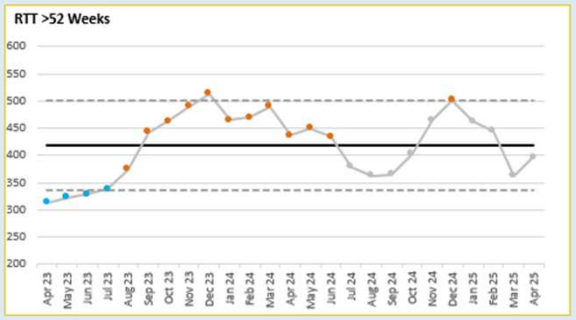


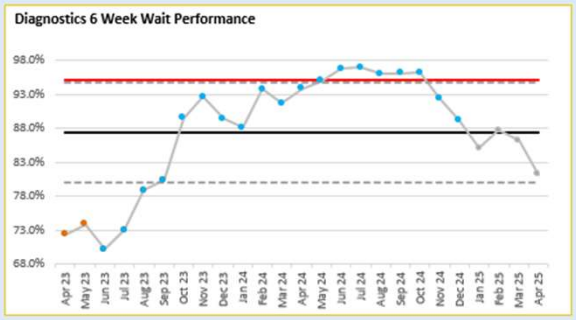


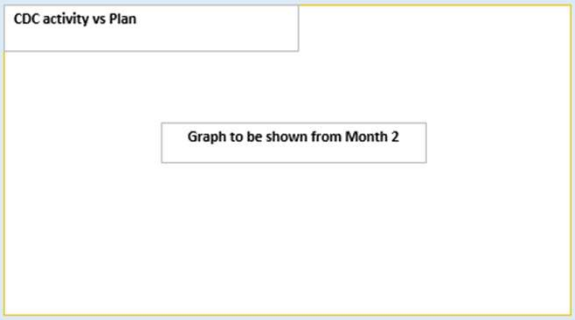












KSO1 AREAS OF FOCUS

Queen Victoria Hospital
NHS Foundation Trust

Area	Summary, impact and actions
Falls	1 fall in outpatients, low physical harm noted.
Safer Staffing Compliance	Safe staffing levels noted throughout the inpatient areas.
Never Events	None
Patient Safety Incident Investigations (Internal)	3 open investigations, 2 new potential investigations related to radiology equipment and service in month impacting service delivery and potential patient harms
Mortalities	1 in hospital death in April; patient with complex conditions had essential surgery for cancer. End of life care given, referred to Coroner
VTE Risk Assessment	Meeting target VTE compliance increased to 97.7% to 99.2% in M1.

KSO1 AREAS OF FOCUS

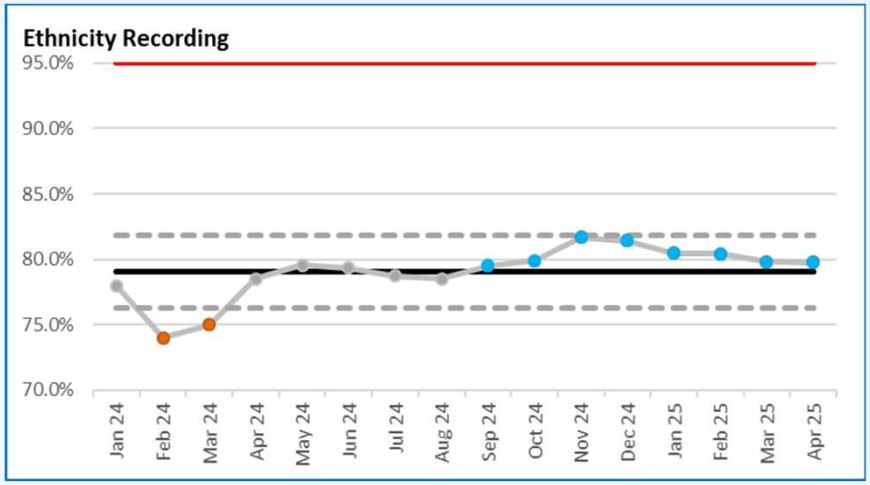
Queen Victoria Hospital
NHS Foundation Trust

Area	Summary, impact and actions
RTT> 65 weeks	The Trust had 2 patients waiting over 78 weeks and 37 patients waiting over 65 weeks at the end of April (M1). This was an improved position against the internal forecast of 45 patients. The Trust are recruiting an additional consultant and using an insourcing provider to treat patients sooner but there are likely to be a small number of 65 week patients into 2025/26.
RTT >52 Weeks %	The Trust achieved 2.2% against a plan of 2.3% in M1 and is predicting to be on plan again in M2.
RTT - 18 week wait - first appointment	The Trust achieved its planned trajectory for M1 and is predicting to remain on plan for M2.
RTT 18 Week Wait Performance	Performance is flagging as 'concerning variation' due to performance deteriorating in the last 6 months of 2024/25 where focus nationally was on reducing long waiters (and subsequently fewer patients were treated below 18 weeks). The target is a M12 (2025/26) target, and will therefore flag as underachievement until M12 (or earlier where possible). The Trust has seen three months' of improvement in the RTT position and achieved its planned trajectory for M1 and is predicting to remain on plan for M2.
RTT Waiting List	The RTT Waiting List reduced from 18,187 to 18,115 in Month 1 and has continued to reduce in Month 2. The waiting list reduction is driven by the RTT waiting list validation sprint – alongside internal service-level focus – which has significantly improved 12-week validation performance and ensured inactive pathways are removed from the waiting list.
Cancer 28 Day FDS	The Trust improved performance from M11 and achieved its planned performance for M12. Trust M12 position 87.3%. Skin 89.8%, Head and Neck 84.4%.
Cancer 62 Days	The Trust improved performance from M11 and achieved its planned performance for M12. Trust M12 position 79.7%. Skin 90.7%. Head and Neck 62.5%. For Head and neck 62 day performance there were 6 breaches. 3 due to diagnostic delays, 1.5 due to patient choice,1 due to outpatient capacity and 0.5 due to theatre capacity. Head and neck consultant recruitment is in progress.
Diagnostics 6 Week Wait Performance	Diagnostic 6 Week Wait Performance deteriorated by 5% in Month 1. This was primarily driven by Sleep studies. Simpler diagnostics are being outsourced and completed within 6 weeks, which is positive for patient experience, and a new electronic referral process is being piloted to add patients to the waiting list sooner. However, inpatient diagnostic capacity constraints are leading to wait times in excess of six weeks for overnight studies given a fixed number of overnight beds available. The Sleep service are exploring potential mitigation actions, including: consideration of alternative diagnostics, review of inpatient diagnostic criteria, exploration into courier services for home studies. The Trust is likely to see DM01 performance challenged for several months due to inpatient diagnostic capacity and an improvement trajectory is being worked up.
MIU 4 Hour Performance	The Trust achieved its planned trajectory for M1 and is predicting to remain on plan for M2.
% Income Vs Plan	The Trust achieved its planned trajectory for M1 and is predicting to remain on plan for M2.
% CDC activity vs plan	The Trust increased activity for M1 (delivering 110% overall, yet with variances at a modality level) and is reviewing each modality to understand actions required to deliver to plan moving forward.
Theatre Elective Utilisation - QVH Site (Capped)	The Trust achieved the 85% GIRFT standard for capped utilisation.

HEALTH INEQUALITIES PRIORITY PROGRESS

Queen Victoria Hospital
NHS Foundation Trust

Area	Summary and actions
Data Improvement	The Trust ethnicity data collection for April is 79.8% and is not yet meeting target. A 12-week task and finish meeting has been established in April with cross-organisational representation to undertake root cause analysis and make targeted improvements based on the Trust's CI approach, The QVH Way. Each Directorate has improving ethnicity recording as an annual goal for 2025/26.



Area	Summary and actions
Mental Capacity Act	A task and finish group has been established to review and improve understanding, processes and pathways in relation to the care of patients that may lack capacity. Some improvements implemented already and risk level reduced.

Queen Victoria Hospital
NHS Foundation Trust

KSO2

To innovate and improve

Ambition

To reflect our future commitment and aspiration to research, innovation and continuous improvement underpinning all that we do

Board Assurance Framework

01 Patient services
02 Workforce strategy
03 Physical infrastructure
04 Long term sustainability
06 Financial sustainability
07 Information assets
08 Partner organisations

2025/26 Annual Objectives (draft)

1. Research & Innovation: Governance, Collaborative Framework & Research Centre
2. Quality Priority: Evidence through measurable Outcome Measures
3. Embed Continuous Improvement.

2025/26 Annual goals

1. Framework to support Research & Innovation established: Evidence of Good Clinical Practice, Research, Innovation & Education Hub established, growth in multidisciplinary portfolio and commercial work including local innovations and partnerships
2. Annual audit plan supports quality compliance and is aligned with Trust strategic intent, every service evidences systematic collection of quality outcome metrics in digital form, Clinical Learning Forum supports cross-organisational multidisciplinary learning from patient stories and outcomes
3. Continuous Improvement programme roll out and development continues across the organisation.

Queen Victoria Hospital
NHS Foundation Trust

KSO2 EXECUTIVE SUMMARY

Research & Innovation:
There is additional support in place for the research and innovation team. Research governance groups are now monthly including all stakeholders and policies are being systematically reviewed. An National Institute for Health and Care Research (NIHR) grant to support shared research with primary care has been awarded and planning is underway to utilise this effectively. A letter in support of an NIHR commercial research application from another primary care group has been submitted. There are ongoing partnership discussions with the Universities of Sussex and Chichester. An application for funding of a new research, innovation and education centre for QVH have been drawn up. A £10million bid has been submitted to NIHR for a research collaboration with commercial partners around innovative elective care pathways related to the CDC.

Quality priority: Evidence through measurable outcomes
Audit planning for 2025/26 is underway with all directorates to ensure plans meet national and local requirements. An audit report collating and evaluating activity for 2024/25 has been prepared and will be shared with the Quality and Safety Committee for discussion and to inform future work. Funding has been received for a part-time data co-ordinator to support reporting on quality outcomes to the British Association for Oral Medicine. The monthly Clinical Learning Forum has been established to share evidence from patient experience.

Embed continuous improvement (CI):
Detail has been provided in the project report below.

Tamara Everington
Chief Medical Officer

KSO2 PROJECT REPORT

Queen Victoria Hospital
NHS Foundation Trust

Continuous Improvement (CI)	Exec Lead: CSO Lead: Head of CI	Reporting Month: Apr-25	Overall Status: R / A / G Green

- The Trust's CI mandatory training video and questionnaire, will be available by the end of June 2025. A test and learn approach will be used with a selected group of Trust new starters, prior to submitting for final Executive approval and sign off.
- Strategy Deployment of development of the Trust's Key Strategic Objectives (KSO) for 2025/26 due to be completed by the end of May 2025, with the development of an A3 for each objective.
- Options around delivery of Experienced Based Co-Design will be confirmed with proposed timeframes by the end of June following meeting with new delivery partner Picker.
- Executive and departmental Improvement Huddles implemented across fifteen areas with huddle boards / virtual boards and training complete. One Huddle area remains paused due to capacity issues, working with Triumvirate team to support. Database of Improvement projects established and information recorded showing strategic priorities and Benefits Realisation as an area of focus for each. Two further huddle areas planned for launch in May and June 2025.
- First Clinical Learning Forum attended by Head of CI with rolling programme to showcase Improvement work and learning from CI across the organisation. Benefits realisation plan updated and was reported at Strategy and engagement sub Committee in May.
- 'Community of Practice of huddle Leads' in place and report outputs directly to ensure sustainability and ownership at local level.

Milestone	Start Date	Expected Completion Date	Commentary
Deliver executive masterclass programme and issue executive Handbook	March 2025	December 2025	Programme on track, Handbook to be delivered May 2025
Mandatory training video launch	February 2025	June 2025	Delayed due to capacity issues internally, testing due with small cohort of new recruits during June 2025
Update IQPR reporting in line with new Trust Key Strategic Objectives (KSO)	March 2025	May 2025	All KSO A3 meetings planned to be completed by end of May 2025
Experience Based Co-design – toolkit cascade across QVH and ongoing support to key staff	June 2025	November 2025	

Date Raised	Risk Description	Mitigating Actions
April 2025	There is a risk that there will be a lack of clinical engagement caused by workforce challenges and time constraints to roll out and development of the CI programme	New Clinical Learning Forum in place alongside robust communications plan.

Queen Victoria Hospital
NHS Foundation Trust

KSO3

To be an excellent employer

Ambition

Our people are our greatest asset and we need to work hard to develop and deliver our workforce for the future.

Board Assurance Framework

01 Patient services
02 Workforce strategy
03 Physical infrastructure
04 Long term sustainability
06 Financial sustainability
07 Information assets
08 Partner organisations

2025/26 Annual Objectives (draft)

1. Embed Values / Behavioural Framework
2. Deliver Equality Diversity and Inclusion Priorities (to include WRES / WDES / Gender pay gap, Ethnicity pay gap, High impact actions, Culture Transformation Steering Group).

2025/26 Annual goals

1. Improvement in engagement score in staff survey
2. Reduction in bank use / spend by 10% (compared to M8 2024/25 out-turn)
3. Reduction in agency use / spend by 40% (compared to M8 2024/25 out-turn)
4. Vacancy rate under 7%
5. Maintain Sickness rate under 4% throughout 2025/26
6. Freedom to Speak up usage to continue benchmarking positively with comparative organisations
7. 95% of job plans to be signed off by 31 August 2025.

Queen Victoria Hospital
NHS Foundation Trust

KSO3 EXECUTIVE SUMMARY

Temporary staffing use has decreased in M1, with a focus through the temporary staffing reduction oversight group and dedicated management by the Heads of Nursing, with substantive roles being filled and turnover decreasing. This has resulted in a lower vacancy rate in M1 (5.3%).

There were no new grievances raised in M1, however there are currently 31 employee relations cases being worked on / supported. Of these, 11 are informal and 20 are formal cases in line with our policies.

Change management support is available via the organisational development / wellbeing team to support colleagues through the ongoing change across the NHS.

A working group across NHS Sussex is being set up for workforce optimisation. This group will review absence levels and support interventions to reduce sickness absence, review recruitment, redeployment and the delivery of workforce plans. QVH are a participant of this group.

April was stress awareness month. QVH hosted a number of 'unwind spaces' to support employees health and wellbeing. Unwind kits were provided to takeaway. Positive feedback was received from staff. A staff wellbeing survey is being promoted to understand how staff are feeling and what additional support can be provided.

The trust is delivering behavioural framework/toolkit workshops from June to September to provide and understanding of how to apply and embed the framework throughout areas of responsibility.

Helen Edmunds
Chief People Officer

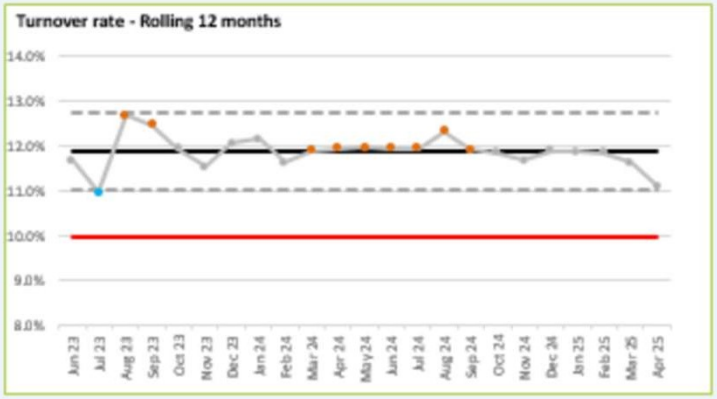
KSO3 BALANCED SCORECARD

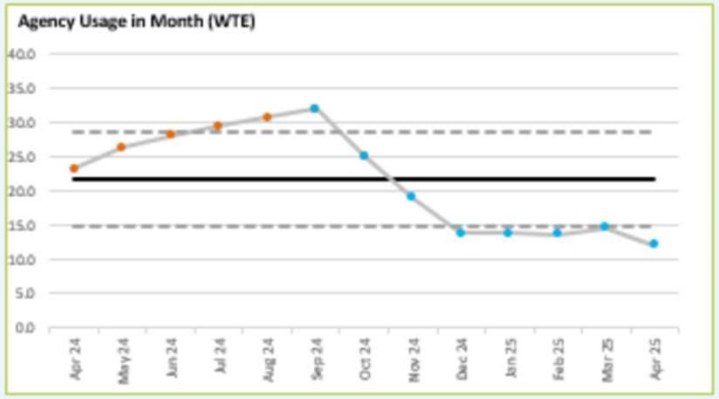
Queen Victoria Hospital
NHS Foundation Trust

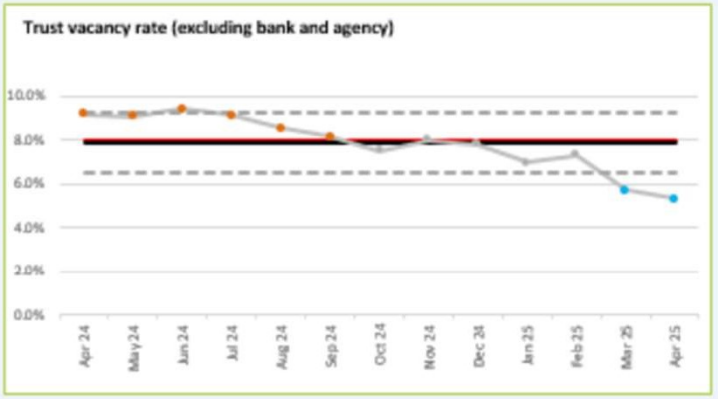
Metric	Latest Month	Target	Variation	Assurance	Actual	Actual Previous Month	Mean	LCL	UCL	Summary
Trust vacancy rate (excluding bank and agency)	Apr-25	8%			5.3%	7.0%	7.8%	6.5%	9.2%	Special Cause - improving variation
Vacancies - Incl Bank & Agency	Apr-25	8%			1.0%	-0.8%	1.9%	-0.6%	4.4%	Common cause - no signficant change
Average Time to Hire - Days	Apr-25	53			68.7	67.3	61.12	21.78	100.46	Common cause - no signficant change
Turnover rate - Rolling 12 months	Apr-25	10%			11.1%	11.6%	11.9%	11.0%	12.7%	Common cause - no signficant change
Sickness absence rate - Rolling 12 months	Apr-25	3%			3.9%	4.0%	3.7%	3.6%	3.9%	Special Cause - concerning variation
Appraisal Rate	Apr-25	90%			83.7%	84.4%	84.4%	81.9%	86.9%	Common cause - no signficant change
Statutory & Mandatory Training Compliance	Apr-25	90%			90.1%	90.3%	92.1%	90.9%	93.2%	Special Cause - concerning variation
Agency Usage in Month (WTE)	Apr-25	-			12.3	14.7	21.78	15.00	28.55	Special Cause - improving variation
Bank Usage in Month (WTE)	Apr-25	-			73.0	98.3	84.20	65.03	103.37	Common cause - no signficant change
Annual Leave Taken	Apr-25	-			14.3%		14.3%			

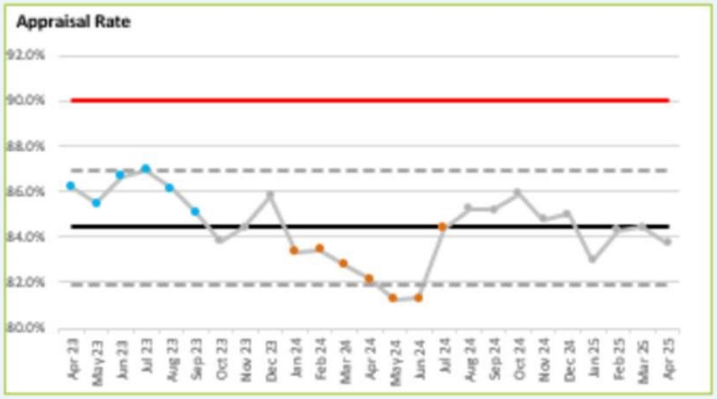
EXCELLENT EMPLOYER KEY METRICS

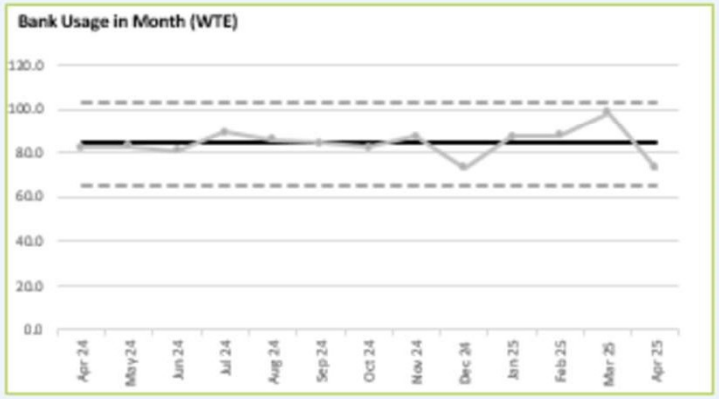
Queen Victoria Hospital
NHS Foundation Trust

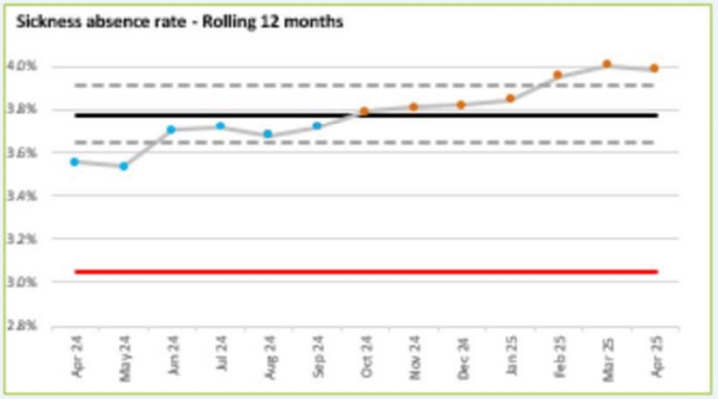












KSO3 AREAS OF FOCUS

Queen Victoria Hospital
NHS Foundation Trust

Area	Summary, impact and actions
People Pulse (Q1 2025/2026)	153 responses, of this 18% demotivated and 12% stressed. Employee Engagement (out of 10) shows positive result: 6.81 (6.41), motivation 6.64 (6.58), Involvement 6.44 (6.38) and Advocacy 7.36 (6.27). However, motivation at QVH declined 6.64 vs 6.92. Support programmes for change management are now available.
Trust vacancy rate (excluding bank and agency)	M1 shows headcount of 1248 (1069.03 Whole Time Equivalent (WTE)) this is an increase from 1240.00 in M12 (1062.55 WTE)
Average Time to Hire - Days	Decrease from M12 to 68.70 in M1, longest delay in Strategy due to delay in funding confirmation at 286 days, Paediatrics had delays with occupational health clearance test results and shortlisting due to high volume, Theatres had 3 shortlisting delays and there were a number of occupational health delays but these were due to candidate tests being required rather than delays with process.
Sickness Absence Rate - Rolling 12 Months	This measure shows 'concerning variation' as performance has been above the mean for 6 months. This measure remains under 4%, which is the system target. The target set within the national operational planning guidance is for sickness to remain under 4%. QVH is a participant of an NHS Sussex working group which will review absence levels and support interventions to reduce sickness absence. It is an ambition for QVH to reduce sickness absence to 3% or less which we are striving to achieve.
Agency Usage In Month (WTE)	Reduction in agency usage from 14.7 in M12 to 12.3 in M1. Highest agency usage was in Allied Health Professional Staff Group at 3.74 WTE, Periop Department at 6.27 WTE; Theatres team at 4.87. Ongoing work underway with Heads of Nursing staff for final sign off and approver for any agency requests within Nursing, rolling out to Medical and Dental over the next month with Clinical Directors and budget holders to approve any requests before going to agency.
Bank Usage In Month (WTE)	Bank has reduced considerably from 98.3 WTE in M12 to 72 in M1. Highest staff group was Nursing at 22.54 with admin & Clerical at 20.77, Periop at 25.91 and Theatres at 10.01 WTE.
Grievances raised	No grievances raised in M1.
% Job plans complete	51% of job plans are currently complete, with focussed work underway and a stretch target of August 2025 to achieve 95%.
Turnover rate	Turnover remains stable at just over 11%. Whilst this is above the 10% target, this has been a static rate for many months. Exit interviews continue to be undertaken and there are no significant patterns / areas of focus.
Statutory and mandatory training	This measure shows 'concerning variation' as there has been a slight reduction in percentage of completion, however is still achieving above 90% completion rate.
Appraisal rate	We continue to strive to meet the 90% completion rate, with a continued focus with managers and highlighting areas that are outstanding.

Queen Victoria Hospital
NHS Foundation Trust

KSO4

To deliver sustainable services

Ambition

That we are cost effective, deliver best value, are committed to our role to support a sustainable environment and the key role of digital in our future pathways and delivery model.

Board Assurance Framework

01 Patient services
02 Workforce strategy
03 Physical infrastructure
04 Long term sustainability
06 Financial sustainability
07 Information assets
08 Partner organisations

2025/26 Annual Objectives (draft)

1. Break even position with delivery of £7.5m Better Value programme initiatives
2. Major Programme: Electronic Patient Record
3. Phase 1 reconfiguration of estates / critical infrastructure
4. System Major Programme: Pathology and imaging networks.

2025/26 Annual goals

1. To deliver the 2025/26 revenue breakeven plan
2. To live within and deliver the capital plan
3. To deliver the £7.5m Best Value programme, including £2.1m corporate cost reduction
4. To ensure the Trust cash requirements are effectively managed
5. To develop the Trust's Medium Term Financial Strategy (MTFS).

Queen Victoria Hospital
NHS Foundation Trust

KSO4 EXECUTIVE SUMMARY

At the close of April 2025, the Trust reported an Income and Expenditure position broadly in line with planned deficit of £0.4m and had a cash balance of £6.9m. Whilst a planned position is positive for M1, there will need to be a significant improvement in Trust contribution to deliver the planned break even position for 2025/26, with the main risk area being delivery of best value schemes of £7.5m (6%) for the year

Income was £0.2m adverse to plan mainly due to an underperformance in activity based income at time of reporting. Subsequent review of uncoded activity has shown that income was close to plan for M1.

Pay overall was broadly in line with recent trends after adjusting for the expected national insurance increase changes in April and estimate of expected pay award increase for 25/26. Agency spend was broadly on trend of recent months and within the 2% target of overall.

The Trust reported delivery of £0.35m efficiencies against plan for M1 of £0.44m. This includes some element of non-recurrent vacancy for M1. Significant level of high-risk schemes remain and significant work is required to ensure the annual £7.5m best value plan is delivered.

The Trust's capital plan for the year was £26.4m of which £18m relates to the CDC. Spend was low in M1 against plan but is expected to catch up in later months.

Simon Marshall
Interim Chief Financial Officer

KSO4 EXECUTIVE SUMMARY

Queen Victoria Hospital
NHS Foundation Trust

Metric	Latest Month	Target	Actual	Actual Previous Month
Breakeven YTD	Apr-25	-£0.43m	-£0.42m	£0.0m
Cash at Bank YTD	Apr-25		£6.9m	£12.9m
Capital Spend YTD	Apr-25	£2.6m	£0.1m	£13.8m
Efficiencies YTD	Apr-25	£0.45m	£0.4m	£6.5m
BPPC (NHS & Non NHS) - volume	Apr-25	95%	91.9%	89.9%
BPPC (NHS & Non NHS) - value	Apr-25	95%	93.6%	89.4%
Agency spend <2% total pay bill	Apr-25	£0.13m	£0.12m	
Agency spend 40% less than 24/25 forecast	Apr-25	£0.124m	£0.12m	
Bank spend reduction of 10% of Total Pay Bill	Apr-25	£0.37m	£0.36m	

KSO4 EXECUTIVE SUMMARY

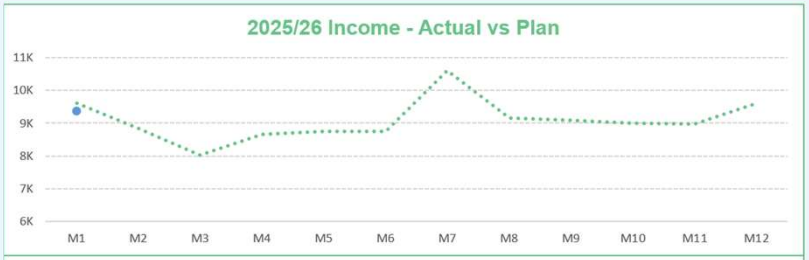
Queen Victoria Hospital
NHS Foundation Trust

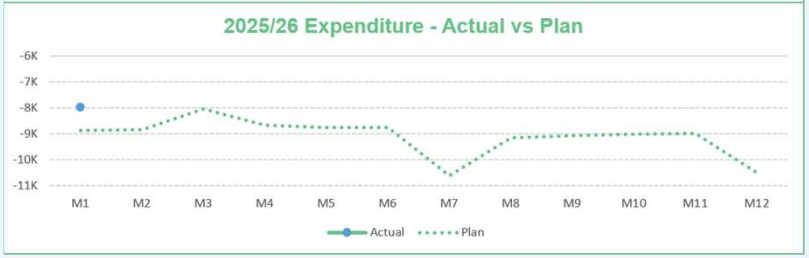
Capital

	In Month £'000			Year to Date £'000			Forecast Outturn £'000s		
	Plan	Actual	Variance	Plan	Actual	Variance	Plan	Actual	Variance
IT	0	0	0	0	0	0	131	131	0
Medical Equipment	83	0	(83)	83	0	(83)	1,000	1,000	0
Estates Maintainance	0	0	0	0	0	0	1,907	1,907	0
Estates Other	750	0	(750)	750	0	(750)	750	750	0
EPR	248	88	(160)	248	88	(160)	2,983	2,983	0
CDC	1,495	0	(1,495)	1495	0	(1,495)	17,949	17,949	0
Other Capital	0	0	0	0	0	0	1,640	1,640	0
Total	2,576	88	(2,488)	2576	88	(2,488)	26,360	26,360	0

Income and Expenditure

	In Month £'000			Year to Date £'000			Forecast Outturn £'000s		
	Plan	Actual	Variance	Plan	Actual	Variance	Plan	Actual	Variance
Income									
Patient Activity Income	9,251	9,019	(232)	9,251	9,019	(232)	114,691	114,691	0
Other Operating Income	350	354	4	350	354	4	4,226	4,226	0
Total Income	9,601	9,373	(228)	9,601	9,373	(228)	118,917	118,917	0
Pay									
Substantive	(5,911)	(5,966)	(55)	(5,911)	(5,966)	(55)	(69,910)	(69,910)	0
Bank	(382)	(361)	21	(382)	(361)	21	(4,228)	(4,228)	0
Agency	(134)	(117)	17	(134)	(117)	17	(1,599)	(1,599)	0
Total Pay	(6,427)	(6,444)	(17)	(6,427)	(6,444)	(17)	(75,737)	(75,737)	0
Total Non-Pay	(2,913)	(2,683)	231	(2,913)	(2,683)	231	(34,943)	(34,943)	0
Total Non Operational Expenditure	(709)	(688)	22	(709)	(688)	22	(8,511)	(8,511)	0
Total Expenditure	(10,049)	(9,814)	235	(10,049)	(9,814)	235	(119,191)	(119,191)	0
Surplus/(Deficit)	(448)	(441)	7	(448)	(441)	7	(274)	(274)	0
Technical Adjustments	23	23	0	23	23	0	274	274	0
Adjusted Surplus / (Deficit)	(425)	(418)	7	(425)	(418)	7	0	0	0





	Annual Target	Forecast Outturn
Income & Expenditure	£0.0m	£0.0m
Cash at bank	£1.9m	£1.9m
Capital Spend	£26.4m	£26.4m
Efficiencies	£7.46m	£7.46m
BPPC (NHS & Non-NHS)		
Volume	95.0%	91.9%
Value	95.0%	93.6%

Further information on the Trust Best Value efficiency programme (CIP delivery against plan) will be included from Month 2 onwards.

KSO4 AREAS OF FOCUS

Queen Victoria Hospital
NHS Foundation Trust

Area	Summary, impact and actions
Breakeven YTD	Position was broadly on plan of £0.4m deficit for M1. Income was £0.2m adverse to plan but following subsequent review of uncoded activity was closer to plan. Reported income underperformance was offset by non-pay underspend.
Cash at Bank YTD	Cash as at M1 was £6.9m against a plan of £5.1m, this was mainly due to delayed payments related to previous year which will be paid in M2.
Capital Spend YTD	The Capital Plan for M1 included £1.5m for CDC and £750k for boiler lease (which was contracted in 24/25). Excluding these items planned spend was £331k in M1 and the underspend in M1 is due mainly to EPR invoices for April not having been received for payment.
Efficiencies (Cost Improvement Plans) YTD	Delivery of £350k vs plan of £453k. Includes element of non-recurrent vacancy. Significant level of high-risk schemes remain and work is being undertaken to ensure the annual £7.5m CIP plan is delivered.
BPPC (NHS & Non-NHS) Volumes	BPPC showed an improvement to the previous month due to a lower number of invoices processed.
BPPC (NHS & Non-NHS) Values	BPPC showed an improvement to the previous month due to a lower number of invoices processed.
Agency spend 40% less than 24/25 forecast	On plan
Agency Spend Less than 2% of Total Pay Bill	On plan
Bank spend reduction of 10% of Total Pay Bill	On plan
Pay Spend	Pay increased to recent trend in M1 mainly due to the expected National Insurance increase and estimate of pay inflation in line with plan
Non-Pay Spend	£0.2m underspent offsetting income underperformance in M1

KSO4 PROJECT REPORT

Queen Victoria Hospital
NHS Foundation Trust

Phase 1 reconfiguration of Estates (including LAU)	Exec Lead: CFO Lead: IDEF	Reporting Month: April-25	Overall Status: R / A / G N/A - New Project

- Estates reconfiguration identified as 2025/26 priority, phases to be defined.
- Initial options for the location of an expanded **Local Anaesthetic Unit (LAU)** will be presented to the Executive Leadership Team (ELT) in June 2025, including associated costings. Will need to explore viable funding opportunities to support this development.
- While a potential location for the expanded LAU has been identified, its feasibility is contingent on ongoing work related to the reconfiguration of inpatient beds, which is currently in progress.

Milestone	Start Date	Expected Completion Date	Commentary
Work is currently underway on the reconfiguration of inpatient beds, which will have an impact on the final location of LAU	May 2025	June 2025	
Options paper was presented to ELT for the expanded LAU	May 2025	June 2025	

Date Raised	Risk Description	Mitigating Actions
20/04/2025	The estates budget presently covers only critical infrastructure maintenance, including essential repairs, statutory compliance, and high-risk remedial works	Explore alternative funding sources such as charitable contributions

KSO4 PROJECT REPORT

Queen Victoria Hospital NHS Foundation Trust

Sussex Pathology Network	Exec Lead: CMO Lead: PMO	Reporting Month: April-25	Overall Status: R / A / G Amber

LIMS – Low Level Design (LLD) are complete and now LIMS is progressing through the first phase of UAT. LIMS and Ordercomms key milestones and timeframes have been agreed and archive details confirmed.
Digital Histopathology (DHP) - All equipment orders have now been received and the slide scanner is undergoing evaluation by the lab technical team. Training sessions are booked with Sectra for PACS access to the stored slide images
Order Comms (ICE) - OCS is currently refining the activities for the current phase of implementation, to ensure that all design and configuration is completed by both Pathology and Radiology ahead of UAT scheduled to start in mid-September. This will align with User Acceptance Testing (UAT) Phase 3 for the LIMS project.
Digital Infrastructure - The scope of this project has recently been reviewed to include the implementation of a shared NPEX and also to facilitate the delivery of the reports from the warehouse. Additional resource has been secured to deliver this. A decision is pending about the procurement of a document archive solution. Procurement support is in place with funding from NHSE capital funds bid.
Managed Service Contract (MSC) - Evaluation teams are currently working on Round 2 responses with moderation sessions booked for June. Round 3 is being collated in preparation for commencement at the end of July.
Network Formation – Dr. Rachael Liebmann has agreed to be the Network SRO for the Pathology Network Formation. A position paper has been circulated to all Trust SROs and onward Trust governance has been completed. Decision made by all Trusts to adopt recommended option 2 - Rework the current Memorandum of Understanding (MOU) with additional terms. This will now be sent to CEOs for sign off.
Laboratory Operating Model (LOM) - An Outline Business Case (OBC) is being written and is due to reach governance by September 2025.Information is being gathered to inform the preferred way forward.
Quality – The project is currently paused and handed over to a reference group for ongoing monitoring. Monthly NHSE PQAD submissions and still being completed and DHP reporting metrics are now included. UKAS ISO 15189:2022 assessments are underway at various laboratories within SPN (QVH ISO15189 Clinical Assessment 9th May 2025)

Milestone	Start Date	Expected Completion Date	Commentary
LIMS User Acceptance Testing to commence	05/05/2025	06/05/2025	
Approval of recommended option for Network Formation and MOU sign off	May 2025	May 2025	
Completion of Round 2 evaluation and moderation for MSC project	May 2025	June 2025	Round 3 scheduled for July 2025 start
Technical completion of 2D barcoding solution for DHP	April 2025	June 2025	Lack off Winpath V5 connectivity/functionality has required alternative data collection approach to be engineered

Date Raised	Risk Description	Mitigating Actions
	Capacity of Trust resourcing insufficient to meet programme timelines	Collaborative working across SPN, agree priority projects, secure additional external resources
	Varying internal governance scheduling delays programme timelines	Assign Trust and Network SROs to manage issues, project boards and steering groups in place, early socialisation of business cases via SROs

KSO4 PROJECT REPORT

Queen Victoria Hospital
NHS Foundation Trust

Electronic Patient Record	Exec Lead: CMO Lead: PMO/EPR team	Reporting Month: April-25	Overall Status: R / A / G Amber

A revised business case summary was approved at Trust Board on 8th May 2025. Recommended option is to proceed with a consolidated clinical go live of Archie EPR programme in Autumn 2025. This has now been communicated to all Trust staff.

A significant amount of work has already been progressed to get the Trust ready for an EPR, including mobilising a team with experience of delivering EPRs, engagement, testing, training strategies and plans approved. Electronic documents have been configured, clinically validated and tested for inpatient documents. Work underway for documents in MIU, Outpatients and Surgical Care. Catalogue build is nearly completed for EPMA.

Governance has been strengthened as the programme has progressed. Within the overall milestone plan, there are activity and milestone trackers around key workstreams including business change, configuration, testing and integration.

Go live readiness assessments at 120, 90, 60, 30 days are being planned prior to go live, including the impact on the Trust from a business continuity perspective.

The Trust has already undertaken stages 1, 2 and 3 of the FD assurance process. We will undertake the 'Moderate Readiness for go live' approach with a draft report from NHSE to assess whether the trust is ready to go live.

PAS planned to go live in Q3/4 2026. Given the complex nature of the programme, the EPR programme board agreed that the programme status is Green/Amber.
Programme finances clarified and included within 2025/26 business planning. Benefits being reviewed for further opportunities with time and motion studies being planned for May/June 2025.

Some challenges regarding finalising a BAU model to support go live and post go live, outpatient scope, accessing Archie at spoke sites, agreeing a reporting approach, MLM/Report writing skills, scope creep.

Milestone	Start Date	Expected Completion Date	Commentary
Archie Go Live	Autumn 2025	Autumn 2025	Programme on track for autumn 25
PAS Go Live	Q3/4 2026	Q3/4 2026	Project on track for Q3/42026. Programme team are finalising project costs in terms of resourcing/supplier costs

Date Raised	Risk Description	Mitigating Actions
Oct-24	Risk of lack of clinical engagement	Medical CAG now established. Additional medical resource is required to support CCIO. SRO is Trust Chief Medical Officer who will also support clinical transformation

Queen Victoria Hospital
NHS Foundation Trust

KSO5

To collaborate with others

Ambition

Core to our future as part of a system, as a leader delivering to multiple Systems and reflecting our ambition in regard to anchor, NHS, academic & commercial activities for the future.

Board Assurance Framework

01 Patient services
02 Workforce strategy
03 Physical infrastructure
04 Long term sustainability
06 Financial sustainability
07 Information assets
08 Partner organisations

2025/26 Annual Objectives (draft)

1. Development of strategic partnerships to deliver corporate sustainability
2. Major Programme: QVH Local - Community Diagnostic Centres at East Grinstead and Bognor
3. Contribution to Sussex Major Services Review.

2025/26 Annual goals

1. Explore and develop a collaborative and sustainable partnership model
2. Deliver Year 1 priorities for the QVH Local model and development of the new build for East Grinstead CDC.
3. To contribute to the Sussex Major Services Review (MSR).

Queen Victoria Hospital
NHS Foundation Trust

KSO5 EXECUTIVE SUMMARY

Local Offer
An options paper regarding the proposed QVH Local, medical model, including frailty and enablement was presented to the Executive Leadership Team (ELT) on 7 April 2025 following approval of the *QVH Strategy 2025-2030* in November 2024. A phased approach was endorsed, to be delivered over the next five years in alignment with the overarching strategy. The initial phase, spanning years one and two, will aimed to focus upon redesigning the existing QVH community and rehabilitation services to enhance productivity, efficiency, and financial sustainability. This foundational work will support the future development of a proactive frailty service, which remains a longer-term strategic objective. Development of an implementation plan is underway, incorporating clear timelines and performance metrics. Engagement efforts are in progress to secure support from clinicians and service managers. The immediate priority is to assess capacity and demand, with a focus on increasing service activity to drive additional income. Concurrently, other factors contributing to operational efficiencies are being identified and targeted for improvement. As part of this programme development the team are working collaboratively with primary care, the wider primary care network, community services, and the ICB to enhance and further develop partnership working. This directly contributes to the Major Services Review (MSR) ambition for Sussex wide collaboration (see below).

Major Services Review
In 2023, the health and local authority partners in Sussex published the Improving Lives Together (ILT) strategy which recognised that public services needed to come together differently to improve health outcomes for patients. Achieving the system's ambition is centred on three agreed long-term priorities: a new joined up community approach through Intergrated Neighbourhood Teams (INTs); growing and developing the workforce and improving the use of digital technology and information. Following this, a detailed case for change was developed in 2024, which outlined seven key opportunities and priorities for improvement across the Sussex ICB. The case for change and priority areas were agreed by the Committee in Common, ICB Board and the Clinical and Care Professional Leadership Group. Of the seven opportunities identified, two areas have been prioritised for further work as part of the Major Services Review (MSR) - the response to move Sussex into the next phase of health and care. Namely 'Core Urgent and Emergency Care' (UEC) and 'Rehabilitation and Intermediate Care'. Initially best practice care models for these workstreams will be co-designed with clinicians and key stakeholders through a series of design groups. QVH attended the first of these groups on 13 May 2025. The final group is expected to be held on 23 June 2025.

CDC – East Grinstead and Bognor
Full Business case including build costs for the East Grinstead CDC approved by the Finance and Performance Committee and will be submitted to Trust Board for approval at the end of May. Key areas of focus over the next period are continuing to optimise current CDC activity in East Grinstead and negotiation with University of Chichester on Heads of Terms for the Bognor programme.

Kathy Brasier
Deputy Chief Strategy Officer

KSO5 PROJECT REPORT

Queen Victoria Hospital
NHS Foundation Trust

Community Diagnostics Centre	Exec Lead: DCEO Lead: PMO	Reporting Month: Apr-25	Overall Status: QVH – Green Bognor - Red

Programme for the delivery of CDCs within the QVH site and on the University of Chichester site (Bognor).

Progress has been made within the following areas at both sites:

1. Planning permission approved on 16th April 2025..
2. EG FBC and tender (with build costs) was approved at Finance and Performance Committee on 20th May 2025. Final business case due to go to Board on 27th May 2025. with the build costs included.
3. Engagement continues with University of Chichester regarding next steps for the Bognor site.
4. Current EG CDC activity is at 64% for 2024/25 compared to the plan, and income is not realised. Urgent remedial work continues to get back to plan. Activity against plan was at 110% for April 2025.

Key areas for focus over the next period are getting approval from the Trust Board for the Full Business Case and the build costs, continuing to optimise current CDC activity in East Grinstead and negotiation with University of Chichester on Heads of Terms for the Bognor project.

Milestone	Start Date	Expected Completion Date	Commentary
Agreement on Heads of Terms	30/4/25	30/6/25	Discussions with University of Chichester on new site for Bognor. Delays in obtaining a draft Heads of Terms from the University.
Full business case development including cost of build	30/4/25	30/5/25	QVH CDC Business Case to Trust Board May 2025 to include tender costs.
Full reporting of CDC activity and plan	30/4/25	30/5/25	Reporting template and CDC modality inputs being developed.

Date Raised	Risk Description	Mitigating Actions
01/01/2025	NHS Funding long-term availability	Trust engaging with ICB and NHSE regarding funding requirements
01/01/25	Governance – FBC approval	Business case with costs approved by F and P.
04/04/25	Actual CDC activity vs plan	Urgent remedial actions being taken to bring back to plan

Trajectories- Operational performance

Queen Victoria Hospital
NHS Foundation Trust

RTT	M1	M2	M3	M4	M5	M6	M7	M8	M9	M10	M11	M12
52ww	2.3%	2.3%	2.1%	1.9%	1.8%	1.6%	1.6%	1.5%	1.4%	1.3%	1.2%	1%
1st appointment	68%	68.8%	69.9%	71.2%	71.6%	72.3%	72.6%	73.7%	74.4%	74.4%	74.8%	75.3%
18 week performance	55.5%	56%	55.5%	56.9%	57.6%	58.5%	59.3%	59.6%	59.9%	60.6%	61.0%	62.4%

Cancer (reported a month in arrears)	M1	M2	M3	M4	M5	M6	M7	M8	M9	M10	M11	M12
FDS	79.4%	79.9%	80.0%	80.4%	80.8%	80.8%	81.0%	80.4%	81.0%	80.0%	80.4%	80.8%
62 days	70.8%	71.4%	71%	72.2%	72.9%	73.2%	75.3%	75.7%	71.8%	71%	75.7%	75.7%

UEC	M1	M2	M3	M4	M5	M6	M7	M8	M9	M10	M11	M12
4 hr standard	98.4%	98.6%	99.0%	98.6%	97.8%	99.2%	98.1%	98.4%	99.1%	99.5%	98.1%	99.0%

Key

Performance achieved trajectory

Performance did not achieve trajectory

Interpretation of Summary Icons for Statistical Process Charts

Queen Victoria Hospital NHS Foundation Trust

Variation/Performance	Assurance: P	Assurance: ?	Assurance: F	Assurance: ○
H	**Excellent** Celebrate and Learn • This metric is improving • Your aim is high numbers, and you have some • You are consistently achieving the target because the current range of performance is above the target	**Good** Celebrate and Learn • This metric is improving • Your aim is high numbers, and you have some • Your target lies within the process limits so we know that the target may or may not be achieved	**Concerning** Celebrate but Take Action • This metric is improving • Your aim is high numbers, and you have some • HOWEVER, your target lies above the current process limits so we know that the target may or may not be achieved without change	**Excellent** Celebrate • This metric is improving • Your aim is high numbers, and you have some • There is currently no target set for this metric
L	**Excellent** Celebrate and Learn • This metric is improving • Your aim is low numbers, and you have some • You are consistently achieving the target because the current range of performance is below the target	**Good** Celebrate and Learn • This metric is improving • Your aim is low numbers, and you have some • Your target lies within the process limits so we know that the target may or may not be achieved	**Concerning** Celebrate but Take Action • This metric is improving • Your aim is low numbers, and you have some • HOWEVER, your target lies below the current process limits so we know that the target may or may not be achieved without change	**Excellent** Celebrate • This metric is improving • Your aim is low numbers, and you have some • There is currently no target set for this metric
○	**Good** Celebrate and Understand • This metric is currently not changing significantly • It shows the level of natural variation you can expect to see • HOWEVER, you are consistently achieving the target because the current range of performance exceeds the target	**Average** Investigate and Understand • This metric is currently not changing significantly • It shows the level of natural variation you can expect to see • Your target lies within the process limits so we know that the target may or may not be achieved	**Concerning** Investigate and Take Action • This metric is deteriorating • Your aim is low numbers, and you have some high numbers • Your target lies below the current process limits so we know that the target will not be achieved without change	**Average** Understand • This metric is currently not changing significantly • It shows the level of natural variation you can expect to see • There is currently no target set for this metric
H	**Concerning** Investigate and Understand • This metric is deteriorating • Your aim is low numbers, and you have some high numbers • HOWEVER, you are consistently achieving the target because the current range of performance is below the target	**Concerning** Investigate and Take Action • This metric is deteriorating • Your aim is low numbers, and you have some high numbers • Your target lies within the process limits so we know that the target may or may not be achieved	**Very Concerning** Investigate and Take Action • This metric is deteriorating • Your aim is low numbers, and you have some high numbers • Your target lies below the current process limits so we know that the target will not be achieved without change	**Concerning** Investigate • This metric is deteriorating • Your aim is high numbers, and you have some low numbers • There is currently no target set for this metric
L	**Concerning** Investigate and Understand • This metric is deteriorating • Your aim is high numbers, and you have some low numbers • HOWEVER, you are consistently achieving the target because the current range of performance is above the target	**Concerning** Investigate and Take Action • This metric is deteriorating • Your aim is high numbers, and you have some low numbers • Your target lies within the process limits so we know that the target may or may not be achieved	**Very Concerning** Investigate and Take Action • This metric is deteriorating • Your aim is high numbers, and you have some low numbers • Your target lies above the current process limits so we know that the target will not be achieved without change	**Concerning** Investigate • This metric is deteriorating • Your aim is high numbers, and you have some low numbers • There is currently no target set for this metric

SPC Chart Key:

- Mean
- Target
- Process limits
- Special cause - concern
- Special cause - improvement

GLOSSARY

Queen Victoria Hospital
NHS Foundation Trust

Abbreviation	Definition
AfC	Agenda for Change
AHP	Allied Health Professionals
BAF	Board Assurance Framework
BLS	Basic Life Support
BPPC	Better Practice Payment Code
BU	Business Unit
CD	Clinical Director
CDC	Community Diagnistic Centre
CDEL	Capital Departmental Expenditure Limit
CDI	Clostridium difficile infection
CEO	Chief Excutive Officer
CFO	Chief Financial Officer
CI	Continuous Improvement
CMO	Chief Medical Officer
CNO	Chief Nursing Officer
COO	Chief Operating Officer
COTD	Cancellations on the Day
CPO	Chief People Officer
CQC	Care Quality Commission
CQUIN	Commissioning for Quality and Innovation
CRL	Capital resource Limit
CSO	Chief Strategy Officer
DATIX	Reporting system for reporting clinical incidents
DM01	Diagnostic waiting times and activity
DNA	Did Not Attend
DSU	Day Surgery Unit
DTA	Decision to Admit
EDI	Equality, Diversity and Inclusion
ENT	Ear Nose and Throat
EPR	Electronic Patient Record
ER	Employee Relations
ERF	Elective Recovery Fund

Abbreviation	Definition
ESR	Electronic Staff Record
F2SU	Freedom to Speak Up
FBC	Full Business Case
FDS	Faster Diagnosis Standard
FFT	Friends and Family Test
FPT	Full Patient Transfers
GA	General Anaesthetic
GIRFT	Getting It Right First Time
GM	General Manager
H&N	Head and Neck
HoD	Head of Department
ICB	Integrated Care Board
ICE	Integrated Clinical Environment
ICS	Integrated Care System
IP	Inpatients
IPACT	Infection Prevention and Control Team
IS	Independent Sector
KPI	Key Performance Indicator
KSO	Key Strategic Objective
LAB	Local Academic Board
LAU	Local Anaesthetic Unit
LEEP	Leadership through Education for Excellent Patient Care
LFG	Local Faculty Group
LIMS	Laboratory Information Management System
MAST	Mandatory and Statutory Training
MIU	Minor Injuries Unit
MRSA	Methicillin-resistant Staphylococcus Aureus
MSC	Managed Service Contract
MSK	Musculoskeletal
MSSA	Meticillin Sensitive Staphylococcus Aureus
NHSE	NHS England
NICE	National Institute for Health and Care Excellence

Abbreviation	Definition
OBC	Outline Business Case
OD&L	Organisational Development & Learning
OH	Occupational Health
OIP	Outline Implementation Plan
OMFS	Oral and Maxillofacial surgery
OPD	Outpatients Department
OPPROC	Outpatient Procedure
PAS	Patient Administration System
PDC	Public Dividend Capital
PDSA	Plan, Do, Study, Act
PID	Project Initiation Document
PIFU	Patient Initiated Follow Up
PLACE	Patient-Led Assessments of the Care Environment
PROM	Patient Related Outcome Measures
PSIRF	Patient Safety Incident Response Framework
PTL	Patient Tracking List
QNET	Queen Victoria Hospital's intranet
QP	Quality Priority
RTT	Referral to Treatment
SDP	Shared Delivery Plan (NHS Sussex)
SLNB	Sentinel Lymph Node Biopsy
SPC	Statistical Process Control
SPN	Sussex Pathology Network
SSCA	Surrey and Sussex Cancer Alliance
TMJ	Temporomandibular Joint Dysfunction
VPR	Violence Prevention Reduction
VWA	Value Weighted Activity
WRED	Workforce Disability Equality Standard
WRES	Workforce Race Equality Standard
WTE	Whole Time Equivalent

Report cover-page					
References					
Meeting title:	Board of Directors				
Meeting date:	10/07/2025	**Agenda reference:**	**45-25**		
Report title:	QVH 2024 NHS Staff Survey Results				
Sponsor:	Helen Edmunds, Chief People Officer				
Author:	Annette Byers, Head of Organisational Development & Learning Lawrence Anderson, Deputy Chief People Officer				
Appendices:	None				
Executive summary					
Purpose of report:	To share the results of the NHS 2024 Staff and Bank Workers survey and additional information from the People Pulse quarterly survey and Health and Wellbeing local survey.				
Summary of key issues	The paper sets out the findings in relation to: • QVH substantive Trust, directorate and Business Unit results • Benchmarking against previous year's results • Benchmarking against other Specialist Acute Trust results • QVH WRES/WDES findings • People Pulse Survey and Health and Wellbeing Survey **QVH results overview**: Of the 7 People Promise elements, when rounding up, QVH showed an improvement on 0, the same on 4 and 3 small decreases compared to 2023. On the themes of staff engagement and morale, QVH also showed a small decline. QVH surveyed **1185** eligible substantive staff compared to **1123** in 2023. Of these, **683** responded making a **58%** return, a slight decrease from **59%** in 2023 Key areas for improvement are experiences of staff who declare a disability and staff feeling staff to speak up.				
Recommendation:	The Board is asked to note the information and the next steps arising from the information detailed in the NHS Staff Survey 2024 report and additional local reports relating to staff health and wellbeing.				
Action required	Approval	**Information**	Discussion	Assurance	Review
Link to key strategic objectives (KSOs):	KSO1: To deliver outstanding care	KSO2: To innovate and improve	**KSO3**: **To be an excellent employer**	KSO4: To deliver sustainable services	KSO5: To collaborate with others
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:	30/06/2025	Decision:		

Next steps:	Work continues with teams to support action plans arising from the staff survey results. The Health and Wellbeing team are providing support for staff where required.

Report to: Board of Directors
Agenda item: 45-25
Date of meeting: 10 July 2025
Report from: Helen Edmunds, Chief People Officer
Report author: Annette Byers, Head of Organisational Development and Learning
Lawrence Anderson, Deputy Chief People Officer
Date of report: 10 June 2025
Appendices: None

QVH 2024 NHS Staff Survey Results / People Pulse & Health and Wellbeing Survey information

Executive summary

The results for Queen Victoria Hospital (QVH) NHS Staff Survey 2024 highlights both positive trends and areas for improvement in staff experiences:

- QVH surveyed **1185** eligible substantive staff compared to **1123** in 2023. Of these, **683** responded making a **58%** return, a slight decrease from **59%** in 2023
- Overall the results are similar to the 2023 results. Compared to other acute specialist trusts the Trust is scoring average or above average in the seven people promise themes. Of the 7 People Promise themes, when rounding up, QVH showed an improvement on 0, the same on 4 and 3 small decreases compared to 2023
- 93% of respondents would recommend the care the Trust provides to family or friends
- 88.7% of respondents said patient care is the Trust's top priority – this is above the national average
- 76% of respondents would recommend the Trust as a place to work
- Overall, QVH staff engagement saw a small decline but remains above the national average for Acute Specialist Trusts.
- Recommendations include targeted interventions to support staff wellbeing and experiences, in particular those staff who declared a disability and ongoing engagement to support staff feeling safe to speak up

1. Introduction

1.1 Questions in the NHS Staff Survey are aligned to the People Promise (PP) as well as staff engagement and morale. The PP sets out the things that would most improve our working experience – like health and wellbeing, the opportunity to work flexibly, and to feel we all belong, whatever our background or our job:

1.2 To improve inclusion, belonging and encourage increased participation, the following changes have been made for the 2024 NHS staff survey:

- Permission to recontact question - To support recruitment for cognitive testing to develop future surveys, a new recontact question was added to the 2024 survey (including the survey for bank only workers). This question is only included in the online version of the survey, not for staff completing via the paper questionnaire.
- Suppression - Picker will now apply a double level of suppression for any output that includes a breakdown of the organisation's results by an element (e.g., locality, demographic, etc.).
  - *If only one suppression is applied within a breakdown, the next smallest value will also be suppressed, even if it exceeds the suppression threshold.*
  - *If two or more have the same next smallest value, the one listed first alphabetically will be suppressed.*

This approach ensures the anonymity of individuals within any single suppressed breakdown is protected.

1.3 Each of the 7 PP elements and 2 themes are broken into individual sub-scores. 119 questions were in the substantive 2024 survey, of these, 113 can be compared to 2023 and 101 can be positively scored. QVH results include every question where the minimum 10 responses were received. 48 questions were asked in the bank workers 2024 survey.

1.4 QVH launched the survey on 7 October and closed on 29 November 2024 allowing a period of 8 weeks for staff to have their say. During this time, weekly response rates were emailed to all areas and Workforce & Organisational Development engaged with departments and individuals through meetings, communications, drop-in sessions and walkabouts. Additional trust-wide communications was undertaken, along with promotion of the staff survey at Team Briefs.

1.5 QVH continues to run a mixed mode survey based on the 2023 return rates, with specific areas targeted to receive a paper survey.

1.6 QVH surveyed **1185** eligible substantive staff compared to **1123** in 2023. Of these, **683** responded making a **58%** return, a slight decrease from **59%** the year before. QVH surveyed **182** eligible bank workers compared to **181** in 2023. Of these, **68** responded making a 37% return, an increase from 25% the year before.

1.7 The 2024 benchmarking group for acute specialist trusts has 13 organisations which showed a median **57%** return rate.

2. Substantive headline results

2.1 Of the **7** PP elements, when rounding up, QVH showed an improvement on **0**, remained the same on **4** and had **3** small decreases compared to 2023. On the themes of staff engagement and morale, QVH also showed a small decline.

2.2 The most improved score was for ‘don’t work any additional unpaid hours per week for this organisation, over and above contracted hours’.

2.3 The most declined score was for ‘staff involved in an error/near miss / incident treated fairly

2.4 Core results on patient care, QVH as a place to work and standard of treatment are shown below. When rounding up, QVH has seen no change for Q25a, a 1% decrease for Q25c and no change for Q25d. Compared to the comparator group, QVH is above average for Q25a and Q25d and average for Q25b.

Q25a
Care of patients / service users is my organisations top priority

	2020	2021	2022	2023	2024
Your org	87.40%	88.38%	90.74%	89.17%	88.68%
Best result	91.98%	90.20%	90.74%	90.97%	91.69%
Average result	89.38%	87.74%	84.45%	85.64%	86.06%
Worst result	82.94%	79.02%	80.54%	81.07%	78.89%
Responses	594	636	606	656	678

Q25c
I would recommend my organisation as a place to work

	2020	2021	2022	2023	2024
Your org	71.40%	70.80%	71.74%	75.16%	73.34%
Best result	79.60%	74.29%	78.17%	82.98%	82.90%
Average result	74.66%	70.80%	68.45%	71.12%	73.34%
Worst result	65.89%	56.39%	61.22%	62.46%	63.04%
Responses	593	637	604	655	676

Q25d
If a friend or relative needed treatment I would be happy with the standard of care provided by this organisation

	2020	2021	2022	2023	2024
Your org	93.96%	93.00%	92.64%	92.86%	93.04%
Best result	95.74%	94.30%	92.64%	94.05%	93.23%
Average result	91.83%	89.92%	86.47%	87.83%	89.44%
Worst result	82.17%	69.10%	71.47%	73.90%	72.39%
Responses	594	637	605	653	677

2.5 Staff engagement scores are calculated from nine core questions grouped into three categories (advocacy, involvement and motivation). The QVH engagement score is **7.4** (out of 10), a small decrease from 2023 (7.5), but still above comparator group average (7.3).

2.6 Looking at results (out of 10) in relation to staff experiences with protected characteristics, those who declare as disabled are less positive than other groups.

3. Bank workers headline results

3.1 Of the **7** PP elements, when rounding up, QVH showed an improvement on **3**, remained the same on **3** and had **1** small decrease compared to 2023 results. On the themes of staff engagement and morale, QVH showed improved results.

3.2 Core results on patient care, QVH as a place to work and standard of treatment have seen a **4.5%** decrease for Q30a – care of patients (91% v 95.5%), a **1%** increase for Q30c - place to work (85.1% v 84.1%), and a **3%** increase for Q30d – standard of treatment (98.5% v 95.5%).

People Promise elements, sub-scores and themes in detail

4. Promise 1: We are compassionate and inclusive

	Compassionate culture	Compassionate leadership	Diversity and equality	Inclusion
Your org	7.91	7.27	8.41	7.17
Best result	8.32	7.66	8.81	7.41
Average result	7.82	7.10	8.28	6.97
Worst result	7.27	6.79	7.74	6.64
Responses	678	678	676	677

PP1 overall change: *decreased (7.7 vs 7.8 out of 10)*
Rating compared to benchmarking group: *0.2 above average*

4.1 Promise 2: We are recognised and rewarded

PP2 overall change: *remained the same (6.3 vs. 6.3 out of 10)*
Rating compared to benchmarking group: *0.2 above average*

4.2 Promise 3: We each have a voice that counts

	Autonomy and control	Raising concerns
Your org	7.10	6.80
Best result	7.50	7.51
Average result	7.17	6.76
Worst result	6.88	6.51
Responses	680	675

PP3 overall change: *decreased (7.0 vs 7.1 out of 10)*
Rating compared to benchmarking group: *average*

4.3 Promise 4: We are safe and healthy

	Health and safety climate	Burnout	Negative experiences
Your org	5.72	5.48	8.23
Best result	6.52	5.82	8.60
Average result	5.97	5.38	8.16
Worst result	5.32	4.93	7.86
Responses	680	680	676

PP4 overall change: *remained the same (6.5 vs 6.5 out of 10)*
Rating compared to benchmarking group: *average*

4.4 Promise 5: We are always learning

	Development	Appraisals
Your org	6.73	5.05
Best result	7.03	5.70
Average result	6.68	5.06
Worst result	6.20	4.53
Responses	680	650

PP5 overall change: *decreased (5.9 vs 6.1 out of 10)*
Rating compared to benchmarking group: *average*

4.5 Promise 6: We work flexibly

	Support for work-life balance	Flexible working
Your org	6.65	6.61
Best result	7.05	6.92
Average result	6.64	6.57
Worst result	6.09	6.01
Responses	677	671

PP6 overall change: *remained the same (6.6 vs 6.6 out of 10)*
Rating compared to benchmarking group: *average*

4.6 Promise 7: We are a team

	Team working	Line management
Your org	6.81	7.19
Best result	7.23	7.58
Average result	6.81	7.08
Worst result	6.58	6.75
Responses	658	657

PP7 overall change: *remained the same (7.0 vs 7.0 out of 10)*
Rating compared to benchmarking group: *0.1 above average*

4.7 Theme: Staff Engagement

	Motivation	Involvement	Advocacy
Your org	7.26	7.01	7.93
Best result	7.32	7.46	8.38
Average result	7.09	7.05	7.83
Worst result	6.90	6.74	7.00
Responses	678	680	678

Staff Engagement overall change: *decreased (7.4 vs 7.5 out of 10)*
Rating compared to benchmarking group: *0.1 above average*

4.8 Theme: Morale

	Thinking about leaving	Work pressure	Stressors
Your org	6.45	5.65	6.57
Best result	6.75	6.60	6.99
Average result	6.34	5.97	6.62
Worst result	5.88	5.08	6.35
Responses	678	680	677

Morale overall change: *decreased (6.2 vs 6.3 out of 10)*
Rating compared to benchmarking group: *0.1 below average*

5. Staff engagement

5.1 QVH overall engagement score slightly decreased to **7.4** compared to 2023 (7.5). Compared to our benchmarking group (7.3), QVH rank **above average**. The engagement scores for estates and facilities and for nursing have seen the largest reductions.

Age: 31-40 age group are more engaged than other groups (7.6 vs org average of 7.4) which has significantly improved since 2021 (6.6). 21–30 has the lowest engagement score (7.2 vs 7.4) which takes this group back to the level they were at in 2022 (7.2). Motivation for this group is still significantly below the Trust score (6.8 vs 7.3).

Ethnicity: Staff from a Mixed, Multiple, Asian, Asian British, Black, African, Caribbean, Black British or Other Ethnic Group are significantly more engaged than those from a White background (7.9 vs 7.3). In particular Asian, Asian British staff are significantly more motivated (8.1 vs 7.1) compared to 7.1 for White staff). Asian and Asian British staff are also significantly more involved than staff from a white background (7.5 vs 7.0).

Religion: Hindu staff members are significantly more engaged than 2023 (8.1 vs 6.5) and both Hindu and Muslim staff are significantly more motivated than the Trust scores for this area (8.3 & 7.9 vs org score 7.3). In addition Hindu staff are significantly more engaged in involvement (7.8 vs 7.0). Christian staff members and those who specified no religion were comparable to the organisation average across all areas.

6. 2024 Staff Survey changes

6.1 Questions/areas of improvement

In addition to comparator group changes, a more in-depth analysis of the survey questions data highlights specific questions/areas where QVH has improved by over 3%:

PP	Q	Description	2021	2022	2023	2024	Increase
	q10c	Don't work any add unpaid hrs per week for this organisation, over/above contracted hrs	49.4%	41.9%	43.2%	42.4%	7.0%
7	q7b	Team members often meet to discuss the team's effectiveness	66.3%	59.3%	65.3%	60.9%	5.4%
	q10b	Don't work any add paid hrs per week for this organisation, over/above contracted hrs	64.0%	65.4%	61.0%	59.8%	4.3%
4	q11d	In last 3 months, have not come to work when not feeling well enough to perform duties	55.9%	55.7%	51.4%	52.4%	3.5%
7	q9a	Immediate manager encourages me at work	76.8%	71.7%	73.8%	73.5%	3.3%
	q18	Not seen any errors/near misses/incidents that could hurt staff/patients/service users	72.7%	*	71.2%	69.8%	3.0%

6.2 Questions/areas for development

In addition to comparator group changes, further analysis of the data identifies areas where QVH has decreased more than 3% and this therefore provides areas for improvement:

PP	Q	Description	2021	2022	2023	2024	Increase
	q19a	Staff involved in an error/near miss/incident treated fairly	*	65.0%	71.3%	62.4%	-8.8%
	q14d	Last experience of harassment/bullying/abuse reported	50.0%	55.8%	58.1%	50.2%	-7.9%
3	q25e	Feel safe to speak up about anything that concerns me in this organisation	70.7%	71.1%	74.3%	67.2%	-7.1%
2	q4b	Satisfied with extent organisation values my work	49.0%	51.3%	54.1%	48.5%	-5.5%
1	q8c	Colleagues are polite and treat each other with respect	72.4%	76.2%	78.3%	73.3%	-5.0%
M	q26c	I am not planning on leaving this organisation	62.5%	64.9%	68.5%	63.6%	-4.9%
M	q26b	I am unlikely to look for a job at a new organisation in the next 12 months	52.7%	54.7%	60.4%	55.9%	-4.5%
1	q6a	Feel my role makes a difference to patients/service users	90.4%	89.2%	92.0%	87.8%	-4.2%
3	q25f	Feel organisation would address any concerns I raised	58.0%	60.2%	61.4%	57.2%	-4.2%
3	q3f	Able to make improvements happen in my area of work	55.5%	58.8%	60.6%	56.6%	-3.9%
6	q6c	Achieve a good balance between work and home life	57.0%	60.0%	61.9%	58.1%	-3.8%
2	q4a	Satisfied with recognition for good work	58.8%	59.7%	61.6%	58.0%	-3.7%
3	q5b	Have a choice in deciding how to do my work	58.2%	57.9%	58.8%	55.2%	-3.5%
	q19c	Organisation ensure errors/near misses/incidents do not repeat	*	71.9%	73.9%	70.4%	-3.5%
5	q24e	Able to access right learning and development opportunities when I need to	63.6%	63.7%	70.5%	67.2%	-3.3%
6	q6b	Organisation is committed to helping balance work and home life	50.2%	53.4%	56.8%	53.7%	-3.1%
3	q3a	Always know what work responsibilities are	86.3%	89.5%	90.0%	86.9%	-3.1%
4	q12b	Never/rarely feel burnt out because of work	37.8%	37.6%	42.1%	39.1%	-3.0%

7. Themes summary

All People Promise scores / sub-scores based on all elements and themes

7.1 The majority of PP Elements and themes have remained the same or shown a very small decrease within the 2024 NHS Staff Survey, but some must remain a focus in order to continue enhancing staff experience, these include:

7.1.1 **Overall scores**: The areas where QVH scores declined:

- PP1: We are compassionate and inclusive (7.7 vs 7.8)
- PP3: We each have a voice that counts (7.0 vs 7.1)
- PP5: We are always learning (5.9 vs 6.0)
- Theme: Staff Engagement (7.4 vs 7.5)
- Theme: Morale (6.2 vs 6.3)

7.1.2 **Sub-scores**: Ten PP sub-scores decreased in 2024, the biggest declined results are:

- PP3: We each have a voice that counts – Raising concerns (6.8 vs 7.0)
- PP5: We are always learning – Appraisals (5.0 v 5.3)
- Theme: Staff Engagement – Advocacy (7.9 vs 8.1)
- Theme: Morale – Thinking about leaving (6.5 vs 6.7)

7.1.3 **Continued improvement scores**: Three areas have continued to improve since 2023:

- PP4: We are safe and healthy - negative experiences (increased to 8.3 v 8.1)
- PP6: We work flexibly - flexible working (6.6 vs 6.5)
- PP7: We are a team - team working (6.9 vs 6.8)

Having looked at each of these areas in detail, the following groupings shown are where the scores are particularly lower than the organisation average:

- PP1: We are compassionate and inclusive (Estates & Ancillary)
- PP3: We each have a voice that counts, raising concerns (Disabled, Estates & Ancillary and those aged 21-30)
- PP5: We are always learning, Appraisals (Disabled, Estates & Ancillary, Medical and Dental and those aged 51-65)
- Theme: Morale, Thinking about leaving (Admin & Clerical, Disabled and those aged 21-30)
- Theme: Staff Engagement, advocacy (general decline across all results)

7.2 **WRES/WDES results**: Looking at the WRES/WDES data and returns, QVH needs to focus on improving staff engagement with staff to improve workplace experience. The main area of focus relates to the experience of staff who have a disability or long-term health condition, with actions focussed on improving their experience in the workplace.

7.3 **Retention**: staff were asked if they were looking for another job, the table below shows comparator findings for the past three years. QVH shows some positive results compared to the benchmarked group.

	Q26d If you are considering leaving your current job, what would be your most likely destination?											
	I would want to move to another job within this organisation.		I would want to move to a job in a different NHS Trust /organisation.		I would want to move to a job in healthcare, but outside the NHS.		I would want to move to a job outside healthcare.		I would retire or take a career break.		I am not considering leaving my current job.	
	Avg.	QVH	Avg.	QVH	Avg.	QVH	Avg.	QVH	Avg.	QVH	Avg.	QVH
2024	12.3%	**9.0%**	16.6%	**14.8%**	4.1%	**4.3%**	6.9%	**6.0%**	6.9%	**10.2%**	52.8%	**55.8%**
2023	11.8%	**6.1%**	18.2%	**14.0%**	4.9%	**3.4%**	7.4%	**7.4%**	7.7%	**9.0%**	51.8%	**60.2%**
2022	11.2%	**8.8%**	19.9%	**15.3%**	5.4%	**5.6%**	9.0%	**9.0%**	7.2%	**10.6%**	48.6%	**50.8%**

8. People Pulse Survey / Health and Wellbeing Survey results

8.1 The quarterly People Pulse Survey results received in May 2025 had a 13% response rate from staff. Of those who responded:

8.1.1 47.7% said the organisation was proactively supporting their health and wellbeing. 73% have had a wellbeing conversation with their manager in the past 3 months.

8.1.2 47.7% said they felt well informed about important changes taking place in the organisation.

8.1.3 51.2% indicated they had a positive mood. 75% said they support each other in their teams. Those who indicated a negative mood gave reasons of not feeling supported by other staff and having a high workload.

8.1.4 93% said if a friend or relative needed care, they would be happy with the standard of care QVH provides.

8.1.5 The next People Pulse survey results are due in July 2025.

8.2 The Health and Wellbeing team have a local survey running throughout June to gain greater insights into how staff are feeling at the current time, given the pressures and changes across the NHS.

8.2.1 Responses are starting to come through, with initial feedback suggesting some staff are feeling anxious, with unresolved issues in their teams, there is also comments relating to an inability to take breaks due to workload pressures.

8.2.2 Once the survey closes the feedback will be reviewed to determine areas of focus for the health and wellbeing team during the next quarter.

9. Executive Leadership Team – review of 2024 staff survey

9.1 The Executive Leadership Team (ELT) undertook a review of the 2024 staff survey results at their ELT meeting on the 28 April 2025. There is a recognition all of ELT have a responsibility to work across their areas to support areas of focus for continued improvement in areas where improvements have been highlighted.

In this meeting the following was discussed:

- What are the staff survey results telling us? Where do we focus our attention?
- What are the results saying about our culture?
- Are we doing the right things? What else can we be doing?
- Given both the local and wider landscape across the NHS at the current time, what should we be doing to effectively respond to the survey results?
- How do we integrate the results from the survey and the actions coming out of it into our BAU / programmes of work?
- Each year we send out results to teams, provide the ‘you said we did’ information, provide support for managers to have tram discussions and ask for action plans to be shared, but we get very few responses – how do we do this in a more meaningful way?
- How do we ensure the staff survey results are owned by us all?

All ELT members are following up with their teams to ensure action plans for staff survey areas of improvement are in place. These are being collated by the Organisational Development (OD) team, with support and follow ups with managers being undertaken by the OD team.

10. Summary and ongoing actions

10.1 Following the Staff Survey, recommendations included enhancing diversity and inclusion experiences, prioritising staff wellbeing and addressing workload pressure as key priorities. These were incorporated within our Equality, Diversity and Inclusion (EDI) objectives.

10.2 Since then we have made progress in a number of our EDI objectives, including a programme of building staff inclusion. Q3/Q4 activity included:

- Recruitment of six EDI champions.
- Undertaking 'From Listening to Action' conversations to better understand what inclusion at QVH means to staff. Using the feedback to inform the formation of a Cultural Transformation Steering Group, (CTSG) where there is a place for every voice to be heard and identify activities that will promote positive change through inclusivity. Membership of this group includes EDI Champions and people in roles that work across QVH. Briefing sessions were run for the membership where 25/26 priorities for the CTSG were agreed. Meetings commenced end of Feb 2025.
- Black History Month drop-ins and a collaboration with the Trusts' restaurant BHM menu, in collaboration with the catering team to deliver a diverse black history month menu.

Health and wellbeing initiatives include:

- Temple Spa menopause wellbeing sessions and drop-ins.
- Menopause Cafes for staff facilitated by Wellbeing and Inclusion Manager.
- ICB Collaborative World Menopause Day Webinar, including our own speaker on Pelvic Health, working with three different trusts to facilitate a successful webinar with over 200 members of staff attending.
- Departmental cultural listening exercises, giving staff members a safe space to voice their experiences of their departments, what is going well and what could be improved.
- Wellbeing Talks and Wellbeing MOTs for staff, offering staff a moment to reflect and focus on their own wellbeing and what they would like to prioritise to maintain good wellbeing.
- Wellbeing drop in sessions (June – August) have been advertised via Connect and via the Staywell monthly update / newsletter.

Culture and retention work has included:

- A new vision, values and behaviour framework developed and introduced across the trust. Work is underway to engage staff with the behaviour framework and include this into the NHS Staff Survey 2024 conversations with directorates and teams. The work will involve updating policies, documentation and training programmes to include the framework (e.g. Induction, Appraisal Training, LEEP leadership programme, coaching skills, etc.) and workshops to promote understanding of the framework. We are also engaging key stakeholders to ensure they are embedding the behavior framework into their conversations and documentation, including Freedom to Speak Up service, volunteers' onboarding, recruitment, employee relations conversations.
- A new continuous improvement (CI) programme has been established (the QVH Way). This links to staff having a voice and being able to make suggestions. QVH has a new CI huddle initiative within departments using lean methodology to enable staff to bring small (or big) ideas to the table and develop them further.
- Undertaking conversations with leavers and people who may be at risk of leaving. The aim being to better understand the staff experience of working at QVH and why people leave, as about 19% of leaver reasons remain unknown.
- HR are undertaking culture reviews across some of our directorates. From these we have action plans/support in place to provide development/coaching and other OD interventions.

11. Next steps

11.1 We will use the cultural reviews that are taking place within departments to understand the key themes and triangulate this with the Staff Survey results and People Pulse Survey results.

11.2 The Organisational Development team continue to work with directorates and departments to support their action planning from their staff survey results, with a focus on specific actions from their priority areas.

11.3 Continue to embed the Cultural Transformation Steering Group (CTSG) through 2025/26, with an enhanced focus on our disabled staff, triangulating the staff survey data with that found in our WDES and listening events.

11.4 Continue the work currently being undertaken on learning from those that leave the Trust to understand where morale can be improved and continue with stay interviews for areas of flight risk.

11.5 Work with our Freedom to Speak Up Guardian to understand why staff do not feel able to raise concerns to the Trust, and what further actions can be put into place to improve this.

11.6 Continue to promote the behaviour framework across the Trust.

11.7 Action plan progress for the staff survey to be added as a standing item on the Workforce Committee agenda.

12. Recommendations

12.1 **Enhance Diversity and Inclusion experiences:** In particular, QVH needs to focus on a wide range of experiences from staff who declared a disability. A series of focus groups to be undertaken to help understand lived experiences and discover what QVH can do to improve working arrangements, staff experience and morale.

12.2 **Prioritise staff wellbeing and address workload pressure:** Morale, specifically around stress and burnout have reappeared in the 2024 survey. Morale tends to improve when other aspects of workplace experiences improve. Continued wellbeing support and a proposed manager's essential programme will be a priority for 2025/26, which should contribute to better work place experiences and improve morale. A programme for change management is available and being offered across the organisation to support staff and managers through change. A review of the health and wellbeing offerings to be undertaken in relation to what is available / what more can be made available for medical and dental staff outside of standard office hours

The Board is asked to **note** the content of the report and the actions / recommendations to support staff wellbeing and engagement.

Report cover-page					
References					
Meeting title:	Board of Directors				
Meeting date:	10/07/2025		**Agenda reference:**	**46-25**	
Report title:	Annual review of learning from patient stories				
Sponsor:	Edmund Tabay, Chief Nursing Officer				
Author:	Chris Parrish, Patient Experience Manager				
Appendices:	N/A				
Executive summary					
Purpose of report:	To provide assurance to the Board about embedding learning from patient stories.				
Summary of key issues	The Boards attention should be drawn to the following key areas: • Patient stories are a rich source of information that enable the audience to engage and connect with the imagery that is being described to really put themselves in a patient's shoes • A new process was established this period where patient stories and staff stories are shared with the Board. The CNO and CMO personally invite the (patient) storyteller to the relevant Board meeting. • Three patient stories were due to be shared in 2024/25 FY (breast, facial palsy and skin) • Two patient stories were not shared due to unexpected absence or technology issues • Lessons were learnt from all patient stories (shared or not) and resulting actions have been addressed				
Recommendation:	The Board is being asked to **note** the report.				
Action required	Approval	Information	Discussion	**Assurance**	Review
Link to key strategic objectives (KSOs):	**KSO1:**	KSO2:	KSO3:	KSO4:	KSO5:
	Outstanding patient experience	*World-class clinical services*	*Operational excellence*	*Financial sustainability*	*Organisational excellence*
Implications					
Board assurance framework:	None				
Organisational risk register:	None				
Regulation:	None				
Legal:	None				
Resources:	None				
Assurance route					
Previously considered by:	ECQR and Quality & Safety Committee				
	Date:	16/06/2025 and 01/07/2025	Decision:	Approved subject to comments/amendments	
Next steps:					

Report to:	Board of Directors
Agenda item:	46-25
Date of meeting:	10 July 2025
Report from:	Edmund Tabay, Chief Nursing Officer
Report author:	Chris Parrish, Patient Experience Manager
Date of report:	1 July 2025
Appendices:	None

Patient Stories to Board

Purpose

Patient stories offer a unique and powerful lens into the lived experience of care within our Trust. Sharing these narratives with the Board ensures that we stay close to what matters most to our patients and the impact of care we provide. These stories inform quality improvement, highlight best practice, and identify where learning is needed to deliver safe, compassionate and person-centred care.

Overview of the process

We introduced a new approach in 2024/25 to selecting patient stories for Board presentation. The updated process ensures that the stories chosen are timely, relevant, and aligned with learning or improvement priorities. This has meant that at every other public Board meeting, the Chief Nursing Officer and Chief Medical Officer invite a patient to share their personal story directly with the attendees.

Invitations are typically extended to individuals who have submitted formal feedback through complaints or letters to the Chief Executive. These stories often reflect deeply personal experiences and provide a rich source of learning whether the story is one of praise or concern.

The Board are keen to hear the lived experience of those sharing their story and by listening to those in receipt of our services they gain a real insight into the direct thoughts and feelings of our patients.

Stories presented to the Board

Between April 2024 and March 2025, three patient stories were presented at Board meetings. Two were examples of highly positive patient experience who wished to recognise and celebrate the care they had received. One was an example of an improvement opportunity shared by a complainant about their procedure and the complaint handling process.

1. Breast reconstruction service

A patient shared her journey through the breast reconstruction pathway, praising the professionalism, compassion, and attentiveness of the surgical, nursing, and allied health teams. She noted particular appreciation for the continuity of care and clarity of communication throughout her treatment.

2. Facial palsy service

A second patient spoke of the transformative impact the facial palsy team had on his confidence, mental health and daily functioning. He credited not just the technical skill of the clinical team but the way he was made to feel seen, supported and involved in decisions about her care.

3. Skin service
One rescheduled patient spoke in May 2025 and is captured in this report as they were originally scheduled for the period. She spoke of the impact on her of the complaints handling and how her concerns about her skin procedure and consent were managed. She did not feel that she had been listened to or treated as an individual. She felt the complaints process required revision to be less defensive.

The positive stories offered valuable insight into what “excellent care” looks like from a patient perspective and helped reinforce a culture of excellence, empathy and teamwork.

Stories not presented but acted upon
Two additional patient stories were identified and prepared for presentation but were not delivered in the period due to unforeseen issues. One related to the patient’s availability and the other due to technical difficulties.

Importantly, even where stories are not presented at the Board, the learning they offer is still harnessed. Each narrative is reviewed in full, and relevant themes are escalated for operational or strategic action where appropriate.

Actions and learning from stories shared (or prepared)
All patient stories whether celebratory or challenging have generated meaningful learning and contributed to service improvement. Key actions taken this year include:

- **Eye clinic communication improvements**
  A patient story highlighted confusion and frustration about wait times and diagnostic sequencing within the eye clinic. In response, a review was undertaken of patient appointment letters and on-the-day communication to better explain the structured nature of the diagnostic pathway. Follow-up with the clinic has shown that focus on developing team working and continuous improvement of process is yielding benefits.
- **Awareness of Facial palsy services**
  Feedback revealed that some referring clinicians were unaware of the scope and benefits of our facial palsy services. As a result, a communication plan was developed and cascaded to increase awareness and improve referral appropriateness and timeliness.
- **Enhancement of catering and mealtime experience**
  In response to praise from patients regarding domestic and catering staff, a process was commissioned to build on this excellence. Efforts focused on improving food options and enhancing the overall mealtime experience as part of holistic inpatient care.
- **Complaints Process Review**
  The complaints process has been overhauled between the complaint response and the patient’s story at Board. Changes have introduced early engagement with the patient and more quality checks with both the Directorate Leadership Triumvirate and an Executive Director. This helps ensure that investigation findings and responses are personalised to the complainant. Further improvement in this area is a quality priority for 25/26.
- **Consent**
  There has been extensive consultation and engagement around the consent policy prior to approval and ratification of an adapted approach, which also provides more clarity for patients who may lack mental capacity. Induction now ensures learning on consent and bespoke sessions facilitated by the GMC and NHS Resolution are being organised to support clinicians in deeper consideration around consent, confidentiality and responding to concerns.

Conclusion and next steps
The Board's continued engagement with patient stories underscores our commitment to learning directly from those we serve. The stories shared this year reflect both our successes and areas where greater clarity, communication, or coordination can enhance patient care.

As we look ahead, we will continue to embed the patient voice at the heart of governance and improvement. We are refining our processes to better capture diverse experiences and ensure that feedback whether formal or informal is acted upon in meaningful ways.

Recommendation
The Board is asked to **note** this report.

Report cover-page					
References					
Meeting title:	Board of Directors				
Meeting date:	10/07/2025	**Agenda reference:**	**47-25**		
Report title:	Audit & risk committee assurance report				
Sponsor:	Paul Dillon-Robinson, committee Chair				
Author:	Paul Dillon-Robinson, committee Chair Ellie Simpkin, Governance manager				
Appendices:	Appendix one – Audit & risk committee annual report 2024-25				
Executive summary					
Purpose of report:	To alert, assure and advise the Board regarding matters considered at the last committee meeting.				
Summary of key issues	- The Head of Internal Audit Opinion 2024-25, from RSM, has concluded that there are weaknesses in the framework of governance, risk management and internal control. - The external auditors, Azets, presented their draft annual audit findings for the year ending 31 March 2025. They anticipate issuing an unmodified audit opinion on the accounts. - Azets has identified one significant weakness in their draft Value for Money assessment which relates to instances of non-compliance with Trust policies during 2024/25. - The Trust's Annual Governance Statement 2024-5 concludes that significant internal control issues arose during the year, however, appropriate plans are in place to deliver the required improvement. - The Counter Fraud Functional Standard Return (CFFSR) resulted in an overall rating of green, indicating full compliance. - The committee has reviewed the changes which have been made to the Trust's Standing orders, Scheme of delegation and reservation of powers and Standing financial instructions and recommends the revisions to the Board for approval. - The committee received an update on the effectiveness of the mechanisms in place for raising staff concerns. The decline in the number of staff who responded to the staff survey to say that they feel safe to speak up about anything that concerns them (67.5% in 2024 compared to 74.5% in 2023) was highlighted. - The Audit & risk committee has produced its annual report which summarises the work undertaken by the committee in 2024-25. This is attached at appendix one.				
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:** *To deliver outstanding care*	**KSO2:** *To innovate and improve*	**KSO3:** *To be an excellent employer*	**KSO4:** *To deliver sustainable services*	**KSO5:** *To collaborate with others*
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: 47-25
Date of meeting: 10 July 2025
Report from: Paul Dillon-Robinson, committee Chair
Report author: Paul Dillon-Robinson, committee Chair
Ellie Simpkin, Governance manager
Date of report: 25 June 2025
Appendices: Appendix one – Audit & risk committee annual report 2024-25

Sub-committee assurance report
Audit & risk committee – 24 June 2025

Key agenda items

- **Raising concerns – update**
- **System governance: risk & assurance**
- **Key policies update**
- **Revised Standing Financial Instructions and Reservation of Powers and Scheme of Delegations**
- **Audit & risk committee annual report 2024-25**
- **Internal audit progress**
- **Local Counter Fraud Annual report 2024/25 (including Annual review of Self Review Tool & Annual fraud Awareness Survey)**
- **Local Counter Fraud progress report**
- **Financial assurance**
- **Bad debt provision**
- **Internal audit Annual Report & Head of Internal Audit Opinion 2024-25**
- **Trust audited annual accounts and financial statements**
- **Trust Annual Report & annual Governance Statement 2024-25**
- **External audit year end report 2024-25**

Alert

- The Head of Internal Audit Opinion 2024-25 has concluded that: *'there are weaknesses in the framework of governance, risk management and internal controls such that it could become inadequate and ineffective.'* This is a lower level than last year, which the committee asked about, and the reasons for this opinion include five partial assurance opinions being issued during the year and a lack of progress in implementing actions arising from the audit of contract management in the previous year. The committee is assured that progress is now being made with improvements to contract management, and that there is a focus on implementing agreed actions from all audits on a timely basis.

- The external auditors, Azets, have identified one significant weakness in their draft Value for Money assessment which relates to the Trust's arrangements for effective operation of internal controls due to instances of non-compliance with Trust policies during the 2024/25 financial year. These matters have been discussed by the committee at previous meetings, are reflected in the Annual Governance Statement.
- The committee recommended the Trust's Annual Report 2024-25, including the Annual Governance Statement, to the Board for approval. The Annual Governance Statement concludes that significant internal control issues arose during the year. Where significant controls issues have been identified, appropriate plans are in place to deliver the required improvement.
- An internal audit of risk management has received a partial assurance opinion. Further work is required to standardise the framework in place for identifying, managing and monitoring local risks within corporate functions. Varying levels of engagement with the audit, from specific areas of Trust, was raised by the internal auditor and the process for escalation through the executive leadership team and the committee, where necessary, has been clarified and encouraged.
- The committee received an update on the effectiveness of the mechanisms in place for raising staff concerns. The decline in the number of staff who responded to the staff survey, to say that they feel safe to speak up about anything that concerns them (67.5% in 2024 compared to 74.5% in 2023), was highlighted. The committee was reassured that this is being taken seriously by the executive and the importance of demonstrating that staff are being heard, and action taken, is acknowledged. All available routes for raising concerns continue to be promoted to staff.

Assure

- Azets presented their draft annual audit findings for the year ending 31 March 2025. They anticipate issuing an unmodified audit opinion on the accounts. The committee was pleased to note that the audit process has been positive on all sides.
- The Counter Fraud Functional Standard Return (CFFSR) resulted in an overall rating of green, indicating full compliance. Access to, and completion of, training is a requirement that remains at 'amber'. An e-learning package is being implemented and targeted face-to-face fraud awareness sessions for recruitment and procurement teams are planned.
- The number and value of single tender waivers for contracts over £30k has decreased since the last report to the committee, although it still wishes to keep oversight of the rationale. Contracts awarded since 1 January 2025 have been reviewed to ensure that they have followed the proper process.
- The Audit & risk committee has produced its annual report which summarises the work undertaken by the committee in 2024-25, some of which has informed the Trust's Annual Governance Statement (attached at appendix one).

Advise

- The committee has reviewed the changes which have been made to the Trust's Standing orders, Scheme of delegation and reservation of powers and Standing financial instructions and recommends the revisions to the Board for approval. Given the matters of non-compliance which were identified by the Trust in 2024-25, communication of these governing documents to staff, and compliance with them, is key. The committee has asked for an update on the effectiveness of the revisions in six months' time.

- The basis on which the Trust calculates bad debt provision on aged debts has been reviewed by the committee. The areas with the highest levels of bad debt provision relate to overseas patients and non-government organisations.

Risks discussed and new risks identified

- The committee received an update on System collaboration and risk. QVH and other providers are expected to play a key role in managing the shared risks to the delivery of the Sussex Health and Care System Strategy, Improving Lives Together. The committee were reassured that these risks are reflected in the Trust's own organisational risk register. The committee has highlighted the importance of the Board having assurance that these System risks, where relevant, are being managed effectively by the Trust.

Recommendation

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

Report cover-page					
References					
Meeting title:	Board of Directors				
Meeting date:	10/07/2025	**Agenda reference:**	**47-25**		
Report title:	Audit & risk committee annual report 2024-25				
Sponsor:	Paul Dillon-Robinson, committee Chair				
Author:	Ellie Simpkin, Governance manager Leonora May, Company secretary				
Appendices:	None				
Executive summary					
Purpose of report:	The Audit & risk committee annual report summarises the work carried out by the committee in 2024-25, some of which has informed the Trust's Annual Governance Statement.				
Summary of key issues	Key matters raised by the committee include: • the issues identified included non compliance with the Trust's governing documents, contract management, use of waivers, budgetary control, business planning and recruitment controls. • the time being taken to implement some internal audit management actions • the work being undertaken on the fundamentals of financial grip and control • improvements to contract management • the importance of risk management and assurance being embedded within the culture of the organisation • the development of system-wide risks				
Recommendation:	The Board is asked to note the report.				
Action required	Approval	Information	Discussion	Assurance	**Review**
Link to key strategic objectives (KSOs):	KSO1: *Outstanding patient experience*	KSO2: *World-class clinical services*	KSO3: *Operational excellence*	KSO4: ***Financial sustainability***	KSO5: ***Organisational excellence***
Implications					
Board assurance framework:	Currently in development- BAF risks 5 and 6 somewhat materialised				
Corporate risk register:	Organisational risk related to non-compliance with governing documents				
Regulation:	CQC well led				
Legal:	None				
Resources:	None				
Assurance route					
Previously considered by:	Audit & risk committee				
	Date:	24/07/2025	Decision:	Submit to Trust Board	
Next steps:					

Report to:	Board of Directors
Agenda item:	47-25
Date of meeting:	10 July 2025
Report from:	Paul Dillon-Robinson, committee Chair
Report author:	Ellie Simpkin, Governance manager Leonora May, Company Secretary
Date of report:	13 June 2025
Appendices:	None

Audit & risk committee annual report 2024-25

Introduction

The Audit & risk committee annual report summarises the work carried out by the committee in 2024-25, some of which has informed the Trust's Annual Governance Statement.

Role of the committee

The Board delegates responsibility to the Audit and risk committee to scrutinise the organisation and maintenance of an effective system of governance, risk management and internal control. This includes financial, clinical, operational and compliance controls and risk management systems.

The committee comprises of three non-executive director members. The Trust's internal auditor (RSM), External auditor (Azets) and Local Counter Fraud Service (RSM) attend meetings as well as the Chief finance officer and Company secretary. The Chief executive officer attends as and when required.

During 2024/25, the committee has met on seven occasions. Extraordinary meetings have been held to consider the Trust's risk management framework, internal control matters and the plan for the external audit of the Trust's Annual Report and Accounts for 2024/25. Committee member attendance will be reported in the Annual report and accounts 2024/25, and is included below:

Audit & risk committee							
Register 2024-25							
Name	**04 Jun 2024 ***	**18 Jun 2024**	**04 Sep 2024**	**26 Nov 2024 ***	**11 Dec 2024**	**19 Feb 2025 ***	**26 Mar 2025**
Paul Dillon-Robinson	Y	Y	Y	Y	Y	Y	Y
Russell Hobby	Y	Y	Y	Y	Y	Y	A
Peter O'Donnell	Y	Y	A	Y	A	Y	Y

*extraordinary meeting

Matters escalated to the Board

In 2024/25 the committee escalated the following matters to the Board:

Internal control

An extraordinary meeting was held in November 2024, attended by the full board, to discuss a number of examples of non-compliance or poor governance practice which had been identified. A full and robust discussion was had with the Executive team on

the reasons for the failings, ownership and accountability, the cultural changes needed across the Trust, and how teams and individual staff are being empowered and supported to ensure that the control environment is operating effectively. The committee stressed the significance of the issues identified, the importance of good governance and the need to address concerns as a priority.

The issues identified included non compliance with the Trust's governing documents, contract management, use of waivers, budgetary control, business planning and recruitment controls. At its meeting in March 2025 the committee recognised that appropriate plans are in place to deliver the required improvement and that progress has made to address the non-compliance. The committee received reassurance that there had been no non-compliance in Q4 of 2024/25.

There will be an internal audit on compliance with governing documents during 2025/26.

Clinical audit
The committee identified that there is further work to do on aligning the clinical audit strategy with the Board Assurance Framework and to develop the assurance which the committee receives from the Quality & safety committee on the quality and patient safety aspects of the clinical audit programme. Although the Trust's self-assessment against the Healthcare Quality Improvement Partnership clinical audit maturity index is a low maturity position, there is clarity of the actions being taken to develop the Trust's clinical audit strategy and programme. The importance of the clinical audit programme being aligned to the needs of the organisation was highlighted by the committee

Internal audit
The committee challenged the time being taken to implement some management actions, noting that staff resourcing has been a limiting factor. The committee has stressed the importance of actions arising from internal audit reviews being completed within the agreed timeframes.

Grip & control
Work commenced on the Tactical Measures Programme which aimed to reinvigorate the culture with respect to compliance with financial control and established governance arrangements. There was concern from the committee over the large number of actions and the importance of identifying and focusing on the fundamentals of grip and control, ensuring that they are operating effectively. Progress is now being made to strengthen the controls in place, and thereby provide assurance relating to the effective operation of controls within finance, procurement and workforce, including weekly meetings of the Workforce Control Panel, budget holder training and the establishment of a Financial Controls Review group, chaired by the Chief Finance Officer. The key areas of focus of financial grip and control have been identified, based on an assessment of the risk posed by weaknesses in these areas. The committee highlighted the importance of accountability and noted the cultural shift which is needed to ensure that good governance practices are embedded across the organisation.

Risk management
The committee emphasised the importance of how risk management and assurance must be embedded within the culture of the organisation and the need to ensure they are appropriately linked into the integrated assurance framework.

An internal audit of risk management systems was carried out during Q4 of 2024/25, the outcome of which will be reported to the committee at its meeting in June 2025. The internal audit received an outcome of partial assurance, demonstrating that there is further work to do to embed the Trust's revised Risk management framework.

Contract management
A detailed follow up of the internal audit review of contract management had been carried out by the Trust's internal auditors and found that 'little progress' had been made in implementing agreed management actions. The committee has since been given assurance that progress has been made (e.g. on policy, training and a contracts register) by the year-end.

Use of Single tender waivers
The committee raised concerns over the high use of single tender waivers (STWs). Benchmarking provided by the Local Counter Fraud Service has highlighted that the Trust had a significant increase in the use and value of STWs from 2022/23 to 2023/24. It is important that the value for money considerations are evidenced in any waiver granted.

Security management
The Local Security Management Specialist work plan for 2024/25 and the commissioned surveys of specific aspects of site security management highlighted a number of areas which require improvement. There is work to do on developing the organisation's understanding and management of security risks.

Local Counter Fraud Service
-The Counter Fraud Functional Standards Return (CFFSR) 2024-25 resulted in an overall 'Green' rating. Uptake of staff training has been highlighted as an area for improvement. Ways to increase access to training, including implementing an e-learning package, are being considered.

Policies
The committee's annual review of compliance with the "policy for policies" highlighted that the Trust currently has a large number of policies, a number if which were past their review date. A focused piece of work will be undertaken to review all policies and identify those which should be re categorised as Standard Operating Procedures. The committee requested that a report on the clinical policies, which are overdue a review, is made to the Quality & safety committee and that any key policies which are in the process of being reviewed, which includes the Raising Concerns policy, are finalised as a priority.

Raising concerns
Limited assurance has been received from management with regards to the "effectiveness" of the arrangements in place for staff to raise concerns. There is ongoing work to develop the culture of the organisation which is needed to ensure that staff are able to rapidly and confidently raise concerns. A further update on raising concerns is being brought to the committee in June 2025.

Risks identified/discussed
- The development of system-wide risks being overseen by the NHS Sussex Committee in Common.
- The committee was made aware of an emerging risk to the Trust's financial breakeven position.
- With regard to the organisational risk concerning a non-compliant event involving Standing Financial Instructions or Scheme of Delegation, culture

and behaviour were identified by the committee as key controls and areas in which the Trust has further work to do.

Assurance from committees
Both the Quality & safety and Finance & performance committees have responsibility for seeking assurance that risks within their remit are being effectively managed and mitigated, or that remedial action plans are in place, escalating to the Board where necessary. The Audit & risk committee has reviewed annual assurance reports from the committees. The key matters raised are summarised below.

Finance & performance committee
Reports received by the Finance & performance committee during the period have generally been factually accurate but have lacked forecast and key insights/ analysis. This is an area that the committee is keen to see develop to ensure strengthened assurance. Issues have arisen in relation to financial and operational performance where assurance has been given regarding the outlook (for example, on track to deliver breakeven at year end) which have not materialised. The committee did not receive adequate income and expenditure information and forecasting. The committee requested throughout the year that trajectories for the year are consistently reviewed to ensure that they are robust and realistic.

The following matters have been escalated to the Board and referred to other committees:

- Issues related to financial, operational and workforce performance and not meeting targets
- Capital spend
- High levels of bank and agency usage (which is improving)
- Estates infrastructure issues including Fire safety enforcement notice
- Issues with key projects including. the Trust's capacity to deliver
- Inappropriate governance practice related to Electronic Patient Record programme and signing of a contract which required Board approval
- Contract management

Quality & safety committee
The committee has acknowledged that further work is required to develop the appropriate set of metrics related to quality and safety. There has been improvement to the quality of reports but there is further scope to reduce their length and include an upfront summary of the situation, narrative insight and evidence-based opinion and analysis.

The following matters have been escalated to the Board and referred to other committees:

- Fire safety enforcement notice (actions monitored through Finance & performance committee)
- RAAC (actions monitored through Finance & performance committee)
- Antimicrobial stewardship

Risk of non-compliance with the Mental Capacity Act with low training uptake and inconsistent application

Risk and significant issues
During the year, the committees have reviewed the Board Assurance Framework. BAF risks 5 and 6 have somewhat materialised; there have been a number of compliance breaches reported to the Audit and risk committee.

The highest scoring risks on the organisational risk register have been in relation to the Trust's boiler system, the Trust's electrical infrastructure, further non-compliance with the Trust's governing documents and mental capacity assessments not being routinely carried out.

During the year, a number of notable issues have been brought to the attention of the committees. These include:

- Key project milestones being missed which has made it difficult for the committee to have oversight of adverse outlooks and risks
- There have been challenges with project management, one example being with the delivery of the Electronic Patient Records (EPR) project and business case
- The Trust's ability to forecast has been a concern but the committee has been reassured that progress is now being made on the development of operational and financial forecasting for 2025/26
- There are cultural challenges across the Trust. The committee has noted an increase in employee relations cases arising from people speaking up about poor behaviours. This does indicate emerging confidence in the organisation's ability to address these
- Estates infrastructure issues
- The Trust's compliance with the recommendations of the national NHS Infected Blood Inquiry
- Clinical effectiveness quality priority being rated as red/amber
- Concerns over the time it is taking to complete patient safety investigations and the quality of completed reviews
- A gap in health and safety assurance reporting and monitoring

Committee effectiveness
The Audit & risk committee has undertaken an annual review of its effectiveness and has considered how effective committee members are, committee support, Chairing, meeting arrangements and the quality of papers and assurance provided. The outcome of the review was considered by the committee as its meeting in March 2025. The results were overall positive. The implementation of actions within agreed timescales has been identified as an area for further development, noting that there have been delays in the delivery of actions to address internal control issues.

The committee has also undertaken the annual review of its terms of reference which are in line with best practice guidance issued by the Healthcare Financial Management Association.

A Governor working group for the committee has been established and now meets with the Chair following each meeting of the committee to discuss the key matters and areas of assurance.

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

Report cover-page			
References			
Meeting title:	Board of Directors		
Meeting date:	10/07/2025	**Agenda reference:**	**48-25**
Report title:	Quality & safety committee assurance report		
Sponsor:	Shaun O'Leary, committee Chair		
Author:	Shaun O'Leary, committee Chair Ellie Simpkin, Governance manager		
Appendices:	Appendix one - Patient Safety annual report 2024-2025 Appendix two - Learning from Deaths Report annual report 2024-2025 Appendix three - Safeguarding (Adult and Children) annual report 2024-2025 Appendix four - Infection Prevention & Control annual report 2024-2025 Appendix five - Complaints annual report 2024-25 Appendix six - Research & Innovation annual report 2024-2025 Appendix seven - Appraisal & Revalidation 2024-2025		
Executive summary			
Purpose of report:	To alert, assure and advise the Board regarding matters considered at the last committee meeting.		
Summary of key issues	- The work of the Task and finish group to improve compliance with the Mental Capacity Act (MCA) continues and the risk has reduced as a consequence. There is further work to do and the committee has stressed the importance of ensuring changes are embedded and having a positive impact for patients. - A replacement Cone Beam CT (CBCT) scanner is now place following the critical failure of equipment in April 2025. A recovery plan to address the patient backlog is being worked through with urgent and long waiting patients being prioritised. The committee received assurance that an investigation has concluded that there was no significant patient harm caused as a result of the equipment performance issues. - Following a recent visit from Environmental Health, the Trust has been issued with two Hygiene Improvement Notices. One of the improvement notices is in relation to taking action on staff training. This was raised following a previous inspection which demonstrates that sufficient action had not been taken to improve the position. An action plan, which is being monitored daily, is now in place to ensure improvement. A fuller discussion on this will be had at the next Quality & safety committee to ensure that the committee is assured that lessons have been learned and improvements embedded. - The committee received an update on the process in place for reviewing harm for patients on a cancer pathway. Controls are in place to oversee the long waiting patients including weekly patient tracking list meetings with escalation to the Chief operating officer and Chief medical officer for patients over 78 weeks. - The positive outcome of the Children and Young People Survey 2024 evidences the outstanding inpatient paediatric care delivered at QVH. - The following annual reports have been reviewed by the committee and are presented to the Board for assurance given its specific oversight responsibilities in these areas: o Patient safety o Learning from Deaths o Safeguarding o Infection Prevention & Control o Complaints o Research & Innovation - The committee reviewed the Professional standards: framework for quality assurance and improvement annual report 2023/2024. The committee is satisfied that the Trust is compliant and recommends that the Board ratifies the report		

Recommendation:	The Board is asked to **note** the contents of the report, **note** the contents of the annual reports presented for assurance and **ratify** the Professional standards: framework for quality assurance and improvement (FAQI) Annual Report 2024-2025, confirming that Trust is compliant with the regulations.				
Action required	**Approval**	Information	Discussion	**Assurance**	Review
Link to key strategic objectives (KSOs):	**KSO1:** *To deliver outstanding care*	**KSO2:** *To innovate and improve*	**KSO3:** *To be an excellent employer*	**KSO4:** *To deliver sustainable services*	**KSO5:** *To collaborate with others*
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: 48-25
Date of meeting: 10 July 2025
Report from: Shaun O'Leary, committee Chair
Report author: Shaun O'Leary, committee Chair
Ellie Simpkin, Governance manager
Date of report: 02 July 2025
Appendices: Appendix one - Patient Safety annual report 2024-2025
Appendix two - Learning from Deaths Report annual report 2024-2025
Appendix three - Safeguarding (Adult and Children) annual report 2024-2025
Appendix four - Infection Prevention & Control annual report 2024-2025
Appendix five - Complaints annual report 2024-25
Appendix six - Research & Innovation annual report 2024-2025
Appendix seven - Appraisal & Revalidation 2024-2025

Sub-committee assurance report
Quality & safety committee – 3 June 2025 and 1 July 2025

Key agenda items

- **Quality Account 2024-25**
- **Infection Prevention & Control annual report 2024-2025**
- **Medication safety annual report 2024-25**
- **Learning from Deaths Report annual report 2024-2025**
- **Clinical Audit annual report 2024-2025**

- **Appraisal & Revalidation 2024-2025**
- **Research & Innovation annual report 2024-2025**
- **Antimicrobial annual report 2024-25**
- **Health & Safety annual report 2024-2025**
- **Safeguarding (Adult and Children) annual report 2024-2025**
- **Complaints annual report 2024-25**
- **Patient Safety annual report 2024-2025**
- **Executive Committee for Quality & Risk assurance**
- **Integrated Quality & Performance Report (IQPR) – month 1**
- **Organisational risk register**
- **Annual review of patient stories**
- **Children & Young People's survey**
- **Clinical audit plan 2025-2026**

Alert

- The work of the Task and Finish group to improve compliance with the Mental Capacity Act (MCA) continues. The Trust's consent policy has been updated and changes have been made to the appointment letters and the booking process. There is further work to do and the committee has stressed the importance of ensuring that changes are embedded and having a positive impact for patients.
- A replacement Cone Beam CT (CBCT) scanner is now place following the critical failure of equipment in April 2025. A recovery plan to address the patient backlog is being worked through with urgent and long waiting patients being prioritised. The committee received assurance that an investigation has concluded that there was no significant patient harm caused as a result of the equipment performance issues.
- Following a visit from Environmental Health, the Trust has been issued with two Hygiene Improvement Notices. One of the improvement notices is in relation to taking action on staff training. This was raised following a previous inspection which demonstrates that sufficient action had not been taken to improve the position. An action plan, which is being monitored daily, is in place to ensure improvement. Staff training is being undertaken and a review of processes carried out. The committee requested the use of spot checks in the short-term, to ensure the changes are systemised. A fuller discussion on this will be had at the next Quality & safety committee to ensure that the committee is assured that lessons have been learned and improvements embedded.
- A Never Event regarding a wrong site block occurred in Month two. There was no patient harm and the committee has been reassured that action has been taken to reinforce policy and training in this area.

Assure

- The committee received an update on the current process for reviewing harm for patients on a cancer pathway, acknowledging the need for balance between the time spent in clinical review of patients and time spent treating patients and therefore reducing wait times. Controls are in place to oversee the long waiting patients including weekly patient tracking list meetings with escalation to the Chief operating officer and Chief medical officer for patients over 78 weeks.
- The Trust has been ranked first in the national league table of overall positive scores in the Children and Young People Survey 2024, evidencing the outstanding inpatient paediatric care delivered at QVH.

- The Clinical audit annual report 2024-25 shows breadth in the audits undertaken. Opportunities to use digital systems to support streamlining processes and coordinate data and reporting are being explored. The committee has reviewed the clinical audit plan for 2025-26, recognising that the plan will continue to be developed in conjunction with directorate teams to inform strategy, policy and planning for subsequent years.
- The committee has received assurance on medication safety. Medicines incident reporting numbers are higher than previous, but with low or no harm, taken to indicate that the reporting culture is improving. Processes are in place to address and communicate themes in medication incidents and national safety communications are recognised and acted on in a timely fashion. There is further work to do on improving the process of reporting on shortages of medications.
- The Antimicrobial stewardship annual report 2024-25 has provided assurance that appropriate oversight arrangements are in place to support antimicrobial stewardship across the Trust. Antimicrobial related ward rounds have been initiated to improve prescribing compliance, optimise treatment and support clinical practice, education and learning. Work has started on the configuration of electronic prescribing to maximise monitoring of antibiotic use and prescribing standards.
- The Health & Safety annual report 2024-25 demonstrates encouraging levels of assurance evident through proactive incident reporting. Face fit testing compliance was low, and was highlighted as an area for improvement, which was evidenced over the last four months. The committee has asked for a further breakdown of the non-compliance and insight as to reasons behind this. The committee continues to monitor the action plan to address the gaps in policy implementation and compliance monitoring which were identified in the scoping exercise carried out in February 2025.

Advise

- The committee has reviewed the Trust's Quality Account 2024-25 which highlights the significant achievements of the Trust, acknowledging the areas for improvement. The committee agreed to recommend the Quality Account 2024-25 to the Board for approval at its meeting in June 2025.
- The South East Burns Review report has now been received. The committee will be receiving an update on the outcome and the Trust's response to the report at its next meeting.

Risks discussed and new risks identified

- The committee queried whether the score for risk 16 (mental capacity act) has been reduced from a 16 to a 12 prematurely given that the impact of the actions implemented to date have not yet been proved, but accepted the reasoning for this as the revised letters had improved mitigation.
- The current score for risk 73 (Emergency Preparedness Resilience & Response) has been reduced from a 12 to a 9 as discussions are taking place to ensure that the Trust has resources in place to implement the actions from the previous annual assurance review.
- Risk 147 (critical failure of CBCT equipment) was added to the risk register but is now closed as new equipment has been installed. The committee has been reassured that action is being taken to remedy the impact on the patient waiting list.

Quality annual reports 2024-25

The committee has reviewed and discussed the following annual reports which are presented to the Board for assurance given its specific oversight responsibilities in these areas:

- **Patient safety**
  Key achievements including the embedding of the Patient Safety Investigation Response Framework (PSIRF) and the implementation of the 'Learn from Patient Safety Events' system (LfPSE). There were five investigations and no external Patient Safety Investigations reported in 2024/25. One Never Event relating to the wrong site block was declared. All investigations generated learning and some immediate changes to policy and practice have been made. The committee notes that a Clinical Learning Forum has been established and will developed throughout 2025-26.

- **Learning from Deaths**
  The report provides assurance that there is embedded evaluation and learning around deaths associated with care at QVH that is consistent with best practice. The committee has noted that there is work to do on developing processes which provide assurance in 'real time', demonstrated by the fact that analysis of the 2024/25 deaths is only partially (67%) complete. Structured Judgement Reviews undertaken have been done well and thoughtfully.

- **Safeguarding**
  Improvements have been made to the Adult Safeguarding and Mental Capacity Act training, however, compliance has been challenging and remains on the risk register. The safeguarding team recognises that there is need to carry out further audit activity, which has not been possible to undertake to date. The committee was pleased to note the embedding of the 'think family' culture across the Trust.

- **Infection Prevention & Control**
  The committee welcomes the report which clearly shows the cycle of audit, action and consequence. The committee has asked for a further update on antimicrobial compliance and assurance. Although improvements have been made to the estate, the committee expressed concerns that it appears that there are still issues from an infection control point of view to be resolved. The issues, or risk, if any, needs to be put in context for the Board. The committee asked that assurance on estates matters relevant to quality and safety is provided at a future meeting.

- **Complaints**
  The complaints annual report 2024-25 provides good assurance that the Trust actively listens to and acts upon the voice of patients. Feedback is systematically reviewed and triangulated across multiple sources allowing for a broader and more reliable understanding of themes. The introduction of 'Learning From' meetings which support a collaborative, methodical, and inclusive organisational learning approach is welcomed. For 2025/26 the Trust is reducing the timeframe for complaints resolution from 40 to 30 working days.

- **Research & Innovation**
  There have been significant changes in the past year as the Trust implements its Research & Innovation Strategy. There is ongoing work to stabilise

reporting and governance structures and partnership and collaborative opportunities are being explored. The committee was pleased to note that links with primary care are being developed and the impact of research on addressing health inequalities (HI) is being considered.

- **Professional standards: framework for quality assurance and improvement (FAQI) annual report 2024-2025**
  It has been a positive year with evidence of improved clinical engagement with appraisals and compliance with competency documentation. Progress has been made on the actions identified in last year's report and the L2P digital appraisal platform is now fully implemented. The number of appraisers is increasing and the L2P is being used to systemise processes. The committee is satisfied that the Trust is compliant and recommends that the Board ratifies the report.

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

Report cover-page					
References					
Meeting title:	Board of Directors				
Meeting date:	10/07/2025		**Agenda reference:**	**48-25**	
Report title:	Patient Safety Annual Report 2024/25				
Sponsor:	Edmund Tabay, Chief Nursing Officer				
Author:	Karen Carter-Woods, Head of Safety and Patient Experience				
Appendices:	Appendix one - 'Safety Pin'				
Executive summary					
Purpose of report:	To provide the Board and all relevant stakeholders with a comprehensive overview and assurance around the patient safety processes across the Trust in 2024/25				
Summary of key issues	The Boards attention should be drawn to the following key areas as detailed within the report: • Patient Safety Investigation Response Framework (PSIRF) embedded: no external PSI's reported, one Never Event declared (wrong site block) • 'Learn from Patient Safety Events' system (LfPSE) implemented and embedded • New meeting structure: Patient Safety and Experience sub-committee and Clinical Outcomes and Effectiveness sub-committee commenced in Q3 for upwards assurance to Quality and Safety Committee • 'Safety Pins' introduced – to promote shared learning trust-wide (appendix one)				
Recommendation:	The Board is asked to seek assurance of the continued rigour achieved around safety and patient experience throughout this financial year, and that the work throughout 2024/25 served to strengthen the governance structures and processes				
Action required	Approval	Information	Discussion	**Assurance**	Review
Link to key strategic objectives (KSOs):	KSO1: *To deliver outstanding care*	KSO2: *To innovate and improve*	KSO3: *To be an excellent employer*	KSO4: *To deliver sustainable services*	KSO5: *To collaborate with others*
Implications					
Board assurance framework:	Contribution to the delivery of all KSO's				
Organisational risk register:	The Risk Register is monitored and co-ordinated by the Company Secretary, within the Corporate Team updated by Execs and their teams				
Regulation:	CQC's Essential Standards of Quality and Safety				
Legal:	As above				
Resources:	This report was compiled using existing resources within the team				
Assurance route					
Previously considered by:	22/5/25 - Patient Safety and Experience sub-committee 26/5/25 - Executive Leadership Team – circulated 16/5/25 – Executive Committee for Quality and Risk 23/6/25 - CEO / CMO review 01/07/2025 – Quality and Safety Committee				
Next steps:					

Queen Victoria Hospital
NHS Foundation Trust

Queen Victoria Hospital NHS Foundation Trust
Patient Safety Annual Report

Report covering the period from
April 2024 to March 2025

Document Control: Quality and Safety Committee

Executive sponsor: Edmund Tabay, Chief Nursing Officer

Author: Karen Carter-Woods, Head of Safety & Patient Experience

Date: 1st July 2025

Type: Annual Patient Safety Report

Version: 13

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Status: Public. Written and prepared for the Trust Board

Circulation:

- Patient Safety and Experience sub-committee
- Executive Committee for Quality and Risk
- Executive Leadership Team
- Quality and Safety Committee
- QVH Trust Board

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1.	Executive Summary
	This Annual Patient Safety Report provides assurance that the Trust is meeting its duty in relation to patient safety requirements and standards. Incorporating all aspects of patient safety, this report provides an overview of activity along with fundamental updates, progressive data, work undertaken and achievements. <u>Key messages</u>: • Patient Safety Investigation Response Framework (PSIRF) embedded: no external PSI's reported, five internal investigations and one Never Event declared (wrong site block). All investigations generated learning including, for the never event, some immediate changes to policy and practice. • 'Learn from Patient Safety Events' system (LfPSE) implemented and embedded • New meeting structure introduced: Patient Safety and Experience sub-committee and Clinical Outcomes and Effectiveness sub-committee commenced in Q3 for oversight of patient safety in order to provide upwards assurance to Quality and Safety Committee • 'Safety Pins' introduced – to share learning Trust-wide (Appendix)

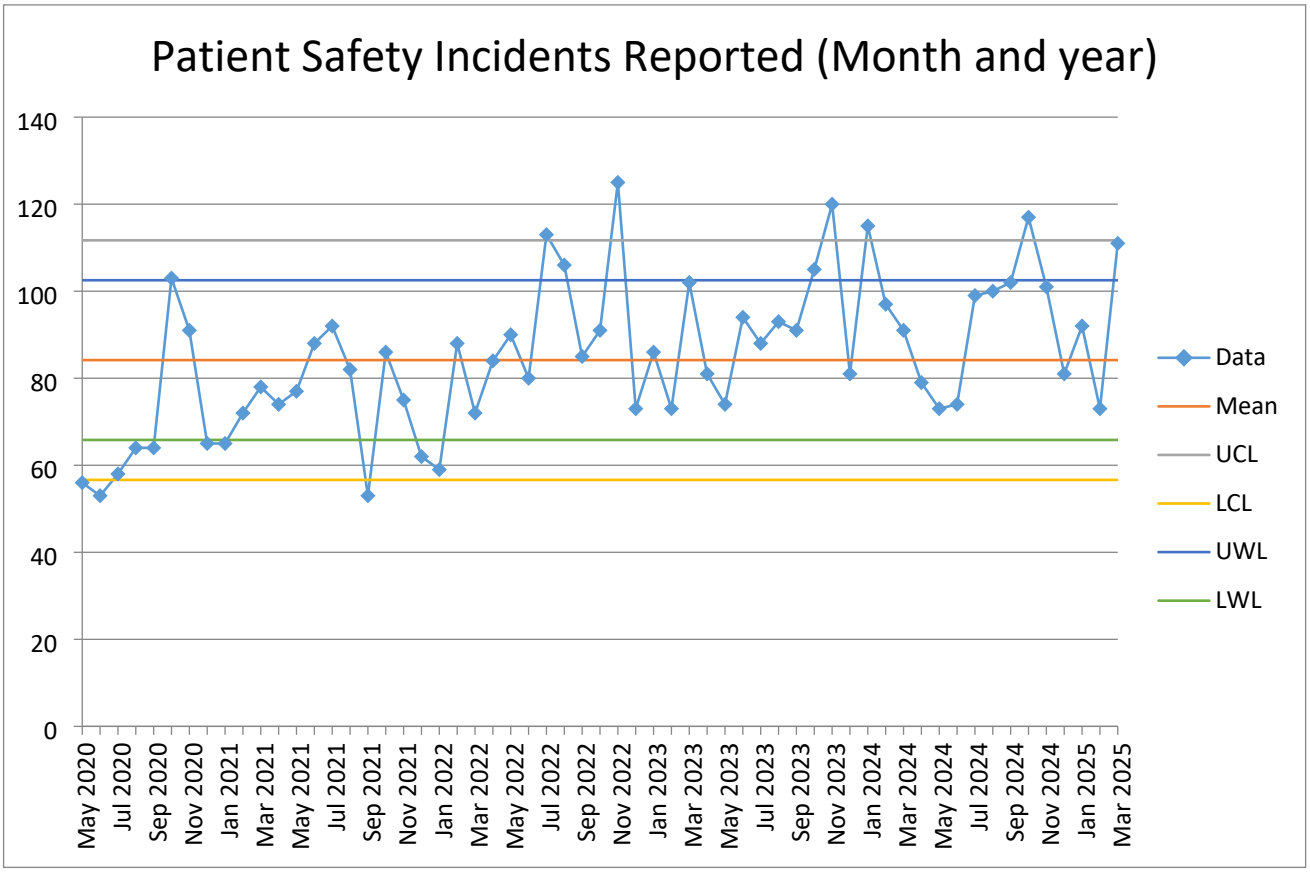
2.	Introduction
	This report has been compiled using analysis of intelligence, patient safety data and activity during the financial year 2024/25. Under the National Patient Safety Strategy, there has been an increase in national and regional Patient Safety events, supporting Trusts with the transition to this different way of investigating and enhancing shared learning.

3.	Service aim, objectives and expected outcomes
	The Patient Safety and Experience Team remain committed to supporting the Trust patient safety and experience agenda ensuring a reporting culture that it is open and transparent, fully embedded, integral to our everyday business, and that improvements in patient safety are prioritised. A fundamental responsibility throughout the organisation has been continuing to promote an environment where all staff are confident to voice concerns about patient safety; the team work with Directorate Triumvirate leads and support all staff with all aspects of safety in the day to day service delivery. The triangulation of incidents, claims and complaints supports the wider learning agenda.

4	Activity analysis / achievement

Incidents:

Data is collected, transcribed onto specialty reports and presented at respective triumvirate meetings by the safety team, along with Action Plan reviews from formal investigations, to maintain a focus on their completion and embedding in practice.



As reflected in the table above, reporting levels fluctuate and have recovered back to pre-pandemic levels; monitoring across all categories ensures there is a good culture of reporting across the organisation.

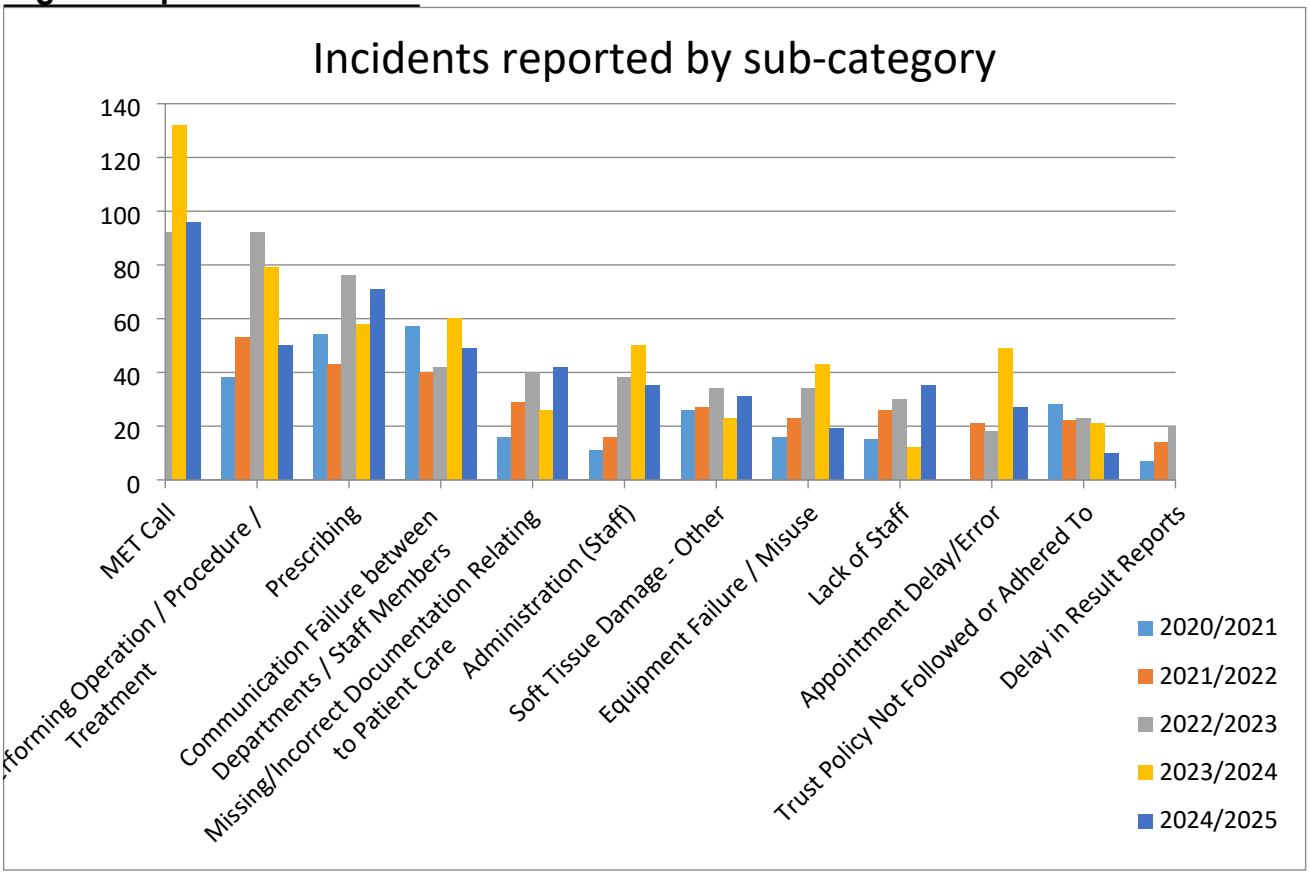
The LfPSE (Learn from Patient Safety Events) system is now fully incorporated into the Datix incident management system and the Patient Safety and Experience Team review all incidents following submission on the Datix system. All reports submitted as patient safety incidents on Datix are received by NHSE at the point of submission.

The Patient Safety and Experience Team monitor that all Datix' are categorised correctly to ensure the appropriate recording of patient safety incidents. The Team work with the staff to improve incident reporting and to capture learning. To date there have been no follow-up queries received from NHSE in respect of any of our reported incidents.

Improvements in the quality and safety of care continue to be a key priority for the Trust Directorates, with the triangulation of learning from incidents, audits, complaints, and patient feedback led by the triumvirates enabling embedding in practice.

'Safety Pins' were launched by the safety team in Q4 and are published monthly to share learning and advance improvements to patient care; these are collated from Trust incidents and, going forwards will also be from the national 'Patient Safety Updates' (Appendix)

Highest reported incidents:



Cardiac Arrest / MET call:

Staff are encouraged to call the Medical Emergency Team (MET) when a patient deteriorates and not to rely on the fact that senior staff are already present; the Trust follow national guidance in the use of NEWS 2 as a method of recognition of deterioration and this is fully embedded.

All MET incidents are reviewed by the Resuscitation and SIM Leads, not just in respect of the response and management of the call but also including, for any 'in-patients' the period leading up to the MET call, to ascertain if there was any delay in the recognition of the deteriorating patient; there were none identified within this reporting period.

Updates on all patients who are transferred out are obtained with assurances and any learning from their outcome shared with MET call investigations informing the content of the simulation training sessions.

Prescribing:
'Prescribing' errors continue to be the most frequently reported medication incident (incorrect prescribing and prescribing omissions). Within the reporting period, all were 'no harm' and the pharmacy team remain committed to ensuring that all errors are reported, fully investigated and any learning shared. (Appendix).

The introduction of Eolas (prescribing application) which replaced Microguide aims to safeguard against such errors. This is promoted at the junior doctor's induction and through relevant clinical groups, however the uptake has been low. Ongoing publication of antimicrobial guidelines continues as does the promotion of users accessing the platform.

Delay in performing operation / procedure / treatment:
This is wide-ranging category, including but not limited to:

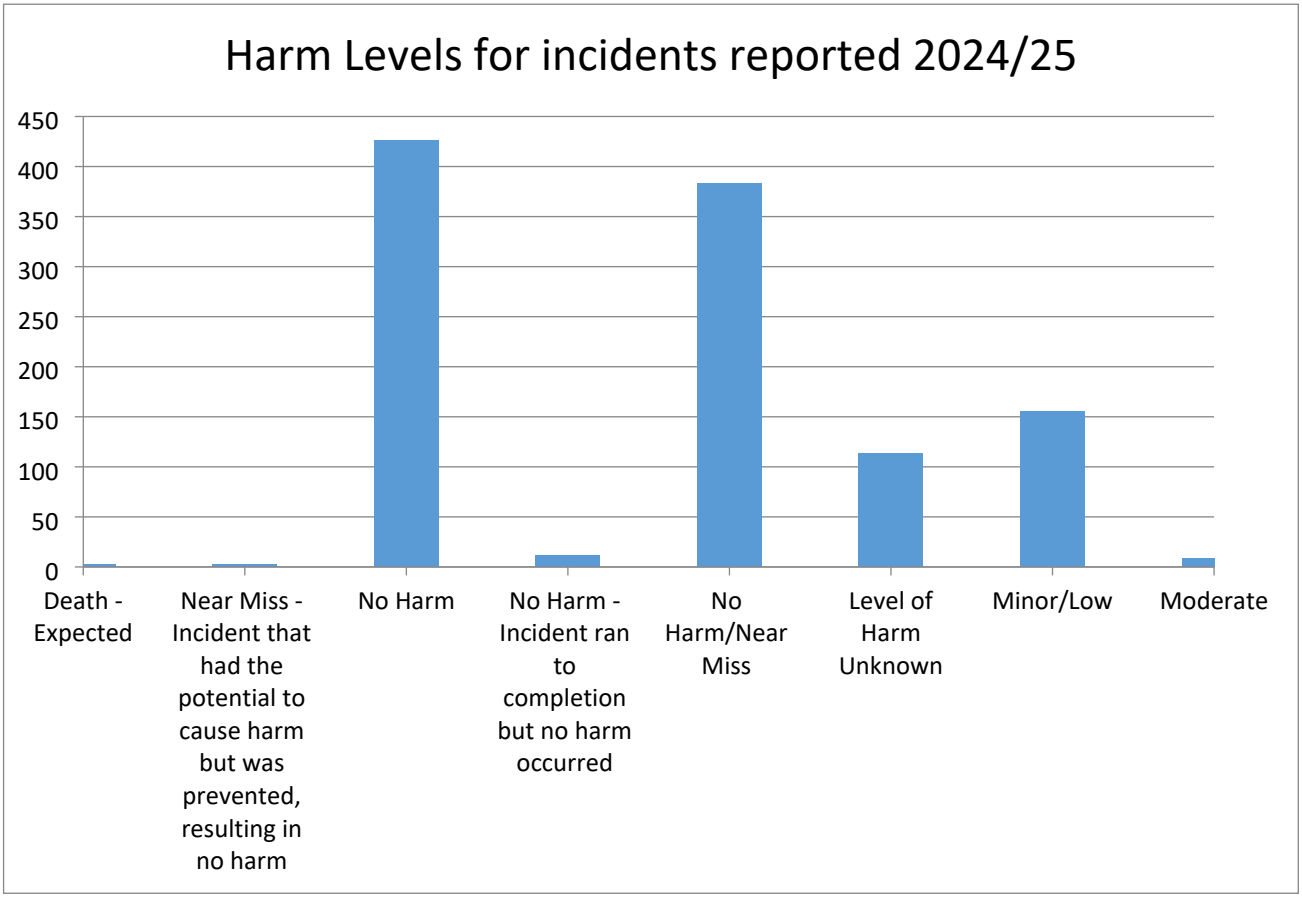
- Appointment / Referral delay
- Investigation / treatment / diagnosis or results delay
- Pre-operative delays
- Delay in performing operation / procedure / treatment

There has been a downward trend in reporting since 2022/23 of these incidents; due to investigations resulting in changes to practice / introduction of new systems and processes or policies etc.

The Patient Safety and Experience Team undertake scrutiny in relation to all the 'sub categories' of reported incidents, identifying any trends / themes and escalating concerns.

Of note, incidents citing 'Lack of Staff' has seen an increase in this reporting period; all reports of unsafe staffing were fully reviewed and it was confirmed for all cases that the staffing levels were in line with National 'Safe Staffing Guidance'.

Levels of Harm:



The highest levels noted with incidents were no harm (426), and 396 'no harm / near miss' reported, the majority of which (as above) were in about '*Delay in performing operation / procedure / treatment*', '*MET calls*' and '*medication*' incidents; no specific themes were identified within the 'no harm / near miss' incidents.

Moderate levels of harm remain low and are all fully investigated.

'Near miss' incidents:
The reporting of 'near misses' is viewed nationally as being positive; rather than staff only reporting when an incident has actually occurred as there is much learning to be gained from near-misses where an incident has been avoided or prevented from happening.

Work commenced by way of 'deep dive' into near misses and additional fields were added to Datix in order to identify what had occurred that ensured an *actual* incident was avoided. This will enable more in-depth learning from incidents. There have been no themes identified within the reporting period.

Reporters are now able to select 'near miss' and provide details about how an incident was avoided; going forwards this will result in the 396 'no harm / near miss' data above being refined within the new fields.

Level of harm unknown:
This is a choice for when the reporter does not know the outcome at the point of reporting; it is required to be updated following investigation in order to confirm the level of harm and incident investigations cannot be approved until this is updated.
All outstanding investigations are monitored within the executive sub-committees for Patient Safety and Experience and Clinical Outcomes and Effectiveness; towards the end of this reporting period there was encouragement towards reducing the number of open incidents.

Moderate harm:

- Two patients were admitted to QVH in poor physical condition and with skin damage: the originating organisations were advised of the harm in order for them to carry out their own investigations.
- A shared patient had delays at UHSx on the 62/7 pathway, Clinical Harm Review concluded moderate harm: UHSx informed and undertook the investigation.
- Corneo-plastics patient required further surgery to remove alternative lesion to the one removed initially (any incident requiring the patient to return to theatre is classified as 'moderate' harm) – Key Learning: photographic requirements increased to include '*clinicians having access to quality photographs on the day of surgery*' and pre-operative policy to be updated in response to the investigation findings
- * Pre-operative patient admitted unwell and transferred out with AKI: full investigation and response to the family was provided - Key learning: condition recognised promptly, some incidental learning identified in respect of documentation omissions.
- * 'Novosorb' (a type of dressing) applied incorrectly, requiring re-application (any incident requiring the patient to return to theatre is classified as 'moderate' harm) – personal learning for trainee involved plus reminder to all new doctors.
- Patient found to have retained foreign object (appeared to be gauze) following gynaecology surgery at a Private Hospital: escalated to them for investigation

The Trust complies fully with Duty of Candour (DoC) in line with Regulation 20. We openly encourage and support patients and their families to participate in investigations, offering and facilitating meetings with senior staff members.

For this reporting period, two formal DoC letters were sent to patients above*.

Patient Safety Investigations (PSII) / Internal Investigations:

Following the publication of the National Patient Safety Strategy in 2019, (the roll out of which was delayed due to the pandemic), the transition from the Serious Incident Framework to the new Patient Safety Incident Response Framework was rolled out. This strategy supports the NHS to investigate incidents openly without fear of inappropriate sanction, working with patients and families and supporting those affected by incidents to improve services.

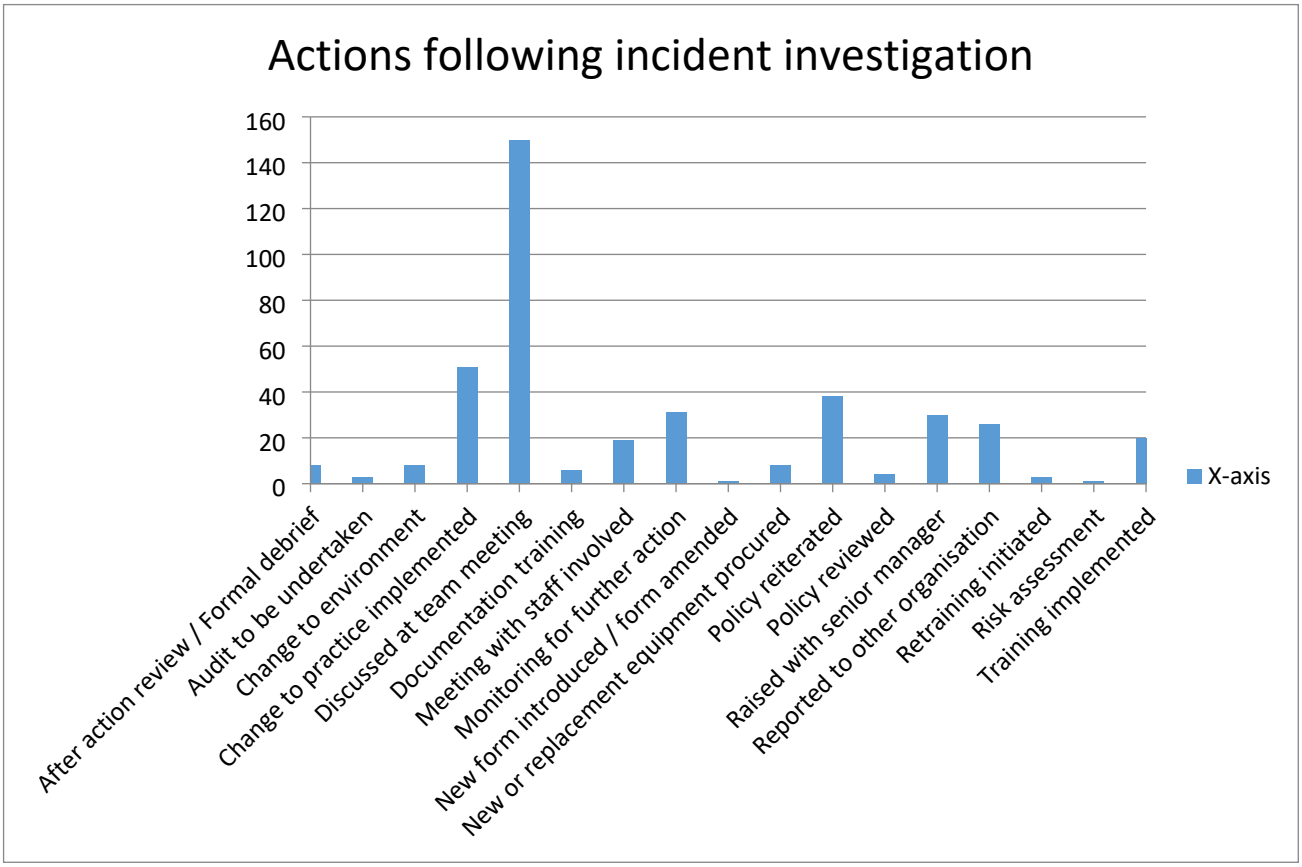
The most significant change is that incidents are no longer investigated due to the level of harm but by the overall opportunities for wider learning; also, '*Root-cause analysis*' has been replaced with '*systems based patient safety investigations*' in order to reflect the systems approach to safety.

There were no externally reported PSII's in this period, five incidents were internally investigated, all of which used the new framework and policy in order to aid and embed the new process.

There was one Never Event declared in 2024/25, a wrong site block on a finger; immediate actions were identified and changes made within the marking processes, there was no harm to the patient, DoC was not required however the patient received a full apology for the error.

All internal incident investigations continue to be discussed openly across the Trust, regardless of specialty, as lessons learned are seldom specific to any one area.

The table below demonstrates the actions, associated with learning, from completed incident investigations:



Incident investigations are now, within the new governance structure, presented at the Patient Safety and Experience and Clinical Outcomes and Effectiveness sub-committees respectively for discussion and approval / closure, with the action plans tabled to return for assurance that all actions have been considered, completed and embedded in practice.

In January 2024, NHSE launched a national consultation around the Never Events Framework, exploring whether it is an effective mechanism to drive patient safety improvement, offering four options as follows:

- Option 1: No change; continue with the current framework
- Option 2: Abolish the Never Events framework and list

- Option 3: Revise the list of Never Events to only include those with current barriers that are 'strong, systemic, protective'
- Option 4: Revise the definition of and process for Never Events to create a new system that does not require all relevant incidents to be 'wholly preventable'.

This consultation completed in May 2024 and the results are yet to be shared / published.

Policy Management

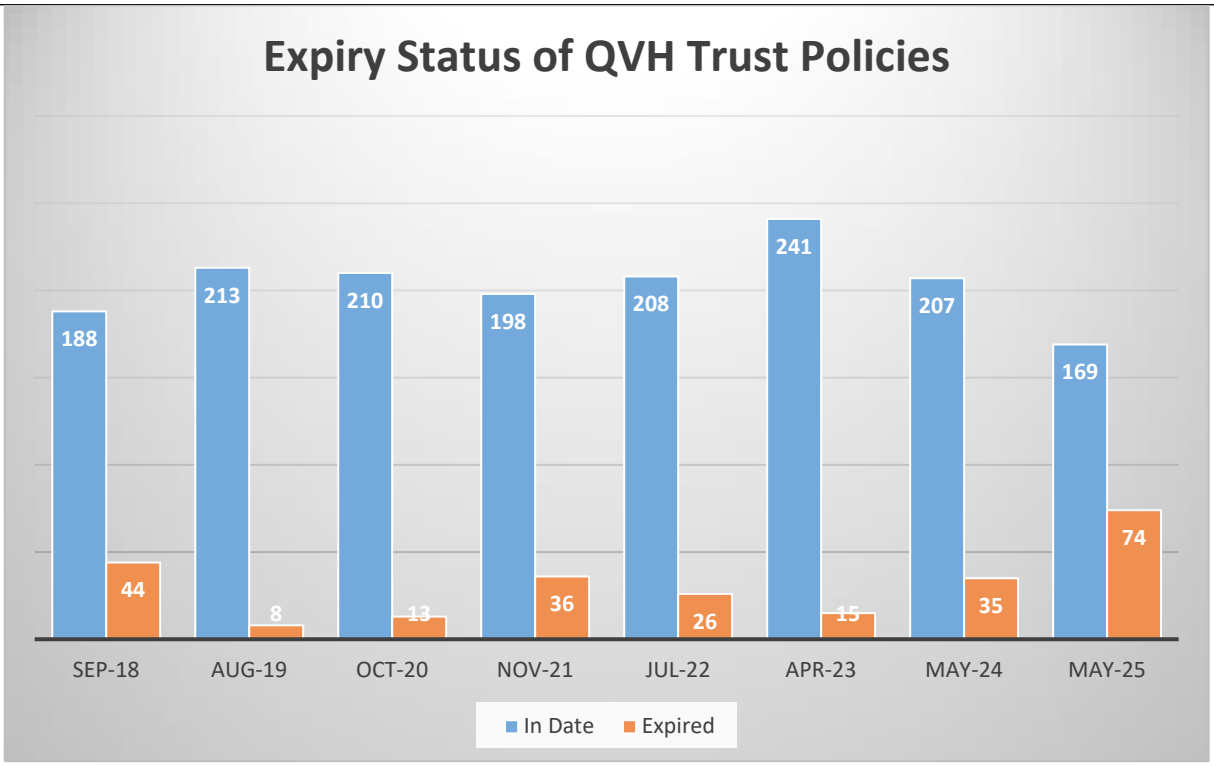
Work has continued around robust policy management during the 2024-25 period.

The *Policy for the Development and Management of Trust Policies* was reviewed by the Company Secretary and is due for ratification in Q1 2025/26; it continues to be implemented through the following actions:

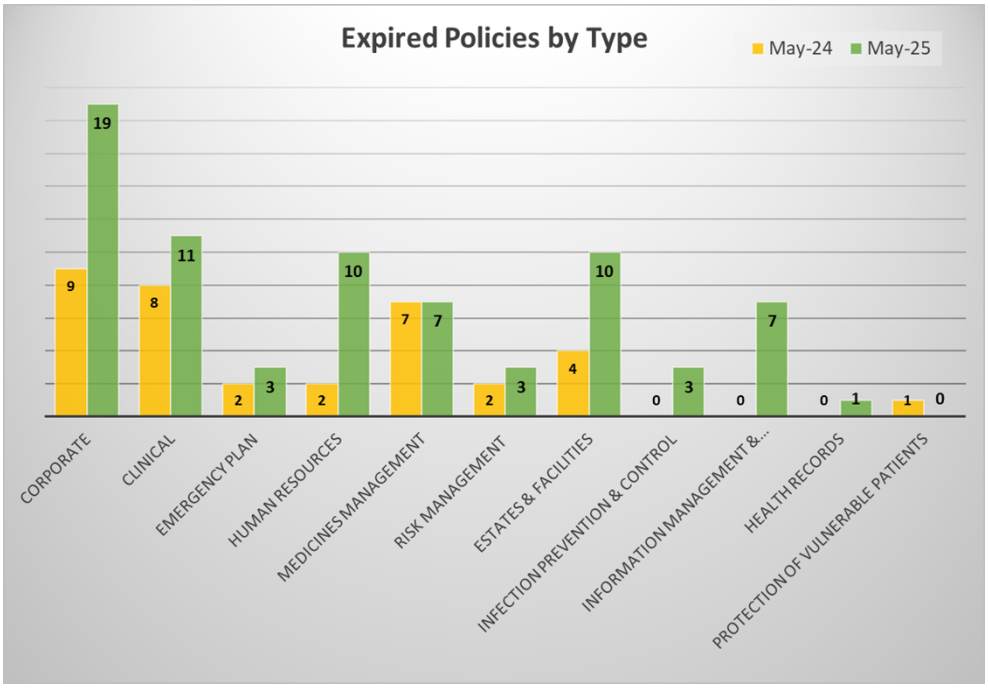
- A Policy Masterfile is maintained by the Patient Safety and Governance Facilitator
- Reminders are sent out 4 months prior to expiry and again at 6 weeks if a response is not received. (This email includes full guidance on the renewal process, a copy of the current QVH policy template and the last Word version of the policy)
- Authors are required to cross-reference any standard operating procedures or guidance related to the policy; this information supports better version control across the Trust.
- Extensions to deadlines are requested via a 'deadline extension form' and approval sought from the executive lead for the policy.
- All policies are monitored through the relevant subcommittees.

Expired Policies:

The number of expired policies is 74 out of 243 Trust-wide policies (30%). Whilst the data below is outside of this reporting period (May 2025) it represents accurate data at the time of report collation; it is noted that the number of expired policies has increased in comparison to previous years, the team continue to request updates from authors, and all outstanding policies and the associated risks are monitored through the executive sub-committees for Patient Safety and Experience and Clinical Outcomes and Effectiveness, chaired by the Chief Nursing and Chief Medical Officers respectively.



Please note: some policies have been removed from circulation or incorporated in to other documents as well as new policies being introduced, so the overall totals may vary between each period



Assessment of risk for expired policies:

A policy that has passed its expiry date will remain available on the intranet (Qnet) to ensure information is always available to staff, however the expiry date is visible; at no point will a policy be removed from circulation without a replacement.

Policy authors are responsible for ensuring their own policies are amended in the event of any of the following irrespective of when the policy is next due to be reviewed:

- Recommendation(s) by regulatory or external scrutiny organisations and/or changes in legislation, national or local guidance or policy.
- Recommendations following an identified risk or incident which has occurred.

Ongoing developments:

- Version control has been improved through the use of Microsoft SharePoint.
- The Microsoft Teams 'policy administration' channel has created improved access for admin staff supporting with policies.
- Work is underway to develop a new Trust intranet enhancing the way policies are accessed by staff. The Patient Safety and Governance Facilitator is working alongside the Communications team to support the implementation.

5 Involvement & Engagement

Inquests:

The Head of Safety and Patient Experience worked with staff, Trust solicitors, patients and their families and coroners' officers in relation to inquests held in this reporting period; co-ordinating Coronial and legal requirements and supporting those staff required to attend. Debriefs and pastoral care was also provided for all staff.

There were two inquests held in this year within the Head and Neck specialty, throughout internal patient safety investigation significant work was undertaken to complete actions plans, multiple staff provided statements and attended the inquests held in February and April 2025 respectively. The families were supported by the Trust, participating in the investigations until the inquests and 'open' invitations to meet with Trust leads was extended following the inquests.

Both Coroners returned narrative conclusions following full inquest hearings, these are conclusions when the Coroner returns descriptive, factual findings. It is used when a 'short form' conclusion (eg. suicide / accident / natural causes etc) is not sufficient.

The investigation action plans were presented at both inquests, reflecting the learning identified in respect of the deaths, both incidental and material; giving assurance to the Coroners of the commitment of the Trust to wider learning resulting in 'Prevention of Future Deaths' (PFD: Regulation 28) reports not being required.

Freedom to Speak up Guardian (FTSU)

During this reporting period an external FTSU company were brought into the Trust; this resulted in a significant increase in contacts made by staff – there were no patient safety issues raised via this route.

Patient Safety Team

The team have maintained their attendance at specialty, directorate and executive level meetings. Reports and information are provided and presented at Governance days, inductions / staff updates and staff forums as required with oversite of investigations, providing support to all staff around all aspects of the patient safety agenda.

	The Head of Safety and Patient Experience attends national and regional meetings as the QVH Patient Safety Specialist and, along with the Patient Experience Manager, participates in NHS Resolution forums in respect of legal claims.
6.	**Learning from Experience**
	The Trust governance restructure during 2024 led to a full review of patient safety reports. The patient safety team have worked collaboratively with the directorate leads to identify key patient safety metrics and information required. The new reports have been continuously updated, developed and progressed for each reporting period; with information from other specialty areas included, sharing incidents and learning wider across the services. Investigations undertaken within PSIRF generated much learning around the new systems and processes, particularly how much more time consuming it was; this being so very different to working within the Serious Incident (SI) Framework, bringing with it understandable challenges around the changes and requirements. In the main this was related to staff having worked for so long within the SI Framework that it was a challenge to adapt to the new way of investigating. Working more closely with patients and their relatives / carers is a pivotal part of PSIRF which the Trust has embraced, offering participation in investigations, discussions and meetings; all of which has been well received by our patients and their families. Some key investigations throughout the year have provided the trust with valuable learning around what we have done well and where we can improve and do things differently to work alongside our patients and their families, to succeed in relationships with them. As part of the overall governance restructure the Joint Hospital Clinical Governance meeting has been replaced by a ‘Clinical Learning Forum’ led by the Chief Medical Officer.
7.	**Recommendations**
	The Patient Safety and Experience Team remain committed to supporting directorates across the Trust by ensuring that learning from incidents continues to be shared meaningfully and effectively. The team will continue to respond to changes as they arise, providing relevant and reliable data that reflects the evolving requirements of patient safety and organisational learning. This ongoing support must be balanced against current resource constraints; at the end of this reporting period, the team’s staffing capacity has reduced by approximately 20%. In line with wider NHS financial constraints, the vacant posts will not be recruited to and will be removed from the establishment. The functions previously held by those roles will be redistributed within the existing team. The trust are looking at new ways of working to support any changes in establishment The team will continue to focus on improving patient safety systems and processes, remaining engaged in identifying and supporting new initiatives that drive continuous improvement and provide enhanced assurance around patient safety performance.

8	**Future plans and targets**
	The Safety and Patient Experience Team will continue to embed and support high level responses to patient safety within the Trust, with key goals for the year to include: • Continued close, supportive working with all staff, clinical leads and managers to enhance individual knowledge and understanding around incident management and patient experience requirements. • Encouraging and supporting ownership of recommendations and findings from investigations, claims and complaints including the completion of action plans and implementation of meaningful learning. • Expansion of robust processes around Inquest requirements – in response to the increasing numbers of upcoming inquests; to fully support and guide staff involved as witnesses. • Working alongside colleagues from other teams to support the progression of the new Clinical Learning Forum as it develops within the Trust as a valuable learning forum. • Ongoing development of expertise within the team to ensure continuation of effective safety and patient experience systems and processes. • Continuous monitoring of the impact on the patient safety team wellbeing in relation to the reduction of the teams establishment.
9	**Conclusions and assurance**
	The patient safety agenda has been maintained throughout this year, working to continue to meet the national requirements of LfPSE and PSIRF, supporting all staff and responding to changes both nationally and within the Trust in order to sustain robust patient safety. All incidents are monitored for levels of harm and work will continue around the information collected from ‘near miss’ incidents to improve care and inform practice. The Safety and Patient Experience Team engage with all staff to continue to maintain and improve safety structures across all areas of the Trust promoting, improving and upholding a substantial safety culture and encouraging reporting of incidents and concerns. The monitoring and oversight of policies continued throughout this year, with all authors fully supported in the management of their policies. Continuous development of the remaining team is essential in order to achieve full potential in ensuring robust, credible and evidenced governance processes across the Trust, to provide the required assurance around this essential element of Trust services.

Appendix: Safety Pin

NHS
Queen Victoria Hospital
NHS Foundation Trust

Outstanding care is enhanced by shared learning; each month we will use the safety pin notice to share lessons learnt and progress improvements to patient care.

Paracetamol risks

Sally* was admitted as an inpatient to the ward for management of a trauma injury. She was weighed on admission and found to be 43kg. During a drug round, she was accidently administered 1g of paracetamol instead of the 500mg prescribed for her weight.

The nursing staff noticed this error and immediately apologised to Sally; no harm was caused.

**name changed to protect patient anonymity*

Lessons learnt

This incident was considered a 'near miss' and relatively low risk. Paracetamol has few side effects for most people, and is often the first-line treatment for mild to moderate pain for patients in hospital, however, there are risks to patients if administered in excess.

A recent patient safety investigation was published by Healthcare Safety Investigation Branch (HSIB: an independent body tasked with investigating serious incidents involving patient safety in NHS-funded care in England) titled '**Unintentional paracetamol overdose in adult inpatients with low bodyweight**'. It outlines a case where an adult patient with low bodyweight died after developing liver toxicity, likely due to an overdose of paracetamol.

The HSIB investigation identified contributory factors that contributed to staff's perception of paracetamol as a largely risk-free medication. Staff told the investigation team that paracetamol is given to many patients on a daily basis and is not a medication they perceive as high risk.

The full report can be viewed here. Of note, one safety observation was:

It may be beneficial for electronic prescribing and medication administration systems to include an alert for oral paracetamol that prompts documentation of a patient's weight and consideration of the risk of liver toxicity when their weight is less than 50kg.

Our Pharmacy team are actively working to include an alert into the new Electronic Prescribing and Medicines Administration (ePMA) system to further enhance patient safety.

For further information on safety pins, or to suggest a story, please contact the Safety and Patient Experience team

Queen Victoria Hospital
NHS Foundation Trust

Report cover-page					
References					
Meeting title:	Board of Directors				
Meeting date:	10/07/2025		**Agenda reference:**	**48-25**	
Report title:	Learning from Deaths annual report 2024-25				
Sponsor:	Tamara Everington, Chief medical officer				
Author:	Tamara Everington, Chief medical officer				
Appendices:	None				
Executive summary					
Purpose of report:	This report provides assurance to the Board that there is embedded evaluation and learning around deaths associated with care at QVH that is consistent with best practice.				
Summary of key issues	Areas for improvement have been identified however, the overall interpretation is that learning from deaths is being applied consistently. • Mortality review process is consistent with national guidance • Local policy and process requires updating to connect information • Good evidence of quality learning from deaths • Subsequent to publication of the report describing the review of patients who died within 30 days of an outpatient procedure, there is one outstanding review as we have been unable to ascertain the cause of death, and one review which is being considered within orthodontic governance.				
Recommendation:	The Board is asked to note the report.				
Action required	Approval	Information	Discussion	**Assurance**	Review
Link to key strategic objectives (KSOs):	KSO1: *To deliver outstanding care*	KSO2: ***To innovate and improve***	KSO3: *To be an excellent employer*	KSO4: *To deliver sustainable services*	KSO5: *To collaborate with others*
Implications					
Board assurance framework:	none				
Corporate risk register:	none				
Regulation:	none				
Legal:	Relevant to coronial inquests as identified in the report				
Resources:	none				
Assurance route					
Previously considered by:	ELT Quality & safety committee				
	Date:	27/05/25 03/06/25	Decision:	Submission to Trust Board	
Next steps:					

Quality & Safety

Annual Report – Learning from deaths

Report covering the period from
April 2024 to March 2025

Document Control:
Executive sponsor: Tamara Everington, Chief Medical Officer / Edmund Tabay, Chief Nursing Officer

Author: Tamara Everington

Date: 21 May 2025

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Contents List

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1.	Executive Summary
	The approach to learning from deaths at QVH is consistent with national guidance and frameworks. As a specialist hospital, QVH collaborates within specialist networks of care as well as with partners and commissioners in review of deaths. Deaths whilst an inpatient or shortly thereafter in patients who have deteriorated are subject to in depth review. Deaths within 30 days of assessment or intervention at QVH are triaged for potential correlation with mortality review undertaken in services as appropriate. The absolute number of deaths related to care at QVH is low consistent with its size and the nature of specialist practice. This report evidences learning from mortality review supported by thorough investigations and detailed action plans. There has been transition in senior leadership and governance related to mortality review processes. Further work needs to be done to consolidate policy and process with regular reporting on this.

2.	Introduction
	The National Quality Board 2017[1] (NQB) published *A Framework for NHS Trusts and NHS Foundation Trusts on Identifying, Reporting, Investigating and Learning from Deaths in Care.* QVH adopts the principles of the NQB framework seeking to learn from all inpatient deaths and those that occur within 30 days of appointments, interventions and treatments. The *NHS Standardised Hospital Mortality Index* (SHMI) is the ratio between the actual number of patients who die following hospitalisation at an NHS trust and the number that would be expected to die on the basis of average England figures, given the characteristics of the patients treated there. QVH is on the NHSE exemption list for participating in SHMI as it is not possible to benchmark our unique patient mix with low numbers of deaths against any other providers. QVH has two policies in relation to patient death: "Bereavement and care after death policy including Trust procedure for Mortuary arrangements" (CNO) and "Responding to and learning from deaths" (CNO). Both policies are under review as there is appetite to move to the national *ReSPECT* process to support end of life planning, and people, processes and governance structures in relation to mortality review have changed in year. It is notable that the core principles within these policies remain unchanged. Surrey & Sussex Healthcare Medical Examiner's Service provides Medical Examiner services, which are independent from the NHS Trust of that name. All deaths are discussed with the Medical Examiner and the service advises whether coronial referral is needed. On 15th April 2024, the Department of Health introduced *Death Certification Reforms* which came into force on 9th September 2024 with

[1] nqb-national-guidance-learning-from-deaths.pdf (england.nhs.uk)

	implementation across the NHS of a new *Medical Certification of Cause of Death (MCCD)*. The ME service supporting QVH helps colleagues ensure that the *Responding and Learning from Deaths* Policy is consistently embedded into practice by: • Providing greater safeguards for the public by ensuring independent scrutiny of all non-coronial deaths • Ensuring the appropriate direction of deaths to the Coroner • Providing an improved service for the bereaved and an opportunity for them to raise any concerns to a doctor not involved in the care of the deceased • Improving the quality of death certification • Improving the quality of mortality data. QVH introduced the national *Patient Safety Incident Reporting Framework (PSIRF)* in December 2023. It utilises the framework to investigate all patient safety-related incidents, including those related to the unexpected death of a patient in our care. The intent of this approach is to achieve the following: • Provide an improved experience for those affected by patient safety incidents • A more proportionate and effective response to patient safety incidents. • An improved range of learning methods • Strengthened governance and oversight The *Learning from patient safety events (LFPSE) service* is now in use across the NHS following decommissioning of the *National Reporting and Learning System (NRLS)* in June 2024. The *Strategic Executive Information System (StEIS)* remains in place as an interim measure whilst use of LFPSE is being embedded. Quality Review meetings between QVH and the Integrated Care Board are currently ongoing. It is recognised that shifts in NHSE and ICB structures may affect these arrangements going forward. Quarterly assurance meetings are held with the CQC with interim timely engagement where any concerns arise in relation to the quality and safety of care. All burns deaths are peer reviewed at the London & South East England Burns Network (LSEBN) through mortality & morbidity (M&M) meetings. National Registry reporting for other elective specialist services includes mortality reporting. The QVH Quality Account provides high level detail on mortality review for our partners and the public.

3.	**Mortality review; aims and objectives**
	To assist with the identification of patients where more detailed investigation may be needed, deaths are classified as follows: • Inpatient deaths at QVH (expected and unexpected) • Deaths within 30 days of QVH inpatient/outpatient episode (unrelated/related) All inpatient deaths are subject to a *Structured Judgement Review (SJR)* by a senior clinician who did not have significant involvement in the care of the patient. All SJRs are reviewed at the Trust Clinical Outcomes and Effectiveness Group, which reports into the Executive Committee for Quality and Risk. Unexpected inpatient deaths are investigated under the PSIRF framework.

	Deaths within 30 days of QVH inpatient/outpatient episodes are highlighted with service Clinical Leads to ascertain whether death was related to hospital care. Where deaths were related to hospital care, discussion and review will take place within the service morbidity & mortality (M&M) meeting. Outputs from M&M meetings are fed back into directorate governance processes and performance reviews. Deaths within specialist services are reported into national registries and also considered within Networks. The aim of these approaches is to ensure learning from deaths that includes those directly involved in the care of the patient, and also the wider organisation and system. Independent review within processes is established to provide assurance that all perspectives in relation to learning have been considered. Information collation and learning is structured to support coronial processes including inquests taking into account any concerns or questions raised by families and loved ones.

4.	**Mortality analysis**
	In 24/25 there were 51 deaths within 30 days of either an inpatient episode or outpatient procedure at QVH. This compares with an average of 30-40 in the previous 3 years. Review of deaths has not identified any reason for this higher number in 24/25. The increase may relate to the greater number of patients treated in year, more severe patient comorbidities and factors related to the Medical Examiner system, which have made deaths in the community more apparent to acute care. Analysis of these 51 deaths is partially complete (67%). No clear correlation has been drawn between deaths and care at QVH to date. There have been 2 deaths in inpatients at QVH in 24/25. SJRs were performed for both patients and these have been shared through governance channels for review and learning. The first death occurred in a patient who had serious advanced comorbidities from which she died. She was cared for on an end of life pathway. No concerns were raised around care, which was rated as good or excellent. The second inpatient death was in a young patient with serious burns and multiple comorbidities. Debriefs have been held. There has been engagement with the family to explore their concerns, and their questions are informing an investigation under the PSIRF framework. Colleagues in the Burns Network collaborated in care of the patient, and their input will be included in the review. Witness statements are being prepared for an inquest anticipated for Autumn 2025. This death has also been reported under the *Learning disabilities mortality review programme (LeDeR).* There have been 3 deaths in patients who deteriorated whilst under the care of QVH and were transferred out having developed multi-organ failure. One death was in a patient with severe burns and other complex comorbidities. An SJR did not identify significant deficiencies in care but an investigation was performed under the PSIRF framework. Minor learning points including the timely transfer of electronic documentation between systems were identified, and these are being addressed. An inquest will follow. A second death was in a patient who underwent surgery for skin cancer but also had serious comorbidities. This patient deteriorated over a weekend and concerns around care prompted an investigation under the PSIRF framework in accordance with the wishes of the family. A number of learning points were identified around admission

	processes and escalation in the event of deterioration. An action plan is being generated and will be monitored. A third death was in a long term patient who had suffered severe burns and required a complex package of care. An SJR has been performed and family questions are informing an investigation under the PSIRF framework which will inform a later coronial inquest. The Burns Network was involved in the care of this patient and have been included in review. There have been 2 inquests with QVH involvement in 24/25. In the first QVH attended in the context of providing expert witness input. Learning from this death, the Psychological Therapies team altered their pathway for patients whom it proves hard to contact with more frequent checks and also follow up with the GP and referrer if there is ongoing non-engagement. The second inquest was into the death of a patient following head and neck surgery at QVH in 2023. A serious incident investigation had been undertaken following this patient's death and a number of areas for improvement were identified including ease of access to emergency equipment, documentation and training. At inquest the Coroner expressed satisfaction with the quality of the QVH investigation, learning and action plan. The Coroner returned a narrative verdict at the inquest indicating that death was from natural causes and that none of the factors identified in the investigation had materially contributed to the patient's death.

5.	**Involvement & Engagement**
	In 24/25 there has been transition in leadership with a vacancy in the Head of Quality & Compliance role which was filled in April 2025. Formal governance structures for the Trust were revised in 24/25. These are still embedding and may need to evolve further as priorities for 25/26 are considered. Experience and collated evidence from 24/25 shows a strong culture of engagement. There is a need to ensure that information and understanding is formally connected and communicated in real-time, and work is ongoing to improve on this. There has been involvement of family and loved ones in mortality reviews where appropriate. The Clinical Outcomes and Effectiveness Group (COEG) has been established as a Trust-wide governance forum for mortality review in addition to governance within services and directorates. Outputs from COEG progress to the Executive Committee for Quality & Risk (ECQR) and Quality & Safety Committee (QSC) for assurance as appropriate. The Board are notified and engaged when an unexpected death occurs in the Trust. The Clinical Learning Forum concept was developed, approved and will be rolled out in 25/26 as a Quality Priority to include consideration of patient deaths. As identified in the introduction, incidents arising from unexpected deaths have been shared within national platforms and networks, with the CQC and with our ICB local commissioners.

6.	**Learning from Experience**
	The following key learnings have resulted from evaluations in 24/25:

	• Transition in senior leadership and revised internal / external governance arrangements require effective handover and transition planning to enable continuous understanding, ownership and reporting • Facilitated hot and cold debriefs followed by SJRs play an important role in ensuring the breadth of issues following an unexpected death are recognised and staff feel supported through processes. • Staff experience inquests as intensely stressful. Detailed investigations with monitored action plans help to support coronial considerations. Support for witnesses prior to inquests helps ensure confidence and preparedness • Including any questions or concerns from family or loved ones in mortality review helps improve the quality of assessment and supports a compassionate response to loss • Understanding of events leading to death even when these did not directly influence the final outcome, helps identify areas for improvement in care

7.	**Recommendations**
	The following recommendations arise from involvement and learning: 1. Update of policies to include clarity on current roles, governance processes and reporting arrangements. This must be agreed, effectively communicated and reconsidered with any new transition of senior leaders or structures 2. Ongoing work to ensure that debriefs and required mortality reviews are scheduled and facilitated so that necessary outputs and actions are documented and progressed in line with standard operating procedures 3. Regular oversight monitoring to ensure investigations are thoughtful, inclusive and timely. Use of all available information to enable triangulation and preparedness for internal learning and coronial processes

8.	**Future plans and targets**
	1. Update of policies in relation to death by 1st October 2025 (noting that agreement on transition to ReSPECT process has yet to be agreed) 2. Evaluation and reporting processes for mortality review agreed and communicated by 1st August 2025 3. Roles and responsibilities for mortality oversight within services, directorates and senior leadership agreed and defined by 1st August 2025 4. Regular governance monitoring meetings include oversight of mortality review detail by 1st August 2025

9.	**Conclusions and assurance**
	There has been transition in leadership and governance arrangements around mortality review in 24/25. This has led to a lack of clarity around roles, responsibilities and reporting arrangements at times. Completed mortality reviews have been well considered and thorough with evidence of learning and relevant action plans.

10.	**Appendices**
	n/a

11.	Report approval and governance
	For approval by the Executive Leadership Team prior to consideration at the Quality and Safety Committee in June 2025

Report cover-page					
References					
Meeting title:	Board of Directors				
Meeting date:	10/07/2025	**Agenda reference:**	**48-25**		
Report title:	Safeguarding Annual Report 2024/25				
Sponsor:	Edmund Tabay, Chief nursing officer				
Author:	Katy Fowler, Named Nurse for Safeguarding and Looked After Children Ian Cruickshank, Named Nurse for Safeguarding Adults and MCA lead				
Appendices:	Section 11 progress on amber actions				
Executive summary					
Purpose of report:	To provide assurance to the Board that QVH is fulfilling its statutory functions for safeguarding and Mental capacity act				
Summary of key issues	**Current Challenges:** • Compliance with the Mental Capacity Act and consent remains a significant challenge. • There is currently no regular on site psychiatric or mental health liaison nurse provision at QVH. • Managing safeguarding concerns is made more difficult by the lack of electronic patient records. • The safeguarding team recognise that there is need for further audit, which has not been possible to undertake to date. • Children being seen outside of children only clinical areas **Current Achievements:** • The safeguarding team continue to embed a 'think family' culture across the trust. • The safeguarding team have worked closely with the EPR implementation team • There is a new protocol for children not brought to appointments known as Was Not Brought (WNB). • The Safeguarding Champions Group has been reconstituted in conjunction with the members. • Improvements have been made to the Adult Safeguarding and Mental Capacity Act training. • MCA remains high risk on the risk register.				
Recommendation:	That the Board **notes** the annual report.				
Action required	Approval	Information	Discussion	**Assurance**	Review
Link to key strategic objectives (KSOs):	KSO1: ***To deliver outstanding care***	KSO2: ***To innovate and improve***	KSO3: *To be an excellent employer*	KSO4: *To deliver sustainable services*	KSO5: ***To collaborate with others***
Implications					
Board assurance framework:	BAF – KSO1				
Corporate risk register:	MCA remains on the risk register.				
Regulation:	CQC				
Legal:	QVH have a legal duty to provide a safeguarding annual report for assurance and scrutiny.				
Resources:	None				
Assurance route					
Previously considered by:	Strategic Safeguarding Group, Patient Safety and Experience. Quality & safety committee				
	Date:	02/07/2025	Decision:	Approved	
Next steps:					

Queen Victoria Hospital
NHS Foundation Trust

Safeguarding Annual Report

Queen Victoria Hospital NHS Foundation Trust
Service Annual Report

Report covering the period from
April 2024 to March 2025

Executive Sponsor: **Edmund Tabay, Chief Nurse**

Authors:
Katy Fowler, Named Nurse for Safeguarding and Looked After Children
Ian Cruickshank, Named Nurse for Safeguarding Adults and MCA lead

April 2025

1. Executive Summary

This annual report provides a summary of activity, progress and multi-agency participation in relation to adults' and children's safeguarding and the Mental Capacity Act (MCA) during 2024/ 25.

The Chief Nurse has executive leadership for safeguarding at Queen Victoria Hospital (QVH).

Safeguarding systems at QVH are well established.

Current Challenges:

- Compliance with the Mental Capacity Act and consent remains a significant challenge. Following the audit completed in 2024 this issue has been assessed as high risk on the organisational risk register.
- There is currently no regular on site psychiatric or mental health liaison nurse provision at QVH. The safeguarding team provide input where there is an identified safeguarding element to support individuals and teams. Psychological therapy service is available to our patients. Arrangements are in place for psychiatric input where this is required in a legal context. It is recognised that enhanced input from a psychiatry multidisciplinary team would be beneficial given the nature of our case mix and this is being explored through a revised service level agreement with our mental healthcare partners.
- Managing safeguarding concerns is made more difficult by the lack of electronic patient records.This is being addressed by the introduction of an Electronic Patient Records (EPR) 'Archie', later on in 2025.
- The safeguarding team recognise that there is need for further audit, which has not been possible to undertake to date for example dog bites, domestic abuse and MCA re-audit.
- Children being seen outside of children only clinical areas.

Current Achievements:

- The safeguarding team continue to embed a 'think family' culture across the trust. This is recognising that it may not only be the patient who is at risk; training supports this.
- The safeguarding team have worked closely with the EPR implementation team to ensure that the new EPR will help facilitate safeguarding and mental capacity compliance across the trust.
- There is a new protocol for children not brought to appointments known as Was Not Brought (WNB). The safeguarding children team will be monitoring compliance and effectiveness through continuous audit during this year.
- Staffing: the current Named Nurse for Safeguarding Adults and MCA Lead is retiring and has been succeeded by the previous Band 6 Adult Safeguarding Specialist Nurse. The Band 6 post is being advertised.

- The Safeguarding Champions Group has been reconstituted in conjunction with the members. The frequency and duration of meetings has changed as well as the focus on case study learning and policy review.
- Improvements have been made to the Adult Safeguarding and Mental Capacity Act training. The training has now been separated with a session dedicated to adult safeguarding and another to the MCA. Both sessions are primarily case study based, using QVH examples to generate discussion.

The safeguarding team have identified key priority areas that reflect priorities within the wider system that will be a focus for the coming year:

- Did not attend -adult at risk. The Was Not Brought policy for Safeguarding Children needs to be replicated for Adults at risk. On occasion non-attendance at hospital appointments is associated with either neglect or self-neglect. This needs to be managed with risks assessments and robust protocols.
- Monitoring of WNB in children, adherence to protocol, overall WNB rates within the trust.
- MCA remains high risk on the risk register and therefore is a priority for the safeguarding team. Work is ongoing to ensure that care and treatment is provided in a safe and lawful way as per the Consent and MCA policies.
- The EPR is a priority, this will provide opportunities to strengthen safeguarding practice and adherence to the MCA.

2. Introduction

Each year a safeguarding report is produced for the Queen Victoria Hospital (QVH) Board to provide assurance that the trust is undertaking its safeguarding responsibilities in maintaining the safety and protection of those at risk of abuse and neglect whom QVH staff become aware of through the course of their work. This report covers the period from April 2024 to March 2025.

QVH is required under statute and regulation to have effective safeguarding arrangements in place to safeguard and promote the welfare of children and adults who are at risk of harm from abuse or neglect. These arrangements include:

- safe recruitment
- effective training for staff
- effective supervision arrangements
- working in partnership with other agencies
- Identification of a Named Doctor and Named Nurse for safeguarding children, plus a Named Nurse for adult safeguarding and Mental Capacity Act lead.

The named professionals have a key role in promoting good practice within QVH, supporting local safeguarding systems and processes, providing advice and expertise, and ensuring safeguarding training is in place, which meets the required quality standards. They are expected to work closely with QVH Chief Nurse, NHS Sussex Designated Professionals, West Sussex Safeguarding Children Partnership (WSSCP) and West Sussex Safeguarding Adults Board (WSSAB), amongst others.

3. Safeguarding Adults

“All staff within the NHS have a responsibility for the safety and well-being of patients and colleagues. Living a life that is free from harm and abuse is a fundamental human

right and an essential requirement for health and wellbeing. Safeguarding adults is about the safety and well-being of all patients providing additional support to those least able to protect themselves from harm and abuse". NHS England

The Care Act provides the legislative basis for Adult Safeguarding. The local authority, who are the lead agency, will use safeguarding procedures in the following circumstances:

- The patient has care and support needs
- They are less able to protect themselves due to their care and support needs
- They are experiencing or at risk of abuse or neglect

The NHS responsibilities for providing support are wider than this, particularly for those experiencing domestic abuse; other patients may not meet the threshold for local authority safeguarding procedures but be at significant risk from abuse, neglect or exploitation and will require support from NHS service providers.

As a provider of secondary specialist health services QVH received referrals of patients who have suffered injuries associated with domestic abuse i.e. hand injuries, facial and skull fractures, lacerations and burns. These may include self-injury. These patients are often at high risk and require risk assessments, safety planning and referral to other agencies: Police and Domestic abuse support services. QVH had 32 patients where there were domestic abuse concerns in the last year. Of these:

10 patients were referred for domestic abuse support services
3 patients were referred to MARAC
2 patients were referred to the Police
NB: In many cases safeguarding measures had been already completed by the referring hospitals.

In order to safeguard patients it is necessary for QVH staff to

- Recognise the signs of possible abuse, neglect and exploitation
- To be professionally curious and provide challenge
- To adhere to making safeguarding personal guidance
- Record and share information appropriately
- Make referrals and liaise with outside agencies
- Agree and action safety/protection plans
- Participate in safeguarding enquiries
- Have systems in place to learn from incidents

In addition to the policies, procedures, training and supervision in these areas immediate guidance, where a possible safeguarding concern is raised, is provided by the Named Nurse for Adult Safeguarding, The Chief Nurse and the Site Practitioners.

QVH adheres to the Sussex Safeguarding Policies and Procedures which provides an over- arching framework to coordinate safeguarding within the Trust.

3.1 Safeguarding Adult activity

The overall safeguarding adult activity levels and training are reported to the Patient Safety and Experience Group, Strategic Safeguarding Group and the Safeguarding Champions Group on a monthly, bi-monthly, quarterly basis, dependant on the frequency of each meeting.

QVH is a specialist hospital with a small number of inpatient beds. A significant proportion of patients undergo day surgery. As a specialist health provider safeguarding measures will have often been taken by the referring hospital in trauma cases.

The number of adult patients in which there are safeguarding concerns totalled 101 in the last year. This figure includes all cases where there are concerns of possible abuse, neglect and exploitation and require initial enquires to be made. This will include cases where safeguarding referrals are made to the local authority. It should be noted that concerns may also be managed using local authority care management intervention and support from domestic abuse services or other actions. This represents an increase from the year 2023-2024 where 76 cases were identified.

In 27 cases, concerns of possible self- neglect were identified. Typically, this involved patients who did not attend their appointments or declined treatment, placing themselves at risk.

4. Safeguarding Children:
'*The welfare of the child is paramount'* is a principle that was enshrined in the Children Act 1989 and remains at the core of safeguarding children practice nationally. This is crucial to improve the outcomes for children and young people.

The Children Act (1989 & 2004) and Working Together to Safeguard Children (2023) place a statutory duty on all NHS organisations to safeguard and promote the welfare of children and young people. Section 11 of the Children Act (2004) specifies that organisations need to make arrangements to ensure that they discharge these functions. Therefore, organisations are expected to complete section 11 self-assessments and provide evidence to the West Sussex Safeguarding Children's Partnership (WSSCP) who monitor and evaluate the effectiveness of arrangements. The Section 11 was completed during 2024. Please see the Section 11 Action plan in appendix 1 for details.

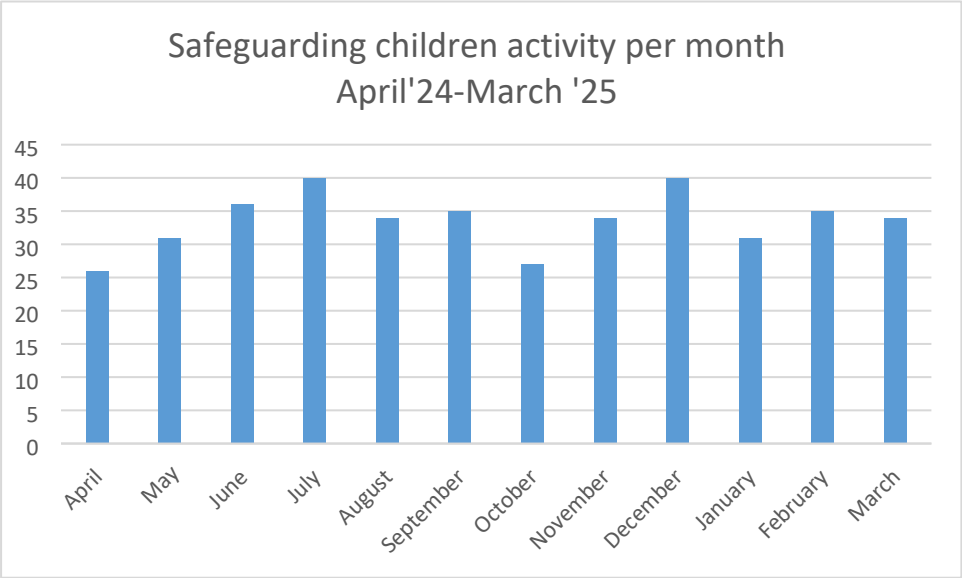
All QVH staff have a statutory duty to safeguard and promote the welfare of children who come into contact with our service, this is defined as:

- Protecting children from maltreatment
- Preventing impairment of children's health or development
- Ensuring children are growing up in circumstances consistent with safe and effective care
- Taking action to enable all children to have the best outcomes.

(Working Together to Safeguard Children 2023)

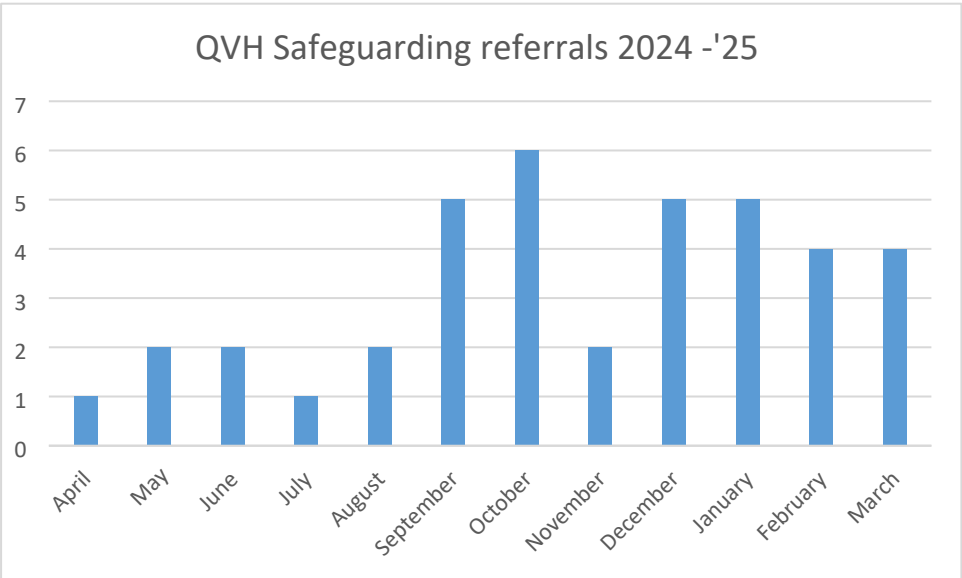
4.1 Safeguarding Children activity at QVH:
The overall safeguarding children activity levels and training are reported to the Patient Safety and Experience Group, paediatric Governance Group, Strategic Safeguarding Group and the Safeguarding Champions group on a monthly, bi-monthly, quarterly basis, dependant on the frequency of each meeting. The table below include all activity by the children's safeguarding team and are reported via datix for recording purposes only. Any incident that needs further investigation will be reported as an incident as well.

Table 1



QVH is a small specialist hospital mainly providing tertiary care for children from across the southeast region and beyond. Many of the children attending QVH have been seen and assessed by professionals elsewhere prior to their attendance. As a result, children who attend with safeguarding concerns may have been identified in the referring hospital and the relevant referrals made to the local authority. The table below shows the referrals made to children's social care during the year 2024-25 by QVH. There have been no specific themes identified for referrals to Children's Social Care by QVH this year.

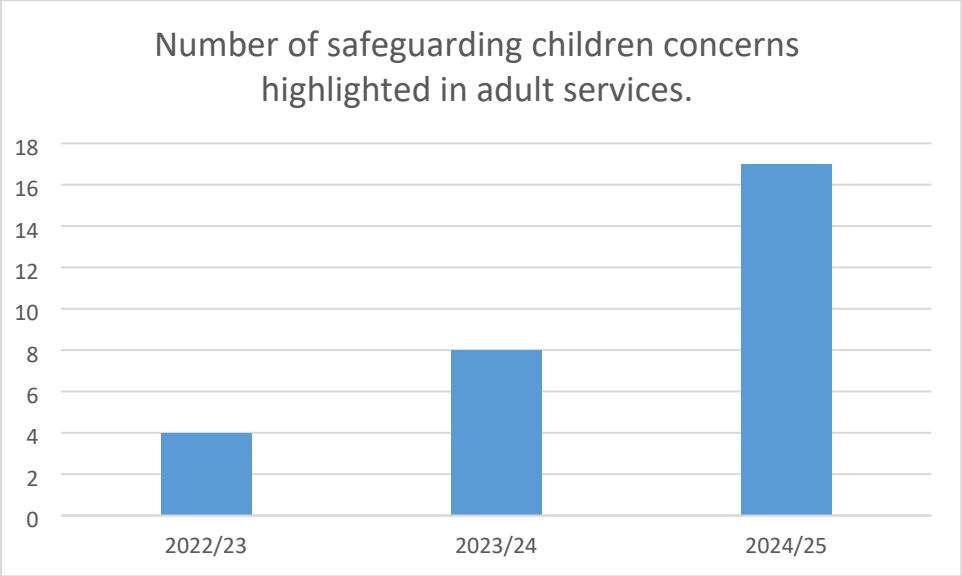
Table 2



Additionally, staff need to consider the welfare of children who they become aware of through their parents or carers. The 'Think Family' approach refers to steps taken by practitioners to identify wider family needs, which extend beyond the individual they are supporting. The table below represents safeguarding concerns raised where children who are not patients at QVH, are identified as being at risk through interactions with their parents or carers, most commonly where there are concerns around domestic abuse. This shows growing recognition of this issue amongst staff and reflects the safeguarding team focus on the 'Think Family' approach.

Training and ad hoc supervision support staff to feel confident to identify and manage these complex situations. The site practitioner team is integral to supporting staff who raise safeguarding concerns out of hours and so they are a specific focus for learning from incidents and good practice. The new EPR will support staff by asking specific questions about any caring responsibilities that a patient may have during admission this enables staff to identify when adult patients have children who may be vulnerable due to the circumstances of their parents or carers.

Table 3



4.2 Looked after Children

Looked after Children or Children in Care are a group of young people who are cared for and accommodated by the Local Authority. This cohort of children may have increased health risks and significant emotional and physical health needs. Although QVH does not have a specially commissioned service for Looked After Children, there is a role in promoting recovery, resilience and well-being for this cohort

Looked after Children training is integrated with safeguarding children training, staff are encouraged to use a trauma informed approach to support all children but particularly those who are care experienced.

The Named Nurse has established good links with the Designated Professionals within the ICB for Looked After Children and attends quarterly meetings with NHS Sussex Looked after children teams.

4.3 Child death

Any child death that occurs at QVH would be unexpected and therefore must follow specific procedures. The safeguarding team have been working with the Chief Nurse to adopt a child death protocol after it was identified that the current one is not appropriate for use at QVH. The team have liaised with the Named Paediatrician for Child Death (UHSx), West Sussex Coroner and Child death team from NHS Sussex.

Child deaths are an extremely rare occurrence at Queen Victoria Hospital (QVH). In the event that a child were to die unexpectedly at QVH or be brought to the hospital already deceased—there is a clear requirement for the case to be referred to the Coroner. The Coroner's direction will inform the Trust on the appropriate steps to take, including where the child's body should be transferred.

To support staff in managing such sensitive and rare situations, a formal pathway is currently being developed. This will ensure all staff understand the correct protocol and actions to take in these circumstances. The Chief Nurse is currently leading this work to ensure care and dignity are maintained throughout the process.

5. Mental Capacity Act and Deprivation of Liberty Safeguards (DOLS):
The Mental Capacity Act (MCA) is a critical piece of legislation designed to safeguard patients who may be unable to make informed decisions regarding their care and treatment. Enacted in 2005, this legislation provides a legal framework for ensuring that all patients receive appropriate and ethical care.

An audit completed in April 2024 found significant gaps in compliance, documentation, and procedural adherence and are consistent with a previous audit in 2022.

Several factors contribute to difficulties in ensuring compliance with the MCA at QVH:

- A high proportion of older patients, particularly those undergoing treatment for skin cancer, increases the likelihood of mental capacity concerns.
- Cancer pathway targets necessitate timely treatment, limiting the flexibility to conduct detailed assessments in advance.
- The absence of an Electronic Patient Records (EPR) system impedes internal communication regarding completed mental capacity assessments.
- The high-volume, low-complexity nature of much of the surgery at QVH necessitates a balance between efficiency and compliance with legal requirements.
- Many patients travel from across the region, making repeated visits for assessments challenging.

A proposed re-audit was postponed at the recommendation of the Chief Medical Officer, as no substantial procedural changes have been implemented and it is not anticipated that any improvements in compliance have been made. It is proposed to re-audit MCA compliance in November 2025.

Recent Compliance Failures
Several cases illustrate ongoing non-compliance:

1. **Patient with Dementia:** A woman in her 80s, diagnosed with dementia in 2023, was listed for surgery without an appropriate mental capacity assessment. Her son, who held Last Power of Attorney expressed concerns regarding her ability to consent and the fact she had been listed for a general anaesthetic.

2. **Patient with Dementia and Parkinson's:** A male patient in his 80s underwent extensive surgery without a mental capacity assessment, despite his known cognitive impairments.
3. **Patient in her 90s:** A patient requiring excision of skin cancer lacked the capacity to consent. The best interest process was not initiated and treatment deferred review for three months.

These cases demonstrate a critical need for systematic change in Consent and MCA processes.

5.1 Training Enhancements
Recent modifications to MCA training requirements include:

- Separation of mental capacity training from Level 2 and Level 3 adult safeguarding training.

It was previously agreed that MCA training be mandatory, standalone, and required every three years, the training session to be face to face and 2 hours duration. The mandatory element of this has not been implemented and staff can complete online training. In the formal recording of training compliance overall 92% of clinical staff have completed MCA training, recognising that there is a need to increase compliance amongst medical. The outcome of the audit and the nature of queries the safeguarding team deal with regarding mental capacity does reinforce the need for more work on training and processes in this area.
It is fully acknowledged that there are significant barriers that impede clinicians from complying with the MCA. As a result, a task and finish group chaired by the Chief Medical Officer has been established to look at the patient pathway and to improve processes:

- Electronic Patient Records (EPR) Implementation**:** Initial work has been undertaken to integrate MCA compliance into EPR systems, including mandatory fields for assessments.
- The corporate risk owner for MCA compliance now sits with the Chief Medical Officer.
- The Named Nurse for Safeguarding Adults and MCA Lead will continue to oversee operational implementation.

There remains significant gaps in compliance with the Mental Capacity Act at QVH. Despite training initiatives and revised policies, audits and case studies indicate continued non-adherence.

Immediate priorities include:

- Ensuring universal completion of mental capacity assessments where required.
- Strengthening training compliance for medical and dental staff.
- Embedding MCA principles into patient pathways, particularly in Skin Plastics.
- Leveraging EPR implementation to enhance documentation and communication.

5.2 Deprivation of Liberty Safeguards (DoLS)

DOLs are a set of checks and procedures in the Mental Capacity Act 2005 designed to protect the rights of people who lack mental capacity and are being deprived of their

liberty in a care home or hospital. These safeguards ensure that such deprivations are lawful, necessary, and in the person's best interests

There have been 12 DoLs applications made by QVH in the year 2024-25.This included patients with dementia, learning disabilities, delirium and neurodiversity.

6. Prevent

Prevent is part of the governments counter terrorism strategy, Contest which is led by the Home Office. Its aim is to reduce the risk to the UK and its overseas interests from terrorism. (Counter Terrorism and Security Act 2015)

The Prevent duty's aim is to stop people from becoming terrorists or supporting terrorism, in the pre-criminal space. It sits alongside other long-established safeguarding duties, helping to ensure that people who are susceptible to radicalisation are supported, as they would be, under safeguarding processes.

NHS providers are mandated to contribute to the Prevent agenda. Within QVH the Chief Nurse is the named organisational Prevent Lead with support from the Named Nurses in implementing the Prevent duty.

Currently, the level 3 Prevent training is delivered via the national e-learning package. With updates delivered during all levels of safeguarding training. The requirement has recently changed from Prevent level 3 being a one off training expectation to require clinical staff to undertake a 3-yearly refresher training. Clinical staff are also required to receive annual updates; the Named Nurses are looking at how this can be delivered to staff, including the use of screen savers and information in Connect.

Compliance at QVH for Prevent training at level 3 is 85%. Guidance provided by the Home Office states that the minimum training compliance target at level 3 should be 85%. Figures are submitted to NHSE via quarterly reports.

QVH has a Prevent delivery plan, which is available to all staff, it outlines responsibilities and signposts staff to discuss concerns with the safeguarding leads or chief nurse.

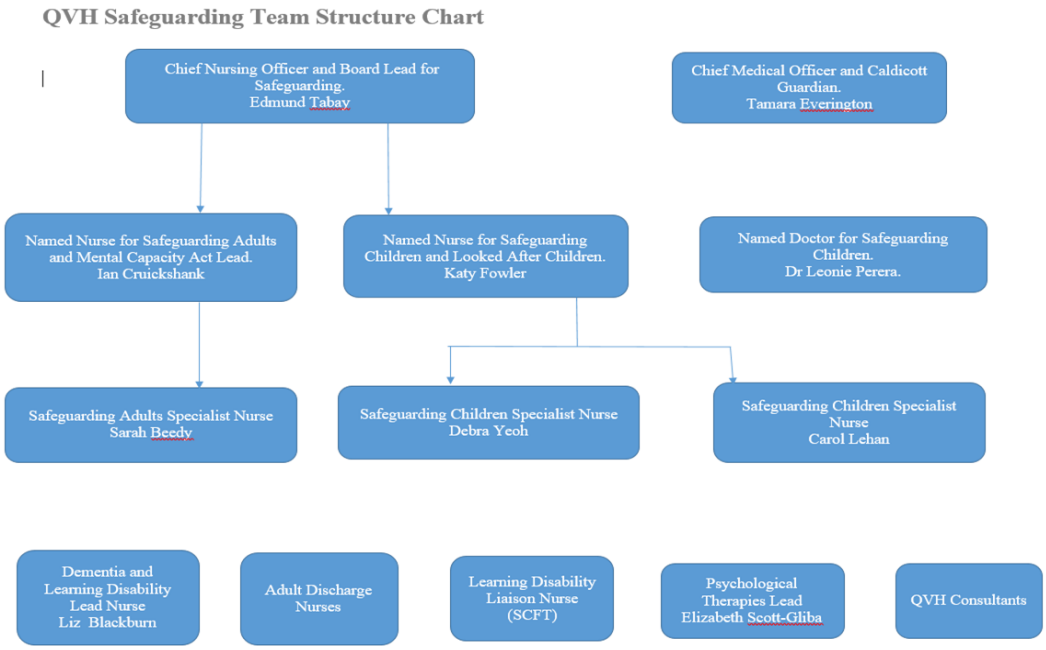
The Safeguarding leads attended the South East Region Prevent leads meeting.

No Prevent referrals were made during the year 2024-25.

7. Sussex Safeguarding Standards

These are 9 standards that enable all parties to identify key benchmarks to ensure an effective auditable approach to safeguarding of all patients.

7.1 Standard 1 Strategic leadership



The Strategic Safeguarding Group (SSG) oversees the development and implementation of adult and children safeguarding across the trust, as well as oversight of Looked After Children, Mental Capacity Act practices and Prevent. Learning Disability and Dementia strategy is now being overseen by the additional needs group. SSG provides summary updates to the Patient Safety and Experience Group chaired by the Chief Nurse.

Across QVH there is a network of link champions from service areas who are invited to attend the safeguarding champions meetings. There is a focus on learning within the group as well as the function of scrutinising policies, protocols and guidance and receiving and disseminating information to and from departments. The safeguarding Champions are responsible for disseminating information from the group to staff as well as making the safeguarding team aware of any challenges or plaudits that are occurring within the departments and clinical areas.

Any relevant policies and procedures will also be taken through other governance groups, for example Paediatric Governance Meetings, Additional Needs Forum and Nursing AHP and HCS Forum.

QVH Safeguarding Governance Structure

Every three years the safeguarding leads meet with the board to enable them to scrutinise the safeguarding arrangements for the trust and to ensure members understand their responsibilities. This was last undertaken in 2023, in line with the intercollegiate documents.

The safeguarding team links with the ICB Sussex Designated Nurses and wider network, including the WSSCP and WSSAB via regular meetings.
The safeguarding team are members of several subgroups and networks which enables QVH to work collaboratively. The Named professionals will be co-opted into additional groups as required.

Safeguarding children meetings	Frequency
West Sussex Safeguarding Children Partnership Group	New arrangements.
Learning and Developments subgroup	Quarterly
Quality and Assurance Subgroup	Quarterly
Child Exploitation subgroup	Quarterly
Children's Health Safeguarding Forum	Quarterly
Child Safeguarding Liaison Group	Bi-monthly
MASH health Working Group	Quarterly
Looked After Children NHS Professionals Meeting	Quarterly
Joint Area Targeted Inspection (JATI) Health Providers Working Group.	Quarterly or as required.
National Network for Safeguarding Children Named Professionals	Monthly
South East Network for Safeguarding Leads	Quarterly
Safeguarding Adults meetings	**Frequency**
West Sussex Safeguarding Adults Board	Quarterly

NHS Professionals Safeguarding Adults	Quarterly
South East Network for Safeguarding Leads	Quarterly
Prevent	Frequency
South East Prevent Leads Network	Quarterly

QVH uses the Datix system to record child safeguarding incidents. Adult safeguarding concerns are recorded on a spreadsheet.
Safeguarding open risks:

There is currently one safeguarding organisational risk.

There is a risk that mental capacity assessments are not being undertaken when required. Work is underway to address this by:

- Training for MCA has been removed from safeguarding sessions giving additional time to address understanding of MCA and application in the clinical setting.
- Task and Finish group to look at process mapping and patient journey from referral to theatre.
- Appointment letters have been changed to invite patients to attend with a supporting person and a request for any Lasting Power of Attorney for Health and Welfare to attend with the patient and provide evidence of this.
- Use of Datix to highlight some of the more significant incidences where MCA procedures have not been used correctly to highlight this to the organisation.

There is one safeguarding departmental risk:

- Minor Injuries Unit (MIU) risk relating to access to previous information held in the trust about patients re-attending. Staff in MIU do not access the full records of patients when they attend; this poses a risk in terms of safeguarding. The trust has procured an electronic patient record system (EPR) which will be rolled out across the trust including to MIU. This risk is monitored at the Strategic Safeguarding Group.

7.2 Standard 2: Lead effectively to reduce the potential of abuse
During this year, the QNet safeguarding page has been revised to be more user friendly. QVH safeguarding policies and procedures are available on QNet.

The safeguarding team have updated policies and guidance throughout the year and where appropriate have added ‘Quick Guides’ to allow staff to access the information they need in a timely way.

For children, the Datix system is used as a data collection system and captures ‘safeguarding incidents’. A spreadsheet has been introduced in the safeguarding adults’ team to collect data. This is used to generate safeguarding data that is reported into various groups and reports. The closure of datix ‘for recording purposes’ incidents, in a timely way has been a challenge this year and work is underway in collaboration with the safety and patient experience team to significantly reduce the backlog of cases that have been actioned but not closed.

7.3 Standard 3: Responding Effectively to Allegations of Abuse

QVH currently use an electronic document management system (EVOLVE). There is a safeguarding section available for all patients, as required. This section highlights where there are concerns flagged about a patient in terms of safeguarding or mental capacity. There is an ability to flag patients at risk on this system, this is used by the safeguarding team to alert staff where there are identified risks e.g.: domestic abuse.

Previously, the safeguarding section had a 'locked box', staff could access this section by using a drop down box to select the reason they want to access the information and provided an audit trail. Following feedback from staff during training this function was considered a barrier to information sharing and has been removed.

Child Protection Information systems (CP-IS) is used by Trauma co-ordinators, Minor Injuries Unit staff and Peanut Ward staff to check whether unscheduled children or young people have a child protection plan or are looked after by a local authority. The result of CP-IS checks should be documented on the child's records and brought to the attention of the treating clinician. Information should be shared with the allocated Social Worker for the child about their attendance.

Professional difference within safeguarding can be the sign of a healthy well-functioning partnership. Differences can arise in a number of areas in multi-agency working. The QVH safeguarding team have used escalation procedures during the year where there was a disagreement around threshold levels for intervention and information sharing with other professionals. The Named Doctor, Nurse and Designated professionals supported this escalation using the appropriate channels as informed by the relevant local authorities' procedure.

Allegations against staff:

The trust has a statutory duty to investigate all allegations against staff working with children and adults at risk. This includes their conduct in a personal and professional capacity.

Allegations against staff are managed in accordance with the allegations against staff guidance, owned by Human Resources. Allegations against staff can be varied and not all relate to safeguarding. The Chief Nurse and HR will share any allegations against staff of a safeguarding nature with the safeguarding team who may need to be involved in an investigation or seek advice from external sources such as the Local Authority Designated Officer (LADO). Information is kept securely, relevant issues are reported to the ICB in the quarterly exception reports.

During 2024-25 there have been no allegations against staff that the safeguarding team have been involved with.

7.4 STANDARD 4: Safeguarding Practice and Procedures

The Safeguarding Team develop a wide range of documents for the organisation, staff and patients in the form of policy, procedures, protocol, guidelines and leaflets. These are available on the Website or QNet.

7.4.1 Restrictive interventions

When a patient is identified as needing any form of control, restraint or therapeutic holding staff need to follow hospital policy. The policies were launched during 2023-24, training is available for key members of staff including the security team.

Any use of restrictive interventions should be reported on datix as an incident. There is a need to audit this activity.

7.4.2 Domestic abuse (DA)

Managing risks, keeping individuals safe and seeking the right specialist advice are all important aspects of patient care when DA is being considered a possibility or has been confirmed. Raising awareness of and managing DA situations is included in all levels of safeguarding training. The Domestic Abuse and Honour Based Abuse policy for patients is nearing the final governance stage and will be published in the near future.

Staff awareness of this safeguarding concern has increased, the emphasis on 'think family' during training has supported staff to consider others who may be at risk in the home, including children.

Domestic Abuse Stalking Honour (DASH) risk assessments can be used by staff to risk assess patients and help inform next steps to protect patients. Worth DA specialist services and the police can provide advice and support to staff at QVH.

During the reporting period, QVH identified 32 cases of domestic abuse. Out of these, three cases were reported to the police, ten were referred to domestic abuse support services and three Multi-agency Risk Assessment Conference (MARAC) referrals were made.

The safeguarding team offer support to staff members who are victims / survivors of domestic abuse.

7.4.3 Safeguarding Audit

The safeguarding team participate in internal and external audits and safeguarding practice reviews.

There has been little opportunity to undertake audits during this year due to increasing workload and the training and orientation of new staff. The MCA and the EPR processes have been prioritised this year.

Any reports and action plans are reviewed and monitored in the QVH strategic safeguarding group and the QVH safeguarding champions group.

The safeguarding team inputs to the WSSCP and WSSAB multi-agency audits as required e.g.: Section 11 self-assessment (child) and Providers self-assessment (adults). The Safeguarding children Named Nurse is a member of the WSSCP improvement and assurance subgroup.

7.4.4 Child Sexual Exploitation, Criminal Exploitation and Modern Slavery

Recognition of Child Sexual Exploitation (CSE) or Child Sexual Abuse (CSA) requires careful assessment and consideration when concerns arise. The Safeguarding

Children Named Nurse is the CSE lead for QVH and supports staff to access specialist support if required. During the year, staff managed one case where a child presented with indicators of CSE. Staff appropriately referred to the Police and Social care services providing support and safety until the multiagency response.

Staff within MIU have a 4 question-screening tool available to them when they have a concern about sexual exploitation. With the new EPR, the safeguarding team are hoping that this will be available to staff across the hospital.

The safeguarding team have worked to update the Modern Slavery and Exploitation Guidance during this year. It aims to guide staff to manage suspected cases of modern slavery and exploitation in patients (both adults and children). A quick guide is being included as an easy to follow document so staff can refer to this quickly where they have concerns. The document has been written to reflect the Pan Sussex Procedures and with the support of the ICB designate nurse team.

NHSE require that trusts have a modern slavery statement on their website, QVH are working to comply with this. The statement will go to the board for approval in May and will be available shortly after that time.

The Procurement Team work within the NHS Terms and Conditions, which require suppliers to comply with relevant legislation. Procurement frameworks are also largely used in the Trust to procure goods and services, under which suppliers such as Crown Commercial Services and NHS Supply Chain adhere to a code of conduct on forced labour. Relevant pass/fail criteria has also been introduced on Procurement led tenders and quotations not conducted via framework.

7.5 STANDARD 5: Staff Competence

Training

Driving improvement in all aspects of safeguarding practice is a continuous process and as such has to be reviewed, evaluated, developed and adapted over time.

Level 1 safeguarding training incorporates both adult safeguarding, child safeguarding and MCA into a single ‘think family’ approach to allow staff to be updated on all safeguarding issues as it is important to recognise the complexities and interconnected nature of safeguarding.

Level 2 training has recently been separated and extended into safeguarding adults and children. This change has been the result of feedback from staff who found that the previous combined session was too long with no break time factored in. The safeguarding team negotiated a longer session of two hours each with a half an hour break for lunch. The sessions are run consecutively to enable staff to attend both, if required to do so.

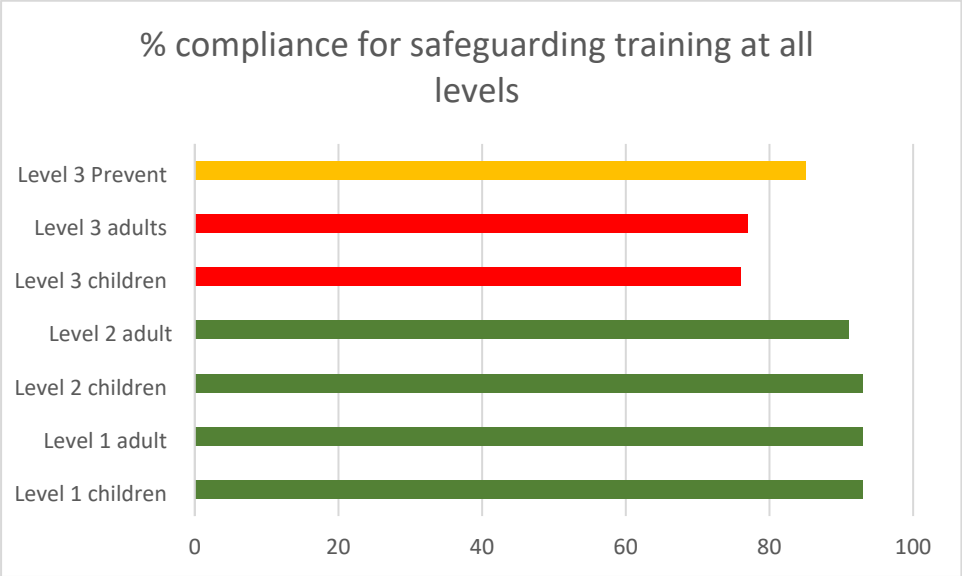
QVH safeguarding team continue to offer level 3 Adult and Child Safeguarding sessions separately for consultants and those members of staff who require this additional level of training. These sessions are now offered four times a year, increasing from two last year. Staff needing to meet the training requirements outlined in the intercollegiate documents, of 8 hours training over 3 years, have the opportunity to access other level 3 training off site, as part of their personal development. Staff

training logs can be used to record additional training and will be self-certified as being completed during their annual appraisal.

The table below records percentage compliance levels from March 2025. Each line is RAG rated with the appropriate colour in line with QVH acceptable compliance figures. (Note: Prevent is required to be at 85% or above by the Home Office, so would be rated as green at the current compliance rate).

The safeguarding Team monitor and report training compliance on a monthly basis. When levels of training fall, the safeguarding team work with the learning and development and medical education teams to encourage staff attendance at the appropriate level of training. The challenge of locum medical staff not providing evidence of compliance from their host trusts has been difficult. The Chief Medical Officer has supported the medical education team by being clear that if staff cannot demonstrate compliance they will be unable to undertake locum work at QVH.

Table 4



There is currently a consultation looking at the safeguarding and looked after children's intercollegiate documents, the proposal being to integrate both into one document and to look at how compliance is recorded. The outcome of this will be available later this year. The safeguarding team plan to review the levels of training that staff require with a view of expanding level 3 training to a larger cohort of staff.

Safeguarding and MCA training has now been separated. Previously both topics were covered in one 1 hour 45 minute session which was insufficient to cover either subject in sufficient depth. Now each topic has 2 hours each. The adult safeguarding training has been revised and is now based on case studies and uses group work. This approach requires learners to analyse and evaluate different scenarios and promotes critical thinking, problem solving and decision making. The feedback for these training presentations has been very positive.

Level 4 training is required by the safeguarding Named Nurses and Doctors. A record of training attended is kept in a log to demonstrate their competence. The safeguarding specialist nurses are also encouraged to attend level 4 training for their development.

7.5.2 Safeguarding Learning and development Strategy

QVH Safeguarding learning and development strategy was updated in June 2024. This document is aligned with the core skills framework document and with national guidance from the NHS England regarding roles and competences for health care staff – from 4 intercollegiate documents (Prevent, Looked After Children, Adults and Children). Following the outcome of the children's intercollegiate document consultation during the coming year, the safeguarding team will revisit the training needs analysis.

Safeguarding responsibilities remain integral to everyone's job description; this is reiterated during safeguarding training.

7.6 STANDARD 6: Safer Recruitment

QVH work to ensure that those working or who are in contact with children, young people and adults are safely recruited and Human Resource processes take account of the need to safeguard and promote the welfare of all. Making sure that QVH do everything we can to prevent appointing people who pose a risk to vulnerable people is an essential part of safeguarding practice and QVH recruit staff and volunteers following safer recruitment procedures.

All staff at the Trust are employed in accordance with the NHS Employers safe recruitment pre-employment check standards. These standards outline a range of checks that organisations in England must undertake when appointing to NHS positions. This includes information about criminal records and/or registration with any professional regulatory or licensing body (including investigations or formal action in relation to fitness to practise) as may be applicable to the role. It also includes obtaining employment history and/or other references which may provide information about any relevant conduct and/or behaviour that might need to be considered as part of our overall assessment of an applicant's suitability for the position in question. downloaded so a complete audit is possible for all new recruits or internal movers

All new staff joining QVH, those who are moving internally to another role within the Trust, honorary contract holders, clinical attachés and Volunteers obtain the appropriate level of DBS for their role before commencing. All clinical staff are appropriately DBS checked depending on their patient contact and the areas in which they work. This is in line with current national DBS guidance.

Should a candidate disclose any convictions, cautions, reprimands or final warnings that are not "protected" as defined by the Rehabilitation of Offenders Act 1974 (Exceptions) Order 1975 (as amended in 2013) in their application form, interview, model declaration or should details of any offences show in a DBS certificate, the Trust undertakes an internal process with the Chief Nurse to review the offence and any possible risk to patients before concluding whether it is possible to continue with on-boarding.

As part of the recruitment process the files of internal movers and ex-employees who have been offered a post at QVH are checked by the advisory team to identify if there

have been previously identified safeguarding issues or if any restrictions have been put in place for that individual.

An honorary contract holder and clinical attachés are not substantively employed by QVH. They may have patient contact or contribute to service delivery. The team will only issue an agreement to start once all mandatory checks have been satisfactorily undertaken. This includes ensuring that the individual has a DBS or Overseas Police Check for those individuals coming from abroad who would not have a current DBS in place. If coming from another NHS Trust a confirmation of checks form will be completed by the individuals employing Trust. This confirms that all pre-employment checks have been completed by the employing Trust, including a DBS check.

These processes are being followed and we have assurance through internal and external formal sample file audits. We also have team file audits to ensure all checks are completed on an individual. All checks are completed through the online TRAC system and once complete the file is downloaded so a complete audit is possible for all new recruits or internal movers.

As part of their induction, new employees, including volunteers, are expected to undertake mandatory training in safeguarding at either level 1, 2 or 3 or be able to provide evidence that this has been completed at another trust within the last 3 years. The Education and Learning team undertake these checks and provide figures that the safeguarding team monitor.

7.7 STANDARD 7: Learning from incidents

Statutory Safeguarding Reviews:

Safeguarding Adult Reviews (SAR)

Safeguarding Adult Boards (SABs) must arrange a SAR when an adult in its area dies as a result of abuse or neglect, whether known or suspected, and there is concern that partner agencies could have worked more effectively to protect the adult.

QVH were involved in one SAR during 2024-25. The primary purpose of this review was to consider the multi- agency working in safeguarding an individual in the community. After the completion of the review, QVH were requested to investigate and report on the patient's subsequent discharge from the hospital, as the patient had complained regarding this during the review. The outcome of this is awaited.

Learning from SARS outside of QVH is shared at safeguarding groups if relevant for care delivery.

Local Child Safeguarding Practice Reviews (LCSPR's).

A LCSPR occurs when a child dies or is seriously harmed, including death by suspected suicide, and when abuse or neglect is known or suspected to be a factor in the death. QVH were involved in one Child Safeguarding Practice Reviews during 2024-25. QVH were identified as an agency which may have important information for the LCSPR at a point later than would usually be expected in the process. Learning has been identified and the safeguarding team are in the process of sharing the outcome of this with staff in a sensitive and supportive way, in collaboration with the psychological therapies team.

QVH have also contributed to safeguarding children rapid reviews where required and learning from relevant other LCSPR's is incorporated in training

Child Death Reviews.

QVH has not contributed to any child death reviews this year.

7.8 Standard 8: Commissioning

The Integrated Care Board (ICB) seek assurance as commissioners of local health services.

The ICB combined exception reports are completed and submitted quarterly.

Sussex Safeguarding Standards Assurance Return was completed in summer 2023.

In early 2024, QVH had a site visit from representatives from NHS Sussex as part of their ongoing assurance work. There were no areas of concern in relation to quality or safety.

A self-assessment tool is completed bi-annually for adult safeguarding for submission to the West Sussex Safeguarding Adults Board (WSSAB) and a similar section 11 (Children Act 2004) self-assessment audit, submitted to the West Sussex Safeguarding Children Partnership (WSSCP). The section 11 was completed during the year. Each of the nine standards is broken down into sub-standards, of which there are 70 in total there were seven sub-standards self-assessed as being Amber. See Appendix 1 for actions undertaken on these seven areas, not all actions sit with the safeguarding team.

7.8.1 External regulation and inspection

QVH CQC re-inspection during February 2019 overall the Trust sustained a 'good' rating and also an 'outstanding' for care. There was no concerns raised regarding safeguarding.
There have been no safeguarding enquiries raised against QVH in the year 2024-25.

7.9 Standard 9: Safeguarding Data

7.9.1 Female Genital Mutilation (FGM)

QVH submit FGM returns to NHS England.
There have been no FGM risk assessments during this year.

7.9.2 Prevent Returns

QVH safeguarding team submits quarterly reports via the NHS England data collection portal.

7.9.3 Safeguarding Commissioned Assurance Tool (SCAT)

This is a new annual return to NHSE, the safeguarding team worked with the Chief Nurse to undertake this new requirement, although an annual return is expected, this can be updated quarterly if there are major changes to report.

8. Recommendations for last year

- Improve compliance with the MCA following the MCA audit. See above for full discussion of MCA compliance achieved during the year.
- To roll out the use of adult safeguarding paperwork across the trust. This will ensure that any safeguarding concerns are highlighted to staff on Evolve.

Evolve is now used to ensure internal information sharing regarding safeguarding concerns and mental capacity issues. This will be strengthened by the introduction of the EPR.

- To continue with the safeguarding audit programme.

The safeguarding audit programme continues to be a challenge due to lack of time and other priorities, including the EPR which has taken a significant amount of time and planning during the year. This will become a recommendation for the coming year with two audits (adult dog bites and WNB) planned for the beginning of the coming year.

- Child was not brought (WNB) to appointments protocol is being revamped and relaunched during the year to provide clearer guidance to staff and template letters to improve information sharing.

  There is a new WNB protocol has been rolled out across the trust, driven by the safeguarding children team, with thanks to the Safeguarding team at the Royal Alexandra Children's Hospital (RACH). The launch has involved the safeguarding named nurse for children attending meetings across the trust with many teams to ensure a carefully planned change in practice that should benefit children and provide staff with a structure for managing WNB.
  A monthly audit is planned to monitor compliance and effectiveness as well as any complaints that came as a result.
  This practice improvement initiative has been a collaborative effort across many departments.

9. Priorities for the coming year

- EPR, to support and monitor the effectiveness of the safeguarding and MCA sections of the EPR.
- To monitor how effectively the WNB guidance is being embedded by audit.
- To continue with the safeguarding audit programme.
- Improve compliance with the MCA
- To continue to highlight 'think family' to support identification of children or adults at risk where QVH staff become aware of them through contact with parents or care giver.

Appendix 1

QVH Section 11 Action Plan for those standards RAG rated Amber:

Standard	Description	Identified Actions	Progress

4.2	There are systems in place to ensure that children and young people are consistently seen and seen alone where statutory guidance and best practice requires that should happen	There is work to be done as we develop the strategy to ensure we are robust in the management of children.	Safeguarding policy under review. Additional information added prompting staff to consider seeing children on their own, if appropriate. EPR will support children to be seen alone by prompting staff to consider this during assessment.
4.3	There are strategies, systems, and initiatives in place to ensure participation and user engagement from children, young people and their families and carers is informing service development. There is evidence of how the voice of the child had impacted on service development.	Senior staff are working on an engagement strategy across the trust.	Information shared with the communications team about engaging with a group who represent looked after children as part of engagement strategy.
8.6	Systems are in place that enable staff to retrieve historical information, and these are shared were necessary to inform assessment of risk.	Current risk in MIU, staff are not able to access previous records for children that have attended the hospital. MIU records are sent to health records 1 month after child attended - not easily accessible. EPR will be adopted across the hospital which will enable staff to access previously gathered information about children who have been seen at QVH before.	This remains on the risk register as a departmental risk. The EPR roll out in MIU has been increased in priority, but the project has been delayed until Autumn 2025 when it will go live across the trust. The risk remains in the meantime. We will then have to ensure that previous records are added to

			Evolve for easy access.
9.13	Managers and frontline practitioners in your organisation know the signs, indicators and effects of child trafficking and modern slavery and how to escalate concerns as appropriate.	Modern slavery and exploitation protocol needs to be updated.	Modern Slavery and Exploitation Guidance updated and published on QNet.
9.15	Managers and frontline practitioners in your organisation are provided with training to recognise children and young people as victims in their own right in regards to incidents of domestic violence and abuse, stalking and harassment. They recognise key indicators of DV&A, as well as understanding the impact and opportunities for referral and intervention as appropriate.	Domestic abuse staff knowledge audit.	Domestic abuse audit via Limes Survey needs to be undertaken during this year.
9.16	Managers and frontline practitioners in your organisation know what to do once Domestic Abuse is identified or disclosed and are aware of local procedures regarding DV&A, including making onward referral to local care pathways for children, non-abusive parents and the abuser.	Domestic abuse patient protocol requires update.	Domestic abuse protocol awaiting final approval at ECQR.
9.17	Managers and frontline professionals are aware of how to identify serious or escalating risk and know how to refer to children's services and MARAC (Multi-Agency Risk Assessment Conference) to support a safety plan for the victim and any children	Domestic abuse patient protocol requires update.	Domestic abuse protocol awaiting final approval at ECQR.

Report cover-page					
References					
Meeting title:	Board of Directors				
Meeting date:	10/07/2025	**Agenda reference:**	**48-25**		
Report title:	Infection Prevention and Control Annual Report 2024/25				
Sponsor:	Edmund Tabay, Chief Nursing Officer				
Author:	Sarah Prevett, Lead Infection Control Nurse Specialist				
Appendices:	Appendix A - IPC Structure Chart Appendix B - IPC Annual Programme Objectives Appendix C - Ratified IPC Policies				
Executive summary					
Purpose of report:	The purpose of this report is to inform and provide assurance to the Board and other stakeholders regarding the systems in place at Queen Victoria Hospital NHS Foundation Trust (QVH) to prevent and control healthcare-associated infections (HCAIs). In accordance with the Health and Social Care Act 2008: Code of Practice for the Prevention and Control of Healthcare-Associated Infections, the Committee receives an annual report from the Director of Infection Prevention and Control (DIPC).				
Summary of key issues	This report covers the period from 1 April 2024 to 31 March 2025 and outlines key activities, outcomes, and developments in infection prevention and control. **Key Highlights:** • The Trust has maintained compliance with Care Quality Commission (CQC) regulations related to infection prevention and control. • The incidence of healthcare-associated infections remains low, with: ○ 0 cases of Methicillin Resistant Staphylococcus aureus (MRSA) bacteraemia ○ 2 cases of Methicillin Sensitive Staphylococcus aureus (MSSA) bacteraemia (1 not attributable to QVH) ○ 0 cases of E. coli bacteraemia ○ 4 cases of Clostridium difficile infection, CDI (1 not attributable to QVH) All cases underwent Root Cause Analysis (RCA), with actions implemented and learning identified where appropriate. • Infection control audits were conducted, and resulting actions and learning have been incorporated into practice. • While formal assurance processes were not fully embedded throughout 2024/25 following trust wide revision to the governance structure, improvements are underway. An Estates and Facilities Sub-Committee has been established to support enhanced oversight, particularly in line with national guidance on ventilation and water safety. • Formal contract meetings related to pathology services were not consistently held during the year due to internal changes. These have now been reinstated to strengthen contract monitoring and assurance. The Trust remains committed to continuous improvement in infection prevention and control and to providing a safe environment for patients, visitors and staff.				
Recommendation:	To **note** the annual report.				
Action required	Approval	Information	Discussion	**Assurance**	Review
Link to key strategic objectives (KSOs):	**KSO1:**	KSO2:	KSO3:	KSO4:	KSO5:
	To deliver outstanding care	*To innovate and improve*	*To be an excellent employer*	*To deliver sustainable services*	*To collaborate with others*
Implications					

Board assurance framework:	Contribution to the delivery of all KSOs
Organisational risk register:	**Risk ID 00000107:** Limited number of staff trained in the use of High Consequence Infectious Disease (HCID) PPE.
Regulation:	CQC, Health and Social Care Act 2008: Code of Practice for the Prevention and Control of Healthcare-Associated Infections,
Legal:	
Resources:	This report was compiled using existing resources within the team
Assurance route	
Previously considered by:	N/A
Next steps:	N/A

Queen Victoria Hospital
NHS Foundation Trust

Infection Prevention and Control

Queen Victoria Hospital NHS Foundation Trust
Service Annual Report

Report covering the period from
April 2024 to March 2025

Document Control: Committees and groups who have approved this report
Executive sponsor: Chief Nurse and DIPC

Authors: Lead Infection Control Nurse

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1. Executive Summary

The purpose of this report is to inform and provide assurance to the Quality and Safety Committee, patients, public, and staff regarding the systems in place at Queen Victoria Hospital NHS Foundation Trust (QVH) to prevent and control healthcare-associated infections (HCAIs). In accordance with the Health and Social Care Act 2008: Code of Practice for the Prevention and Control of Healthcare-Associated Infections, the Committee receives an annual report from the Director of Infection Prevention and Control (DIPC).

This report covers the period from 1 April 2024 to 31 March 2025 and outlines key activities, outcomes, and developments in infection prevention and control.

Key Highlights:

- The Trust has maintained compliance with Care Quality Commission (CQC) regulations related to infection prevention and control.
- The incidence of healthcare-associated infections remains low, with:
    - 0 cases of Methicillin Resistant Staphylococcus aureus (MRSA) bacteraemia
    - 2 cases of Methicillin Sensitive Staphylococcus aureus (MSSA) bacteraemia (1 not attributable to QVH)
    - 0 cases of E. coli bacteraemia
    - 4 cases of Clostridium difficile infection, CDI (1 not attributable to QVH)
      All cases underwent Root Cause Analysis (RCA), with actions implemented and learning identified where appropriate.
- Infection control audits were conducted, and resulting actions and learning have been incorporated into practice.
- While formal assurance processes were not fully embedded throughout 2024/25 following trust wide revision to the governance structure, improvements are underway. An Estates and Facilities Sub-Committee has been established to support enhanced oversight, particularly in line with national guidance on ventilation and water safety.
- Formal contract meetings related to pathology services were not consistently held during the year due to internal changes. These have now been reinstated to strengthen contract monitoring and assurance.

The Trust remains committed to continuous improvement in infection prevention and control and to providing a safe environment for patients, visitors and staff.

2. Introduction

The Trust recognises that the effective prevention and control of healthcare-associated infections (HCAIs) is essential to delivering safe, high-quality care. Robust infection prevention measures are embedded in day-to-day practice, supported by clear processes and strong organisational leadership.

This report provides assurance to the Board that the Trust remains compliant with the Health and Social Care Act 2008: Code of Practice for the prevention and control of HCAIs. It outlines performance for the period 1 April 2024 to 31 March 2025 and highlights key achievements and future priorities in infection prevention and control.

The Trust remains committed to continual improvement in line with the principles of:

- Delivering continuous improvement in care
- Meeting the needs of patients

Patient safety is central to the Trust's infection prevention strategy. A consistent, collaborative approach across all teams supports a safe environment and high standards of care.

2.1 The Infection Prevention and Control Team (Appendix A)

The Infection Prevention and Control (IPC) service is delivered by a dedicated team comprising:

- Director of Infection Prevention and Control (DIPC)
- Infection Control Lead Nurse Specialist (full time)
- Infection Control Nurse (part time)
- Administrative Assistant – currently vacant

Microbiology and virology services are provided by University Hospitals Sussex (UHSx), which supports QVH with remote consultant microbiologist input, including 24-hour advice and attendance at virtual ward rounds, Multi-Disciplinary Teams (MDTs), and governance meetings.

2.2 The Director of Infection Prevention and Control (DIPC)

The IPC Team reports directly to the DIPC, who is the Trust's Chief Nursing Officer (CNO). The DIPC is accountable to the Chief Executive and is responsible for the strategic direction and oversight of infection prevention and control. The DIPC attends Trust Board and governance meetings, including the quarterly Infection Control Group.

In 2024/25, the CNO/DIPC retired in July 2024. An interim was appointed during the transition, and the substantive CNO/DIPC took up post in January 2025.

3. Service aim, objectives and expected outcomes

All NHS organisations must ensure that they have effective systems in place to control healthcare associated infections (see Table 1). The prevention and control of infection is part of the Trusts overall risk management strategy. Evolving clinical practice presents new challenges in infection prevention and control, which need continuous review.

Table 1: The requirements of the Health and Social Care Act (2008)

Compliance criterion	What the registered provider will need to demonstrate
1	Systems to manage and monitor the prevention and control of infection. These systems use risk assessments and consider the susceptibility of service users and any risks that their environment and other users may pose to them.
2	Provide and maintain a clean and appropriate environment in managed premises that facilitates the prevention and control of infections.
3	Ensure appropriate antimicrobial use to optimise patient outcomes and to reduce the risk of adverse events and antimicrobial resistance.
4	Provide suitable accurate information on infections to service users, their visitors and any person concerned with providing further support or nursing/ medical care in a timely fashion.
5	Ensure that people who have or are at risk of developing an infection are identified promptly and receive the appropriate treatment and care to reduce the risk of transmission of infection to other people
6	Systems to ensure that all care workers (including contractors and volunteers) are aware of and discharge their responsibilities in the process of preventing and controlling infection.
7	Provide or secure adequate isolation facilities.
8	Secure adequate access to laboratory support as appropriate.
9	Have and adhere to policies, designed for the individual's care and provider organisations that will help to prevent and control infections.
10	Providers have a system in place to manage the occupational health needs and obligations of staff in relation to infection.

The Trust maintains a comprehensive suite of infection control policies aligned with national guidance. These are reviewed at least every three years, or sooner if required, by the Infection Control Nurses and relevant clinicians. Policies are approved by the Infection Prevention and Control Group (IPCG) and the Patient Safety and Experience Sub-committee (PSE), before ratification by the Executive Committee for Quality and Risk (ECQR).

QVH's internal assurance framework includes a structured infection prevention and control programme supported by:

- Policy and procedural guidance aligned to best practice
- Regular audits and compliance checks
- Tailored education and training
- Direct access to specialist IPC advice
- Mandatory infection surveillance
- Quarterly and annual reporting to governance groups

The IPCG, chaired by the DIPC, meets quarterly and includes representation from Estates, Facilities, Pharmacy, Clinical Teams, Microbiology, and the Integrated Care Board (ICB). The DIPC provides regular updates to ECQR, Executive Leadership Team (ELT) and Trust Board, with additional antimicrobial oversight provided by the Trust's antimicrobial pharmacist.

Infection control insights are also shared across other forums including:

- Health and Safety Group
- Clinical Outcomes and Effectiveness Group
- Medicines Management Oversight Governance Group (MMOGG)
- Antimicrobial Stewardship Group
- Pathology and Nursing Quality Forums
- Task-specific working groups

Collaborative Working

The Infection Prevention and Control Team (IPACT) works collaboratively with clinical and non-clinical teams to embed IPC principles into planning for estates developments, refurbishments, and service changes. Despite some disruption to assurance forums during the year, a new Estates and Facilities Executive Sub-Committee has been established and will commence from June 2025 to provide a structured and consistent assurance mechanism.

Infection Prevention and Control microbiology activity

All the trust microbiology specimens are processed in accredited laboratories, with accreditation being monitored and audited by UHS pathology/microbiology providers. Assurance is given to the Trust for the SLA contract management and through the quarterly pathology meetings.
The results of all microbiology samples are checked, by the ICN's for positive colonisation or infection that may have the potential to spread and cause harm. This process allows the ICN to monitor patterns in infection rates, identify samples that are multi-drug resistant (MDR) and identify clusters of positive results that are showing a pattern through either department or organism type. Significant, reportable or unexpected results are also relayed to the IPACT or the ward via the on-call microbiologist. Regular virtual ward rounds have been held with the Microbiologists and individual departments and the Microbiologists continue to provide support and advice virtually through 24 hour telephone cover, virtual attendance at MDT's and virtual attendance at specific assurance meetings such as the antimicrobial steering group and IPCG. The assurance process to monitor the SLA with UHS has not been held this year with only one Pathology Contract review meeting being held with limited attendance. This concern has been raised to the Business Unit Managers who oversee this contract as at present there is no assurance being received that the SLA is in date, fit for purpose or being adhered to.

Infection prevention and control link persons (ICLP)

The ICLP group meets quarterly and acts as a vital link between the IPC team and front-line staff. Members conduct monthly audits, attend educational sessions, and promote compliance with IPC standards.
Key updates in 2024/25 included:

- Guidance on measles, MPox, and staff illness
- Review of 11 infection control audits
- RCA discussions for reportable infections (3 CDI, 2 MSSA, 1 Pseudomonas, 2 MRSA

colonisation)
- Review of 17 updated IPC policies
- Training on Personal Protection Equipment (PPE), antibiotic use, and swabbing

External Meetings

QVH remains actively engaged with regional and national IPC networks through webinars and virtual meetings. This ensures access to current best practice and allows QVH to contribute to policy development at the regional level**.**

Mandatory Surveillance

Mandatory surveillance data is required to be submitted to UK health security agency (UKHSA) for the following alert organisms:

- Staphylococcus aureus (S. aureus) bacteraemia – both Methicillin Resistant Staphylococcus aureus (MRSA) and Methicillin Sensitive Staphylococcus aureus, (MSSA)
- Clostridium difficile infection (CDI)
- Escherichia coli (E. coli) bacteraemia
- Pseudomonas aeruginosa bacteraemia

Carbapenemase-producing enterobacteriaceae (CPE), Glycopeptide Resistant Enterococci bacteraemia (GRE) and Vancomycin Resistant Enterococcus bacteraemia (VRE) are reported to the ICB as required and to UK Health Security Agency (UKHSA) on a quarterly basis.

IPACT also monitor Urinary Tract Infection (UTI), Acinetobacter, Pseudomonas, Klebsiella spp and all other Multi Drug Resistant (MDR) organisms.

Target thresholds are set by the UKHSA for each Trust every financial year for mandatory reportable infections.

Root Cause Analysis (RCA)

The Trust continues with the protocol for RCA review for all reportable infections and, for all MRSA bacteraemia the Post Infection Review (PIR) process.

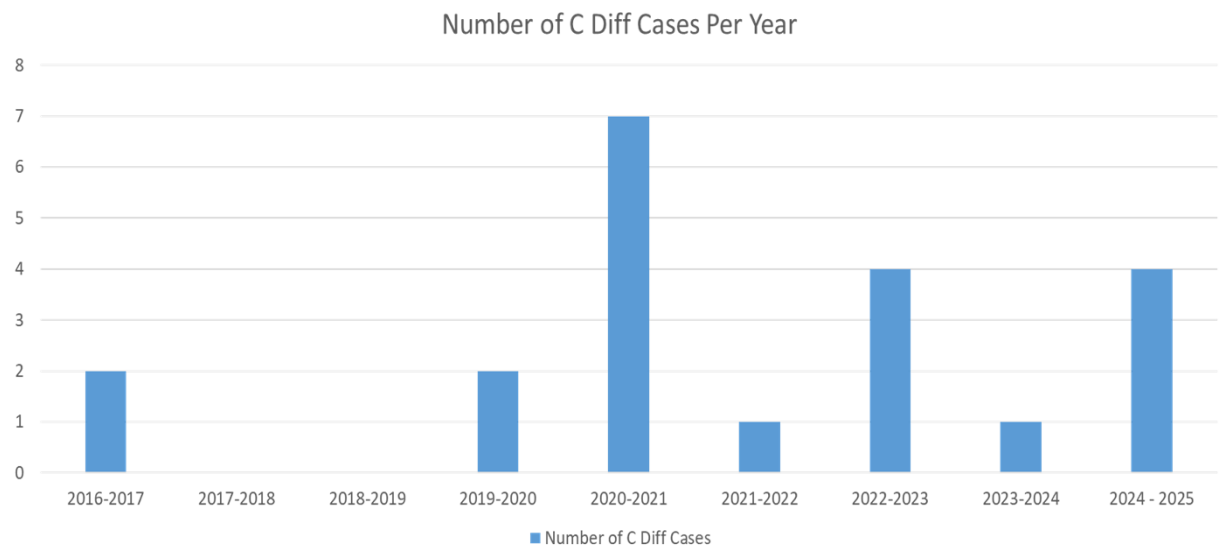
MRSA Bacteraemia

QVH have a target of zero cases of avoidable MRSA bacteraemia every year – the trust achieved this during the 2024/2025. As of now, there has been no update or revision to this target for 2025/26.

***Clostridium difficile* infection (CDI)**

QVH had four reportable CDI cases against a target of zero (Figure 1). One case was not attributable to QVH. RCAs identified:
- Two cases related to non-compliant antibiotic prescribing
- One likely present on admission but delayed sampling led to attribution
- All cases were isolated with no secondary spread. Learning has been shared with relevant teams, and additional training provided

Figure 1



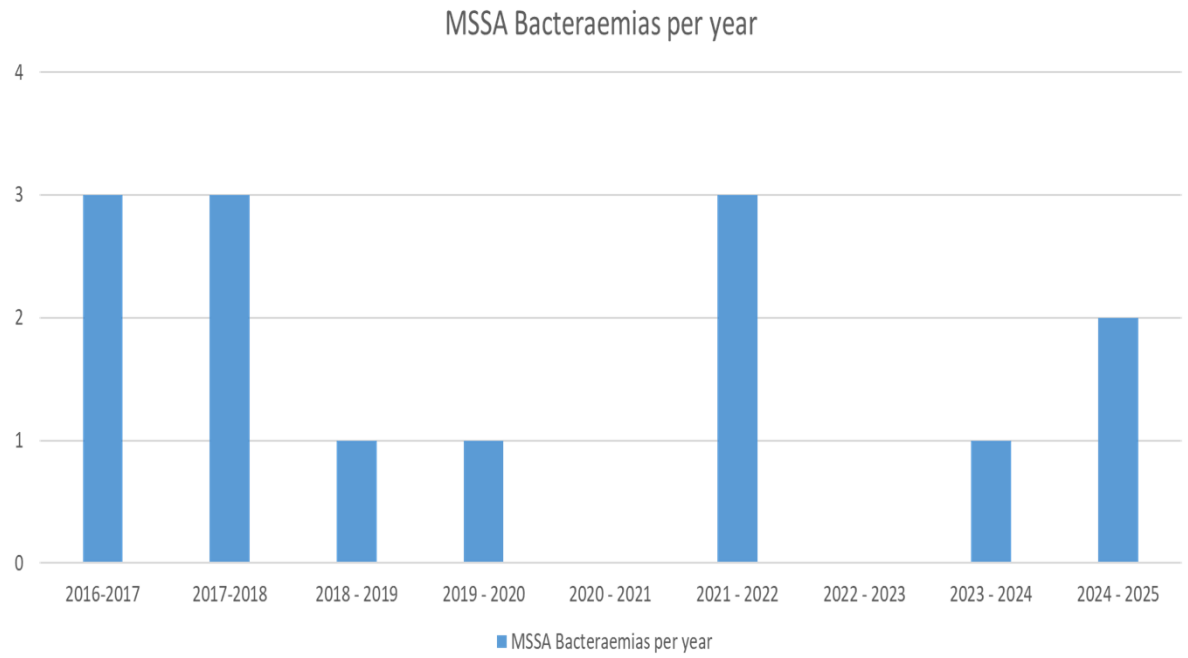
MSSA bacteraemia

While there is no formal target for MSSA bacteraemia, all cases are investigated to prevent avoidable infections. In 2024/25, QVH reported two MSSA bacteraemia cases:

- Case 1: Not attributed to QVH. The sample was taken within six hours of admission, and the patient was promptly transferred to another hospital. All appropriate actions were taken.
- Case 2: Attributed to QVH. The patient was a long-term burns case with extensive wounds and multiple co-morbidities. RCA identified these factors as likely causes. The infection was successfully treated with antibiotics following microbiology advice. No secondary cases occurred.

Figure 2 illustrates MSSA bacteraemia trends over time

Figure 2

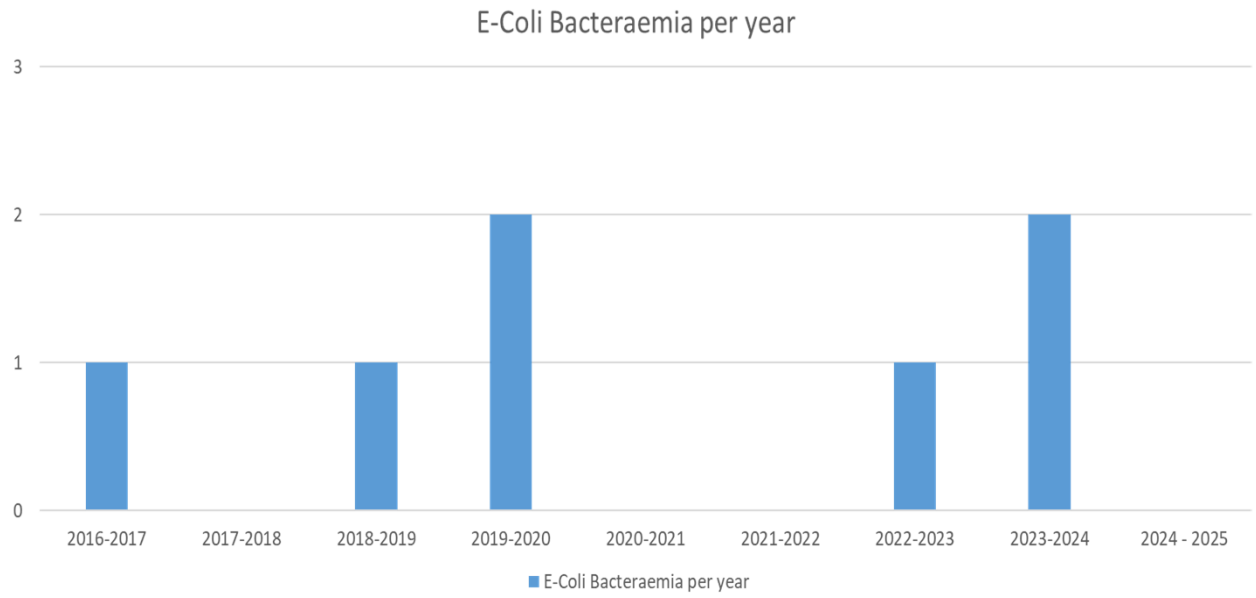


E. Coli bacteraemia

The target threshold for *E.coli* bacteraemia for QVH in 2024/25 was set at one case. The Trust met this threshold with no cases reported.

Figure 3 illustrates E.coli bacteraemia trends over time

Figure 3



Glycopeptide resistant enterococci bacteraemia (GRE)

No reportable GREs or VREs have been identified at QVH. No target has been set by NHS England to date. There have been no Trust acquired GRE infections in the last 10 years.

MRSA positive patients April 2024 to March 2025 (Infected and colonised)

A total of 219 MRSA cases (colonisation or infection) were recorded in 2024/25, up from 129 the previous year. Following discussion of these figures by the ICN and the South East coast IPC network it was felt this rise is a reflection of wider sector trends as it is being seen across the network, although formal national MRSA colonisation data remains limited due to non-mandatory reporting.
Breakdown of MRSA cases:

- 129 detected on or before admission
- 66 were previous positives
- 7 classified as healthcare-associated
- 17 of unknown origin

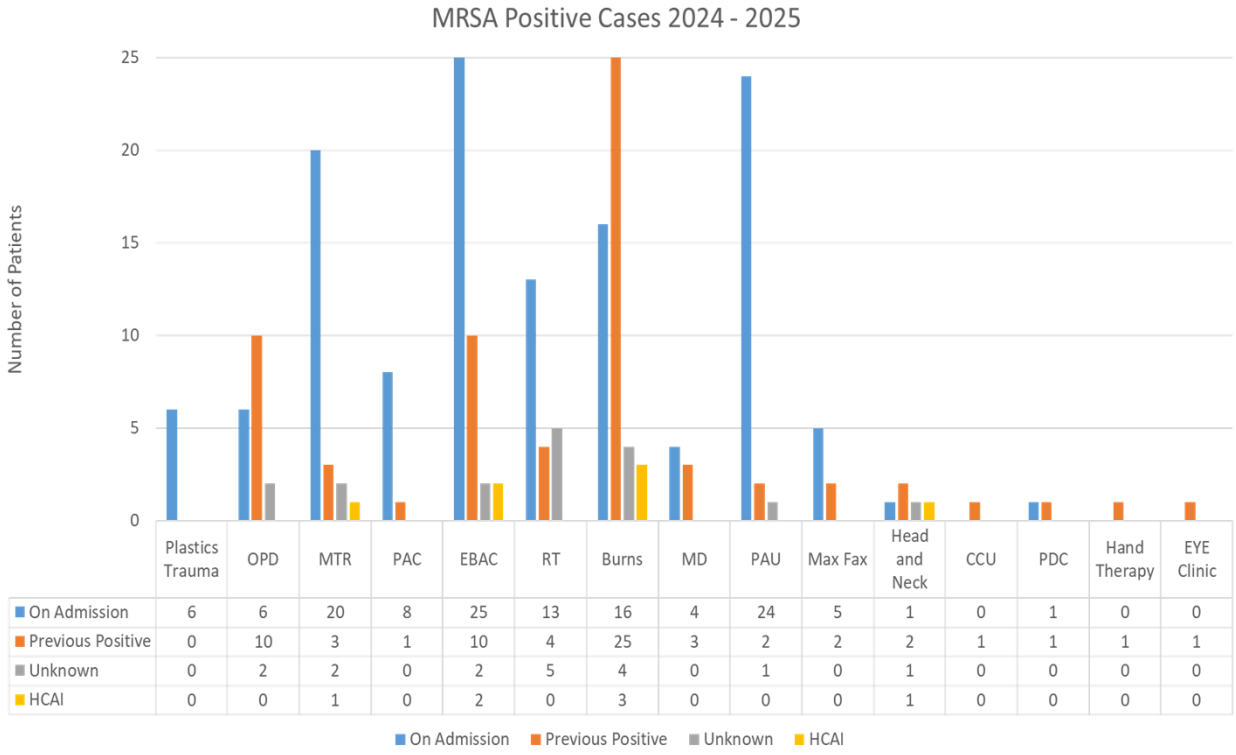
Crucially, no MRSA bacteraemia was reported. All cases were identified via surface or wound swabs. Assurance can be taken from this report that despite a significant rise in MRSA cases being identified there was no outbreaks or onward transmission which evidences that the MRSA policy relating to screening and isolation is being implemented and working well. Current isolation facilities are meeting this upward trend however the IPACT have included provision for cohort nursing within the MRSA policy if the number of positive cases continue to rise. The IPACT continue to advise on individual cases and scenarios when there are pressures on beds, assessing each scenario on a case by case basis to make the best possible decision for management of an infected patient using the hierarchy of controls as laid out in the National Infection Prevention and Control Manual.

QVH follows a targeted screening protocol in line with national guidance. Not all patients undergo

baseline swabbing, which can limit source tracking. However, all positive cases are monitored for trends in patient demographics and resistance. No transmission events or outbreaks were identified during this period.

Figure 4 shows MRSA cases by department and case type (e.g., on admission or previous positive).

Figure 4



	Plastics Trauma	OPD	MTR	PAC	EBAC	RT	Burns	MD	PAU	Max Fax	Head and Neck	CCU	PDC	Hand Therapy	EYE Clinic
On Admission	6	6	20	8	25	13	16	4	24	5	1	0	1	0	0
Previous Positive	0	10	3	1	10	4	25	3	2	2	2	1	1	1	1
Unknown	0	2	2	0	2	5	4	0	1	0	1	0	0	0	0
HCAI	0	0	1	0	2	0	3	0	0	0	1	0	0	0	0

4.	Activity analysis/ achievement

External regulation and inspection by Care Quality Commission (CQC), NHSI and commissioners

The CQC did not conduct any inspections in between April 2024 to March 2025 relating to Infection Prevention and Control. The Trust continues to monitor compliance set out in the Health and Social Care Act (2008) through a robust audit plan and assurance process.

The Trust Board

The Trust Board has responsibility for overseeing infection control arrangements and has been kept informed by the DIPC providing exception reporting and quarterly reports produced by the lead ICNS.

Key Performance Indicators (KPIs)

IPC KPIs include hand hygiene compliance, MRSA screening, and the incidence of reportable infections. All relevant outcomes and audit results are presented in this report. All IPACT staff completed mandatory training and annual appraisals during the reporting year.

Complaints

No formal IPC-related complaints or claims were received this year. One concern was raised in February 2025 regarding a post-surgical infection. A full investigation confirmed adherence to protocol, with the exception of inappropriate attire. Feedback was shared with the clinical team to reinforce best practice and professional presentation.

Infection Prevention and Control Learning and Development

IPC training remains part of the Trust's mandatory programme, delivered through e-learning and face-to-face sessions across staff groups. Additional departmental training addressed themes emerging from audits and surveillance.
Training content includes:

- Infection transmission and prevention
- Hand hygiene and PPE use
- Waste and spillage management
- Antimicrobial resistance
- Safe clinical practices

Training compliance remained high across all quarters, averaging above 90%, though improvement is ongoing for bank staff.

Table 1 shows the training compliance figures for all staff groups including permanent, bank, clinical and non-clinical

Table 1

	Required	Achieved	Compliance %
Quarter 1	1365	1269	92.97%
Quarter 2	1387	1287	92.79%
Quarter 3	899	798	88.77%
Quarter 4	1433	1299	90.65%

The ICNS was once again invited by the University of Brighton to deliver infection prevention and control training to student pharmacists, recognising the ICNS as an expert in the field.

In addition to the above mandatory training all clinical staff are required to undertake annual FIT testing to ensure they are able to correctly wear appropriate respiratory protection (FFP3 mask). Compliance with this training remains low. 10 more FIT tester's trained and 12 new FIT testing kits purchased to facilitate and ensure adequate access to trainers and equipment. Multiple reminders sent to all staff both in emails and in Connect. FIT testing linked to staffs individual competencies in ESR so that compliance can be monitored through the annual performance development review (PDR) each staff member has. The IPACT will continue to promote the need for compliance with annual FIT testing.

Table 2 shows the current compliance figures for FIT testing as of the end of March 2025

Table 2

Fit Testing - 1Yr

Date	Staff group	Assignment Count	Achieved	Compliance %
As at 1st Apr 2025	Perm staff	636	383	**60.22%**
	Non Perm staff	156	39	**25.00%**
	All staff	792	422	**53.28%**

Infection Prevention and Control audit

Clinical audit is a fundamental component of clinical governance and underpins the assurance process for a high-quality service (CQC, 2010). The IPACT maintained an audit timetable that is monitored to ensure compliance with national recommendations for assurance. The following audits have been undertaken in the period April 2024 to March 2025.

Surgical Site Infection Audit (SSI)

The SSI audit for the year 2023/2024 was conducted in two parts, with both looking specifically at breast surgery patients. The first part of the audit which was undertaken in the financial year 2023-2024, all breast surgery patients who were admitted from November – December 2023 were audited. This involved collecting baseline data for all eligible patients. These patients were then written to and asked to complete a questionnaire 30 days post-surgery detailing if they had any problems post operatively This part of the audit showed an SSI rate of 33%. The second part of this audit involved auditing the same surgical cohort of patients with the difference that these patients were asked to use a skin and nasal decolonisation in the 5 days leading up to their date of surgery. This was done by patients being given a prescription for the decolonisation at pre-assessment along with information on the audit and the post-op questionnaire for them to complete 30 days post-surgery. This was done for all patients admitted from January – March 2024 unfortunately we only received 1 response from these group which we believe is likely due to patients forgetting about the questionnaire as it was given so far in advance. As a result, the infection control team extended this audit period into the 2024/2025 year and re-wrote to all identified patients asking them to complete a new audit questionnaire. Of the 39 responses, 19 answered 'No' to "Did your surgical wounds heal without problems". Of these 19 responses, 9 were deemed to have an SSI, receiving antibiotic treatment post operatively and meeting 2 or more of the criteria above giving a SSI rate of 23%, one was readmitted for IV antibiotic treatment. There was no correlation to surgical team, theatre used or surgery date. As a result of this the infection control team in conjunction with the wider MDT did not recommend that pre-op decolonisation be used for all elective surgical cases as minimal drop in SSI rate did not compensate for the increased cost and process of administering the decolonisation. Multiple meetings and discussion held to understand the high SSI rate with possible answers being medical staff prescribing antibiotics when not needed and documenting infection when an alternative diagnosis such as haematoma is more probable. Breast team to monitor and train staff on correct management of post op patients. IPACT to re-audit within the next 12 months.

Aseptic technique audit

Initial compliance was 73%, with missed hand hygiene opportunities noted. An updated audit tool has improved participation and compliance, reaching 87% by January 2025**.**

Q2 Antimicrobial Stewardship (AMS) data

A four-day review by the Antimicrobial Pharmacist assessed antibiotic prescribing across Head & Neck, Burns, CCU, and the Canadian Wing. The audit highlighted gaps in documentation, with missing indications (up to 89%) and durations (55%). Timely reviews within 48–72 hours were inconsistently performed, and no patients were stepped down from IV to oral antibiotics during the audit. Findings will inform future improvement actions led by the Antimicrobial Stewardship Group**.**

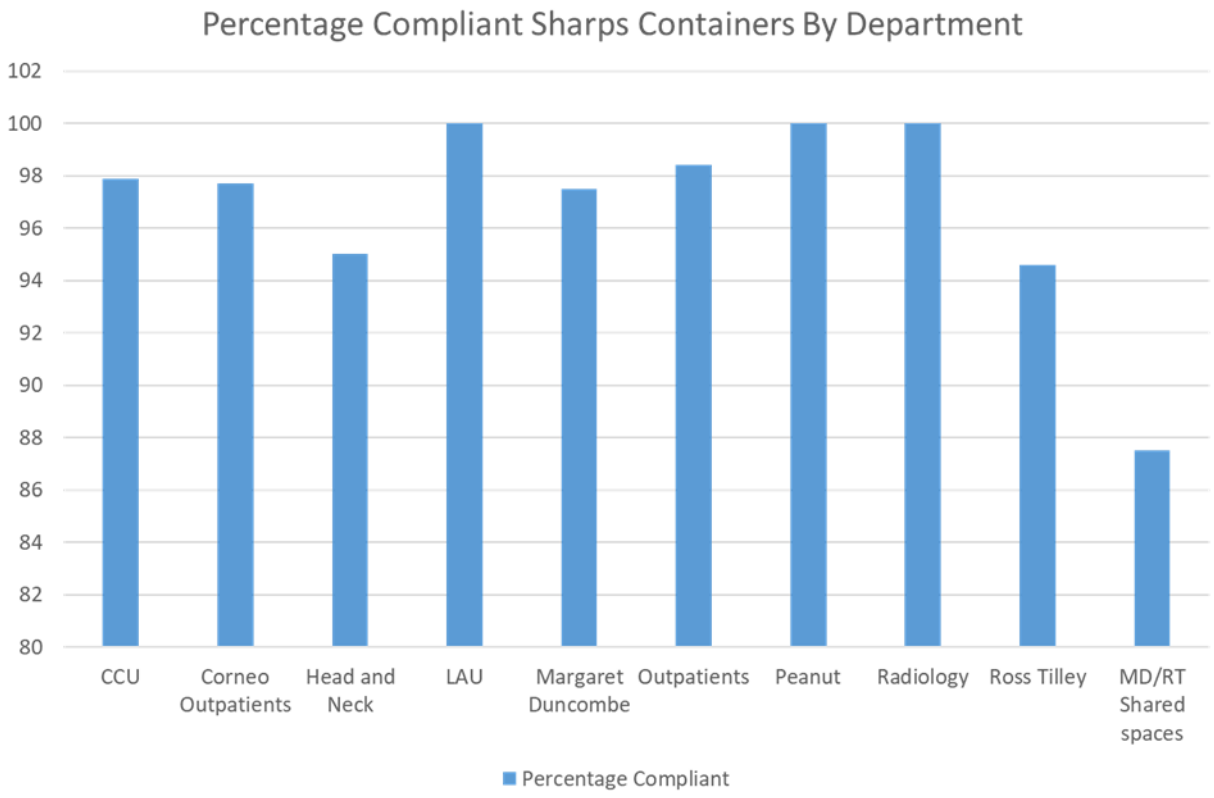
Trust wide Sink audit

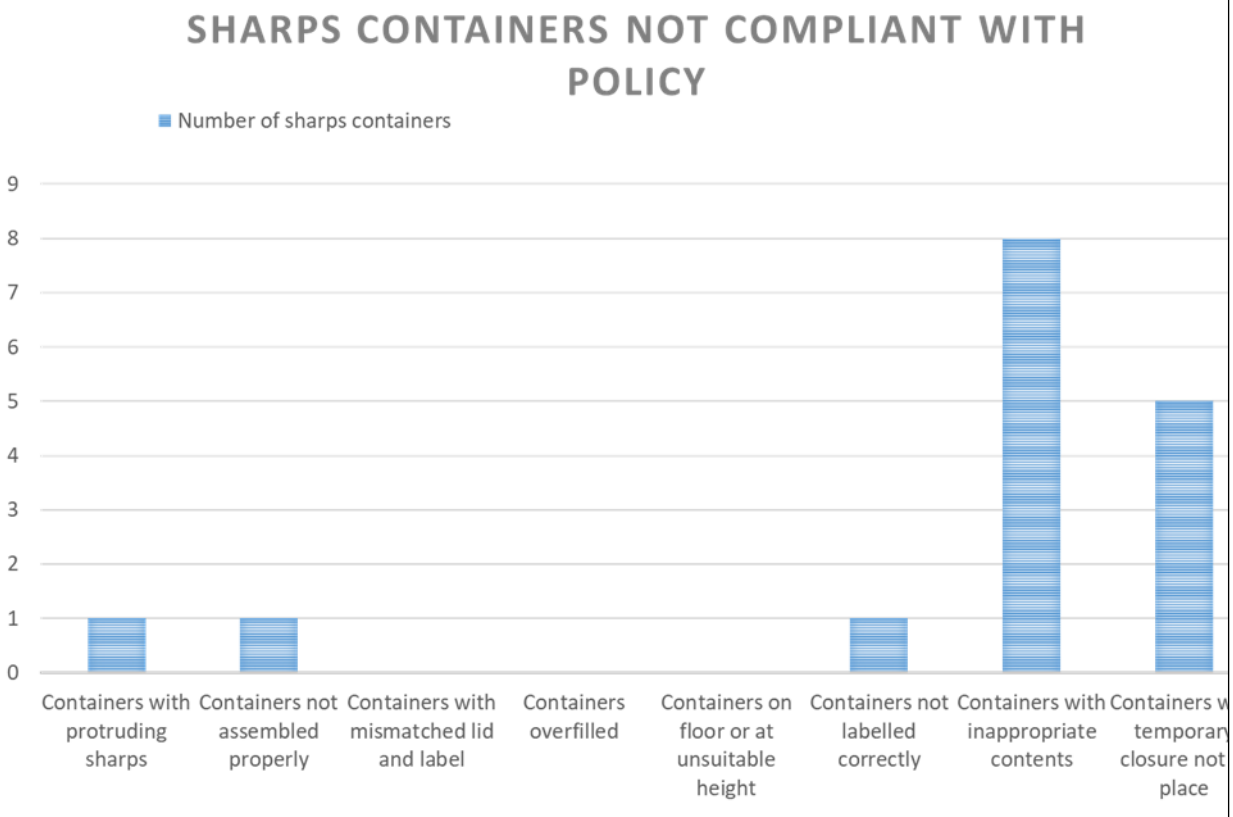
A comprehensive audit of 332 handwashing sinks across 31 clinical areas revealed 38% compliance with HBN 00-10 standards. Theatres showed high compliance, while areas such as physiotherapy and outpatient departments revealed issues like non-compliant tap design and sink placement. Results have been shared with Estates, and a replacement programme is being planned collaboratively to address infection risks**.**

Sharps box audit

Conducted in partnership with supplier Daniels in September 2024, this audit identified the main issue as inappropriate disposal of PPE and packaging in sharps containers (Figure 5). The shared treatment room between Margaret Duncombe and Ross Tilley had the lowest compliance. Departments have received targeted reminders and training offers**.**

Figure 5





Aseptic Technique Audit – January 2025

This annual audit, led by senior nurses, showed improved compliance at 87% (up from 73%). Enhanced audit tools contributed to more complete submissions. Areas for improvement included hand hygiene and sterile fluid handling. Education and leadership remain key to maintaining standards.

Isolation Room Audit

A snapshot audit confirmed correct allocation and use of isolation rooms for infectious patients, with no inappropriate usage detected. Ongoing advisory support and re-audit plans are in place for 2025–2026**.**

Surgical Site Infection Audit

Audits were initiated in Q4 for minor skin procedures and major breast surgeries. Patients received follow-up questionnaires 30 days post-operation. Results are expected in June 2025 and will inform surgical practice improvements.

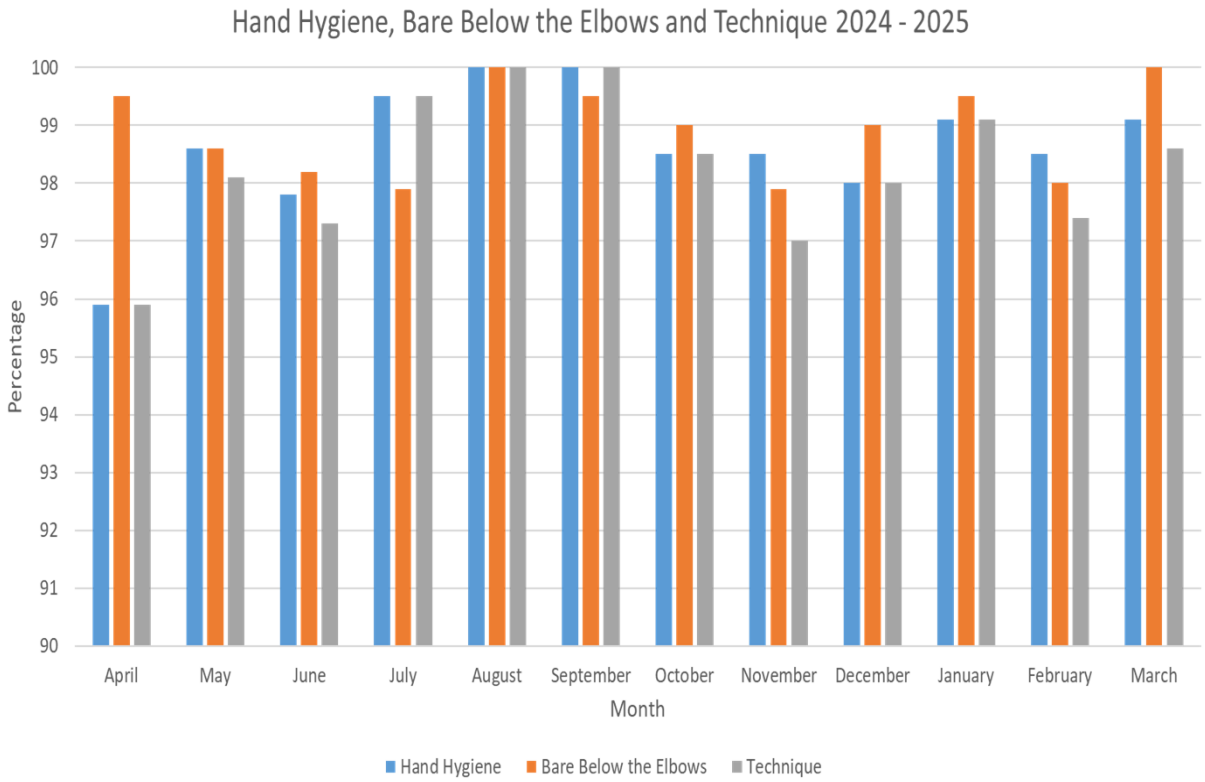
Gloves Off Campaign

This campaign has been launched Trust wide with the aim of this project being to reduce unnecessary glove usage in turn reducing procurement and waste costs. A reduction in these will have a positive impact on our carbon footprint by reducing the carbon emissions associated with the production, packaging, transportation and disposal of single use plastics (SUP's). This is in line with the Trusts Green plan 2022 'working towards a 57% reduction in our NHS carbon footprint'.

In addition, this project aims to empower staffs understanding of appropriate glove use through education posters and a risk assessment tool that will enable a quick assessment whether gloves are required or not.

Hand Hygiene Audits

Figure 6

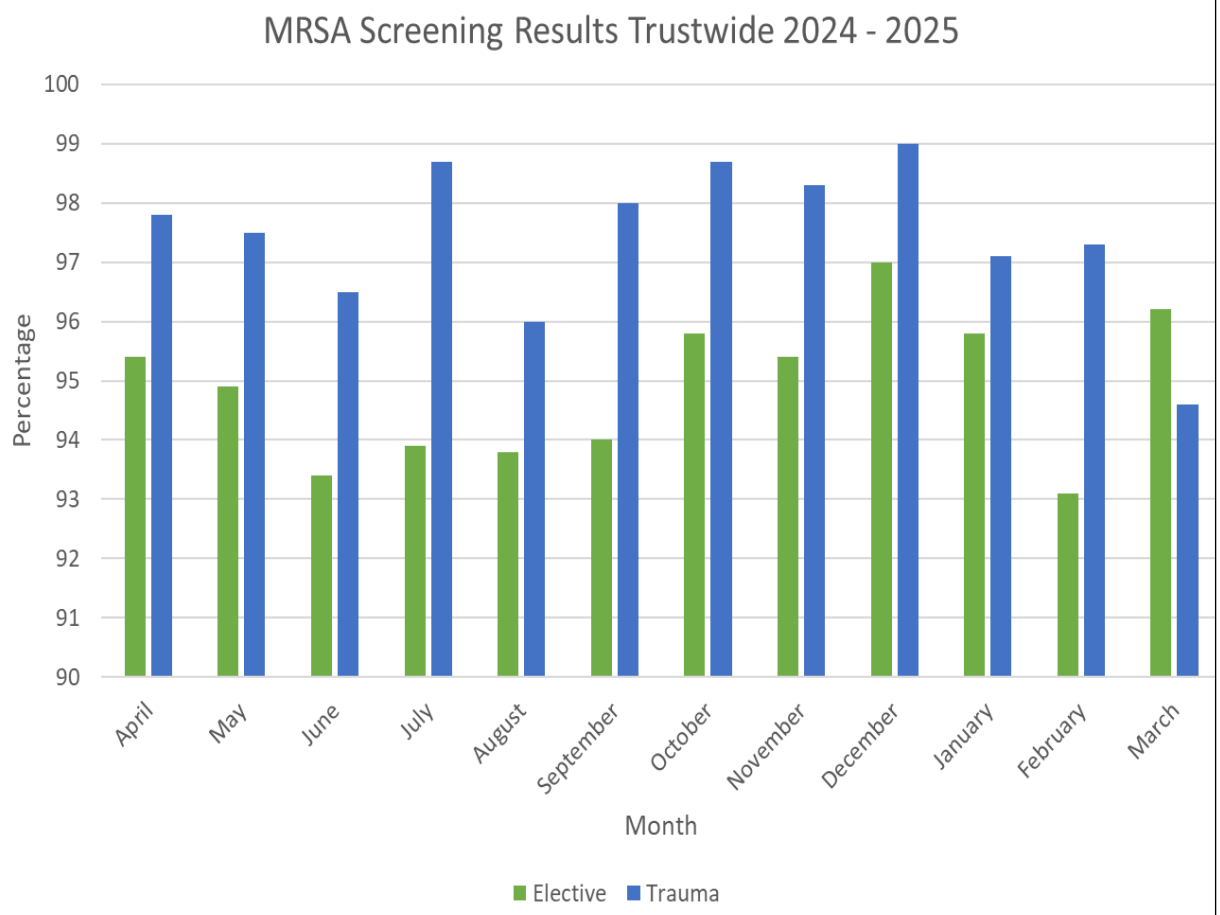


Monthly audits conducted by Infection Control Link staff maintained >95% compliance (Figure

6) across all areas. Ongoing training, leadership support and visible reminders help reinforce standards.

MRSA screening

Figure 7



Monthly audits continue to monitor adherence to Trust policy. A noted dip in elective screening compliance has prompted targeted staff training (Figure 8). Results and actions have been shared with areas concerned.

Infection prevention and control policies, procedures and guidance for QVH staff and patients

IPACT have developed guidance for the organisation, staff and patients in the form of policy, procedures, protocol, guidelines and leaflets. All documents are placed on Qnet. All documents have been systematically reviewed and updated in collaboration with relevant services and
Governance groups (see Appendix C).

Influenza arrangements

During 2024/25, support has again been given to the management of influenza (flu), with the ICNs encouraging vaccination of staff within the annual flu vaccination programme. Flu vaccination update is reported through the emergency planning reporting system.
The Infection Control Team co-ordinate the FIT testing programme for clinical staff to ensure safe practice is delivered, the monitoring of FIT tests has now been incorporated into the staff formal education records as clinical staff are required to be FIT tested annually.

Notable events, including Outbreaks

April–June 2024

- Antimicrobial Pharmacist commenced post and stewardship audits initiated.
- One hospital-acquired *C. difficile* case identified; RCA completed.
- Masking and distancing reinstated in two departments due to staff COVID-19 cases (no patient transmission).

July–September 2024

- Two MRSA cases in Burns and CCU; no linked outbreak.
- One *Pseudomonas* Blood Stream Infection (BSI) likely catheter-associated; management actions taken.

October–December 2024

- Continued antimicrobial compliance issues; app updated and stewardship leads to be appointed.
- Two *C. difficile* cases (one hospital-acquired), one MSSA BSI, all appropriately managed.

January–March 2025

- One *C. difficile* case linked to prolonged antibiotic use.
- One case of fully resistant CPE *E. coli*—contained with no spread.
- Bed bug infestation managed with full eradication.

MPox Alert

In August 2024, an Urgent National Alert circulated relating to an increase in Clade I Mpox virus infections. The IPACT co-ordinated the Trust response through ensuring effective communication being sent to all staff highlighting the signs and symptoms of MPox, immediate actions to take if a patient presents with suspected or confirmed MPox including PPE, isolation, cleaning, transfer and contact details for support/notification/advice. Advice reviewed when national guidance updated with information shared with Teams as soon as possible. Preparedness discussed at both internal and external assurance meetings. No cases of MPox identified or suspected within the Trust.

5. Involvement and Engagement

Antimicrobial report

The Antimicrobial Pharmacist produces a separate, detailed annual report outlining antimicrobial stewardship activities and audit findings. The compliance with antimicrobial requirements has continued to be a priority this year with a regular antimicrobial steering group being held and chaired by a designated Consultant Anaesthetist, identification of antimicrobial champions and formation of antimicrobial/microbiology ward rounds. A new antimicrobial pharmacist was employed who is overseeing the regular auditing of compliance with the Trusts antimicrobial prescribing policy and overseen the move to the antimicrobial app, Eolas, which is available for all staff to guide antimicrobial prescribing.

Decontamination and disinfection report

Nasendoscope and theatre equipment decontamination continues via the Wassenburg system, with routine servicing and water testing in place. Minor fluctuations in water quality were effectively resolved using approved thermal cleaning methods. No service interruptions occurred. Annual external audits by the Authorised Engineer ensure compliance with national standards. A summary report is presented quarterly by the Trust's Decontamination Lead.

Facilities report

Domestic Supervisors conduct weekly audits of clinical areas and quarterly audits for non-clinical spaces. Identified cleaning issues are resolved promptly, typically within 48 hours, followed by re-audits. The deep cleaning programme remains on schedule, with all areas cleaned annually as per national standards. A quarterly report summarising audits and

actions is shared at governance meetings, including the Infection Prevention and Control Group (IPCG).

Estates report

IPACT remains committed to working collaboratively with the Estates department to ensure environmental safety.

There has been no Estates quarterly reports produced since April 2024 and limited attendance from the Estates team at IPCG meeting. The absence of regular Estates assurance meetings which were disbanded at the start of the year has contributed to challenges in tracking ongoing work streams.

There are outstanding infection control concerns relating to Estates such as lack of assurance with ventilation, lack of stakeholder engagement for new builds and refurbishments, and no assurance relating to water safety for almost 12 months.

The ICNs has raised concerns throughout the year around the assurance and processes in place for National requirements for IPC estates work as without this structure there can be no assurance that work has been undertaken and if all safety requirements are being met or are there actions required.

Water Safety

The Trust is required to take monthly water sample (Approximately 25 tests per month) for the monitoring of legionella Pneumophila bacteria within the domestic water supplies. This work should be undertaken by an external water company. All outlets should be inspected for the presence of flexi pipes / dead legs / blind ends, with any defects identified rectified e.g. flexi pipes removed & replaced with copper hard piping. Dead Legs / blind ends to be removed as far as practically feasible. All Legionella sampling should be monitored by the Trusts RP of water safety, with actions taken when required. Pseudomonas samples are required to be taken every six months within augmented areas (CCU, Head & Neck and Burns unit). Results should then be presented in the Estates quarterly reports including any positive results and associated remedial actions and brought to any relevant assurance meetings. No water safety reports have been submitted through the IPCG since May 2024 with verbal assurance only given. Due to the stepping down of the estates specific assurance meetings twelve months ago there has been no process to monitor water testing, management of the water contract or monitoring of actions.

Infection Control Risks and incidents.

The Infection Control Nurses (ICNs) respond to all incidents reported through the Datix system. Each report is reviewed to determine the appropriate response, which may include support, advice, or further investigation. Incident themes are reviewed quarterly to identify potential areas for learning and service improvement.
The Trust currently holds one Infection Control risk on the Corporate Risk Register:

- **Risk ID 00000107:** Limited number of staff trained in the use of High Consequence Infectious Disease (HCID) PPE. National training availability is expected to resume in summer 2025. Interim mitigation measures, including alternative PPE and clear transfer protocols with partner organisations, are in place and monitored. Relevant external stakeholders are aware and supportive of the current arrangements.

This related to a National recommendation for all Trusts to train key staff in the appropriate use of HCID PPE. Whilst no training is available Nationally, the ICNs worked with the IPC network to train 2 members of the Site practitioner team in HCID PPE through training delivered by SECamb. Appropriate HCID PPE purchased and stored in separate emergency plan cupboard. All other clinical staff reminded of high level PPE and Don-Doff process. Training offered if teams or individuals requested. Communication sent out regularly in emails

and Connect to ensure staff aware of the process if they admit or see a patient suspected of having a HCID.

Contract monitoring -Sussex ICB Infection Prevention and Control Standards

The Trust completes the annual Board Assurance Framework (BAF) for the Sussex ICB, detailing compliance with national IPC standards. Any gaps are supported by evidence of mitigations or action plans. ICB representatives are invited to quarterly IPCG meetings and receive all relevant reports, including RCAs. No outbreak meetings were required during this reporting period.

6. Learning from Experience

The Trust recognises that maintaining strong infection prevention and control (IPC) practices is essential to delivering safe and high-quality care. While the overall rates of healthcare-associated infections have remained low, opportunities for learning and improvement continue to emerge through our daily practice, incident reviews, and audits.

Over the past year, key learning points have centred on the need to improve compliance in areas such as MRSA screening, antimicrobial stewardship, audit completion rates, and consistent delivery of IPC training. The infection control team has responded by exploring alternative, more flexible educational formats—such as short, focused ‘bite-sized’ training sessions—to increase accessibility and staff engagement.

The Infection Prevention and Control Team is actively increasing its visibility across clinical areas, offering real-time support, guidance, and education. Departmental inspections are being expanded to ensure local teams have the support needed to meet IPC standards and to provide an immediate opportunity for feedback and improvement.

Additionally, greater emphasis is being placed on ensuring the physical care environment supports safe practice. This includes working more closely with Estates and Facilities to address risks proactively during refurbishments or new builds, and ensuring that IPC requirements are considered at every stage of planning and delivery.

While an electronic audit solution was considered to support audit reliability and coverage, financial constraints meant this could not be implemented in 2024/25. The team will continue to optimise current auditing methods to ensure data is meaningful and drives service improvement.

7. Recommendations

Based on the findings of this report, including audit outcomes, governance activity, incident reviews, and patient feedback, several key recommendations have been identified to guide further improvement in the coming year.

- Strengthen compliance with MRSA screening and antimicrobial prescribing: These areas remain high priorities, with targeted interventions planned to reinforce practice and provide support to clinical teams.
- Revise audit methods to enhance utility and engagement: Improvements to the structure and timing of audits will ensure they are used effectively to drive change and monitor progress.
- Modernise training delivery: In response to national shifts in training guidance, IPC education will be restructured to be more accessible, flexible and relevant, including the rollout of department-level training and engagement initiatives.
- Improve Estates collaboration**:** A key focus will be to enhance joint working between IPC and Estates, particularly to ensure environmental risks are identified and managed effectively during building works and maintenance programmes.

These actions are designed to embed best practice, promote staff ownership of infection

	control standards and reinforce a culture of continuous improvement.

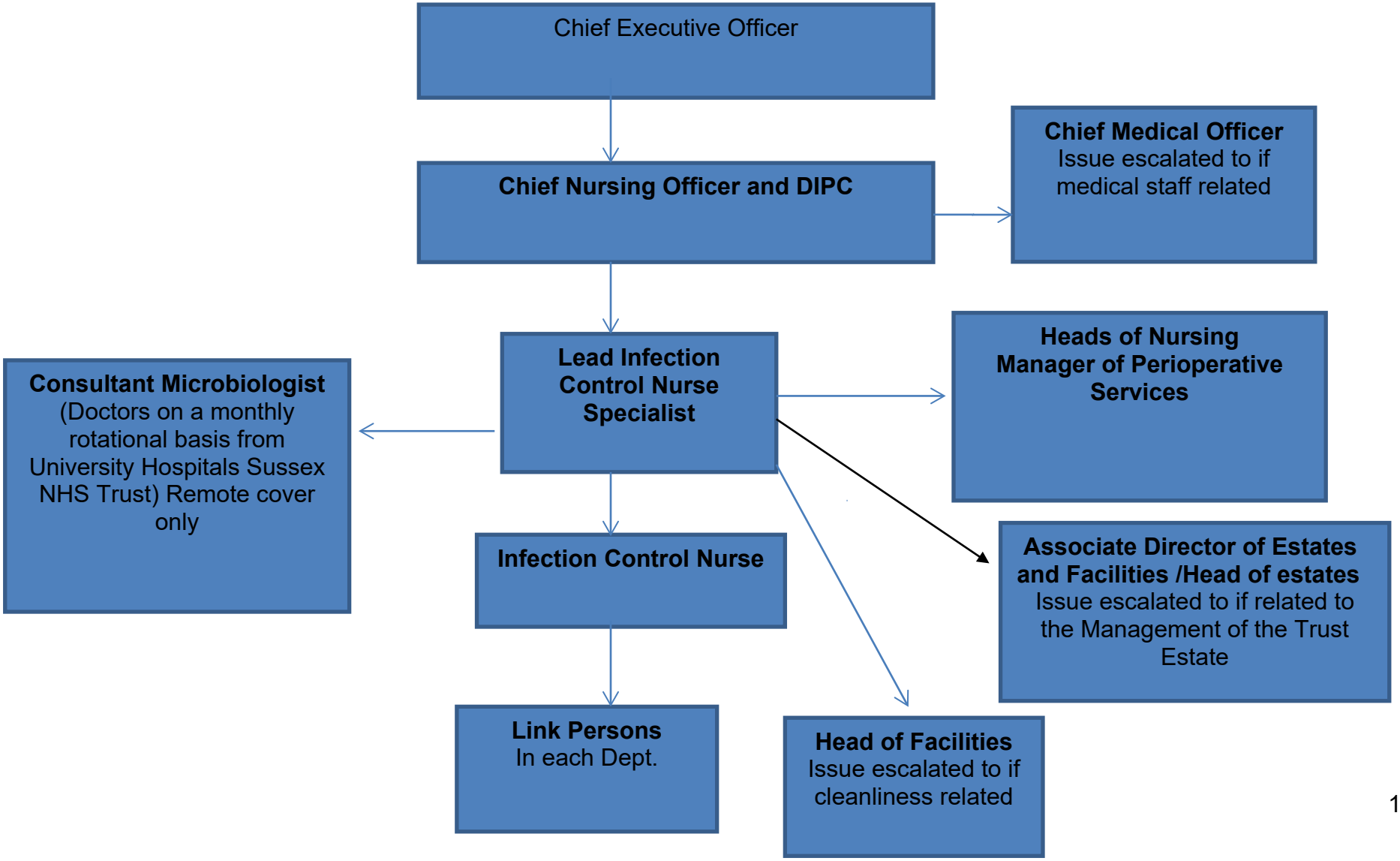
8.	Future Plans and Targets
	Looking ahead, the Infection Control Team will continue to embed IPC into every aspect of patient care and staff practice as per the Annual Programme Objectives (Appendix B). Key goals for the upcoming year include: • Embedding robust and targeted auditing to identify areas for improvement and monitor adherence to infection control standards across all departments. • Expanding access to meaningful training through tailored education sessions that are adaptable to staff roles, availability, and learning preferences. • Reinforcing fundamental standards of infection control, such as hand hygiene, environmental cleanliness, and equipment decontamination, through a blend of proactive inspection and real-time support. • Working collaboratively with Estates and Facilities to ensure that new projects and routine maintenance reflect current IPC guidance and national expectations. • Maintaining low rates of infection through active surveillance, rapid response to incidents, and effective communication across teams. The overarching objective remains the prevention of avoidable infections and the delivery of safe, high-quality care in all clinical settings.

9.	Conclusions and assurance
	This report provides assurance that the Trust has effective governance and operational systems in place to manage infection prevention and control in accordance with the Health and Social Care Act (2008): Code of Practice. Through comprehensive audits, staff education, alert organism surveillance, and proactive incident management, the Infection Control Team has supported the delivery of safe care and maintained strong performance in preventing healthcare-associated infections. The Trust benefits from a strong internal assurance framework, complemented by regular external oversight. Collaborative working with the ICB, local peer review processes, and guidance from the Chief Nursing Officer/DIPC contribute to a well-supported and responsive IPC programme. Infection control policies and procedures are regularly reviewed and updated in line with national guidance, ensuring staff have access to current best practice. The Infection Control Team remains a visible and accessible source of advice, actively supporting teams across the Trust to embed safe, evidence-based infection control practices.

10.	Report approval and governance
	This annual report is submitted to the Quality and Safety Committee for consideration and approval.

11. Appendices

Appendix A **Infection Prevention and Control Structure Chart 2024/2025**



Appendix B

Infection Control Annual Programme Objectives for 2025/26

Infection prevention and control continues to be a top priority at both National and local level. The IPACT, under the direction of the DIPC and with the full support of the Board of Directors and Governors, will continue to ensure that the highest possible standards in infection prevention and control are applied and achieved at the QVH.

This action plan contains new areas of activity and a number of on-going areas of particular importance. A large amount of activity is on-going and not included in the action plan.

Department	Section	Action	Frequency
Microbiology	Management	Continued review of pathology provider to ensure safe and efficient service delivered	On-going
Microbiology	Management	Continued review of pathology provider IT systems, e.g., the provision of electronic reporting in a useable, reliable format and request for regular list of blood cultures taken	On-going
Microbiology	Management	Continued review of antimicrobial prescribing	On-going
IC	Management	Maintain input into Clinical Audit Meetings and Consultant mandatory training	Quarterly
IC	Management	Maintain input into the review of any new Estates project from start to finish	On-going
IC	Management	Continue to review the Board Assurance Framework related to the Health and Social Care Act (2010)	Annually
IC	Management	Quarterly IPACT report for Board	Quarterly
Theatres	Management	Decontamination Lead to continue monitoring of decontamination of equipment in conjunction with the decontamination staff within Theatres	Ongoing
IC	Management	Review policies in line with DoH and NICE National guidance and Trust timescale	As required
IC	Management	Continued attendance at external meetings and Infection Prevention Society annual conference	On-going
IC	Surveillance	Continue mandatory surveillance and reporting in line with DH requirements including MRSA, MSSA, *C. difficile* and *E. Coli*	Monthly
IC	Surveillance	Enhanced surveillance (RCA/PIR) of *C. difficile*, MRSA, MSSA and *E. coli* bacteraemia	When new case identified
IC	Surveillance	Continue speciality specific surgical site infection audit	Annual
IC	Audit	Audit sharps policy compliance	Trust wide annual

IC	Audit	Continue hand hygiene audit and compliance	Monthly
IC	Audit	Audit compliance with MRSA policy Audit compliance with MRSA screening	Monthly
IC	Education	Mandatory training: Clinical Non-clinical Induction Junior doctors Consultants	ELearningElearningX1 month X6 year X2 year Available through e-learning
IC	Education	Link person training	quarterly
IC	Education	Deliver training to staff on current issues and attend department meetings on request	As required
Estates	Management	Involvement in the Capital Programme	As required
Estates	Management	Review of estates policy and new guidance	As required
Estates	Management	Involvement in reviewing water sampling and ventilation results	As required
Estates	Management	Involvement in the prioritising of general refurbishment works within the Trust	As required
Decontamination	Management	Review of decontamination and disinfection policy	As required

Appendix C

Ratified IPC Policies April 2024 – March 2025

- Management of Staff with MRSA Colonisation
- Policy for Isolation
- Management of Patients with Clostridium Difficile
- Standard Operating Procedure (SOP) – QVH COVID Screening SOP for Patients and Staff
- Decontamination and Disinfection Policy
- Guidelines for the Management of Head lice
- Guidelines for the Management of Scabies
- Procedure for the Management of Spillage of Blood or Bodily Fluids
- Policy for the Collection of Microbiology Specimens
- Christmas Decoration Guidance SOP
- Covid Admission screening SOP for patients and staff
- Screening and Management of MRSA positive patients
- Uniform and Dress Code policy approved at IPCG however ownership of policy Transferred to the corporate team with infection control to advice on future updates
- Guideline for the Prevention of Surgical Site Infections
- Management of Outbreaks
- Management of Patients with Tuberculosis

Report cover-page					
References					
Meeting title:	Board of Directors				
Meeting date:	10/07/2025	**Agenda reference:**	**48-25**		
Report title:	Complaints Annual Report 2024/25				
Sponsor:	Edmund Tabay, Chief Nursing Officer				
Author:	Chris Parrish, Patient Experience Manager				
Appendices:	N/A				
Executive summary					
Purpose of report:	This report provides a comprehensive overview of complaints for the period April 2024 to March 2025. It evidences how we actively listen to and act upon the voice of patients. It highlights the impact of feedback on us and how we remain focused on fostering a culture of openness, compassion and continuous improvement.				
Summary of key issues	Overall patient satisfaction remains consistently high. QVH achieved top national rankings in the Adult Inpatient and Children and Young People Surveys, reflecting our continued dedication to high-quality, person-centred care. While FFT scores remain strong, response rates fell below target. Positive feedback frequently acknowledges staff professionalism and the quality of care, while recurring themes for improvement include communication, clarity of information, and waiting times. Feedback is systematically reviewed and triangulated across multiple sources including complaints, PALS and FFT responses allowing for a broader and more reliable understanding of themes and trends. In addition, the Trust targets have been met for complaint acknowledgement and response times. A key advancement this year has been the introduction of 'Learning From' meetings, involving the Patient Experience Manager and Leadership Triumvirates, which is central to a collaborative, methodical, and inclusive organisational learning approach.				
Recommendation:	To **note** the report.				
Action required	Approval	Information	Discussion	**Assurance**	Review
Link to key strategic objectives (KSOs):	**KSO1:**	KSO2:	KSO3:	KSO4:	KSO5:
	To deliver outstanding care	*To innovate and improve*	*To be an excellent employer*	*To deliver sustainable services*	*To collaborate with others*
Implications					
Board assurance framework:	None				
Organisational risk register:	None				
Regulation:	LASS and NHS Complaints (England) Regulations 2009				
Legal:	None				
Resources:	None				
Assurance route					
Previously considered by:	Patient Safety and Experience Sub-Committee, ELT, ECQR and Quality and Safety Committee.				
	Date:	22/05/2025, 02/06/2025, 16/06/2025 and 01/07/2025	Decision:	Approved and Approved subject to comments/amendments	
Next steps:					

Queen Victoria Hospital
NHS Foundation Trust

Queen Victoria Hospital NHS Foundation Trust
Complaints Annual Report

Report covering the period from
April 2024 to March 2025

Document Control: Quality and Safety Committee
Executive sponsor: Edmund Tabay**, Chief Nursing Officer**

Authors: Chris Parrish**, Patient Experience Manager**

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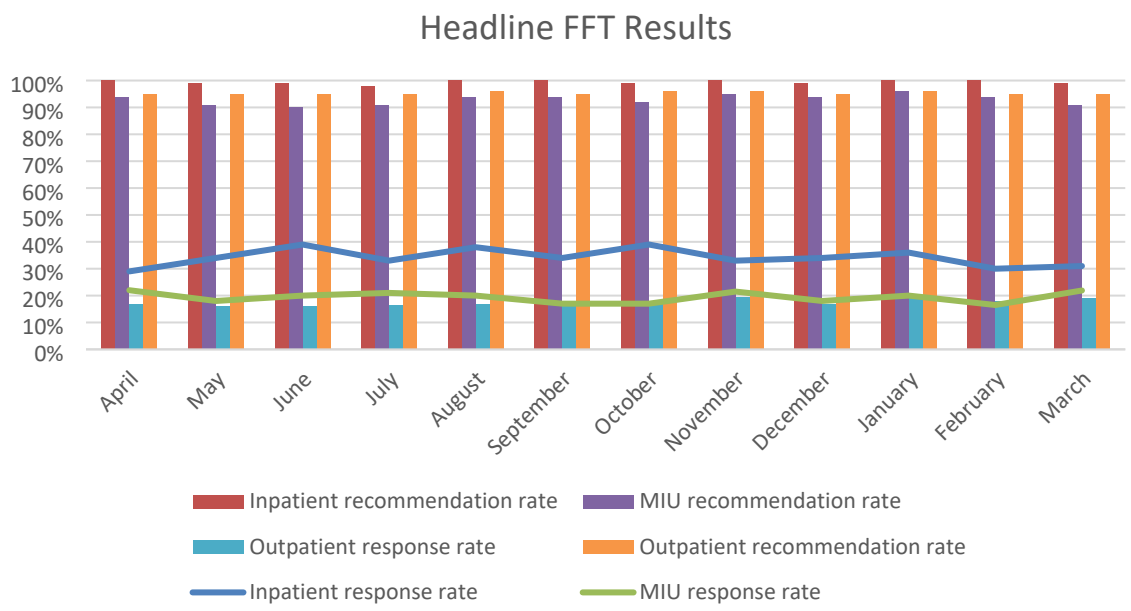
1.	Executive Summary
	This report provides a comprehensive overview of patient experience feedback at Queen Victoria Hospital (QVH) for the period April 2024 to March 2025. It draws on a range of sources, including the Friends and Family Test (FFT), national and local surveys, PALS enquiries, complaints, direct engagement, and digital feedback platforms. Overall patient satisfaction remains consistently high. QVH achieved top national rankings in the Adult Inpatient and Children and Young People Surveys, reflecting our continued dedication to high-quality, person-centred care. While FFT recommendation scores remain strong, response rates particularly in inpatient and outpatient settings fell below target. Positive feedback frequently acknowledges staff professionalism and the quality of care, while recurring themes for improvement include communication, clarity of information, and waiting times. At the heart of our patient experience approach is the belief that every piece of feedback presents an opportunity to improve. Compliments affirm what we are doing well; concerns and complaints guide our learning and service development. Feedback is systematically reviewed and triangulated across multiple sources including complaints, PALS and FFT responses allowing for a broader and more reliable understanding of themes and trends. In addition, the Trust targets have been met for complaint acknowledgement and response times. A key advancement this year has been the introduction of 'Learning From' meetings, involving the Patient Experience Manager and Directorate Leadership Triumvirates, which is central to ensuring a collaborative, methodical, and inclusive approach to organisational learning. This is further strengthened by the updated governance structures, including new subcommittees focused on patient experience and clinical outcomes. The creation of the Leadership Triumvirate has allowed for a more consistent and grounded view of complaints to be disseminated across the Trust. This has improved the communication and standardisation of the process to answer and learn from patient feedback. This report evidences how QVH actively listens to and acts upon the voice of patients and those important to them. It highlights the impact of feedback on service improvements from changes in communication and clinic procedures to enhanced discharge planning and illustrates how learning is shared across teams and with patients and families. Through this ongoing work, we remain focused on fostering a culture of openness, compassion and continuous improvement.

2.	Introduction
	The year 2024-25 was a significant year for patient experience as the launch of the organisational strategy in November 2024 was the culmination of over two years of development. The focus of our strategy is to deliver on our vision of being a centre of excellence that rebuilds lives and supports communities for a healthier future. This has provided a refocus to what matters to our patients and how we can work with them to provide the services that they need. Within the scope of this report is FFT, PALS, Complaints, National Surveys and other feedback channels (such as board stories and website feedback). Analysis of this feedback, the themes and triangulation of the feedback then helps us to recognise the lessons from the feedback to take advantage of the improvement opportunities being shared. In addition to this strategic development, more practical changes such as the merger of the Patient Experience Team and Patient Safety Team have occurred. The greater access to information will allow the newly formed Safety and Patient Experience Team to enhance collaboration, streamline processes and improve service delivery.

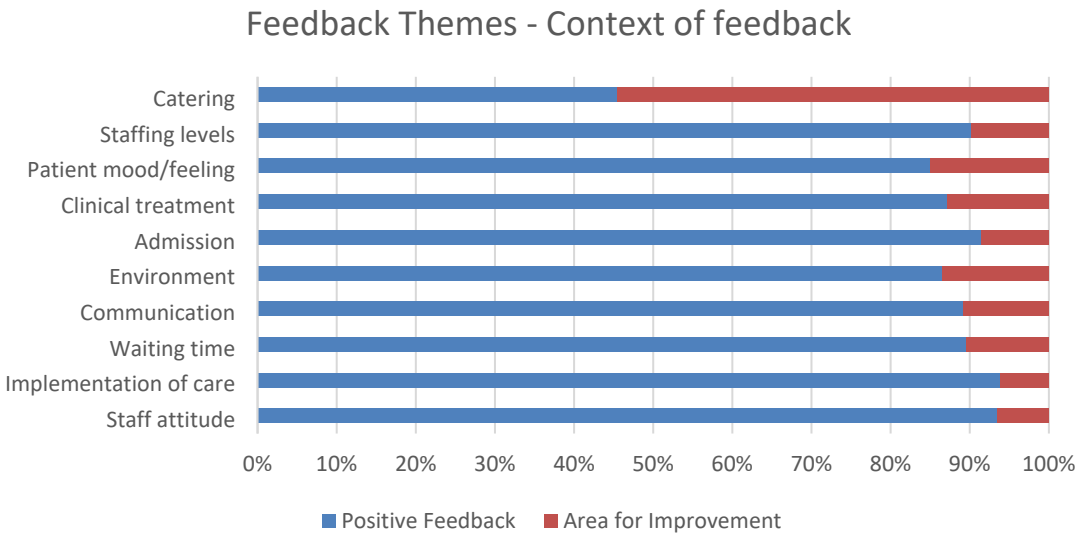
3.	Service aim, objectives and expected outcomes
	The Safety and Patient Experience Team are committed to supporting the Trust patient experience agenda ensuring a reporting culture that it is fully embedded, integral to our everyday business, and that improvements in patient experience are identified and prioritised. A fundamental responsibility throughout the organisation is fostering a culture and environment where all staff are confident to voice concerns about patient experience and respond to feedback in a non-judgemental way. The introduction of leadership triumvirates has helped the team to support all staff with patient experience in the day to day service delivery and as part of specific projects and quality improvement programmes. A strong commitment to ongoing triangulation of incidents, claims and complaints supports the wider learning agenda. Key targets include: • 90% of all complaints will be acknowledged within three working days • 90% of all complaints will be closed within forty (40) working days • 40% of all inpatients will provide FFT feedback • 95% of all inpatients are likely or very likely to recommend us to friends and family • 20% of all outpatients will provide FFT feedback

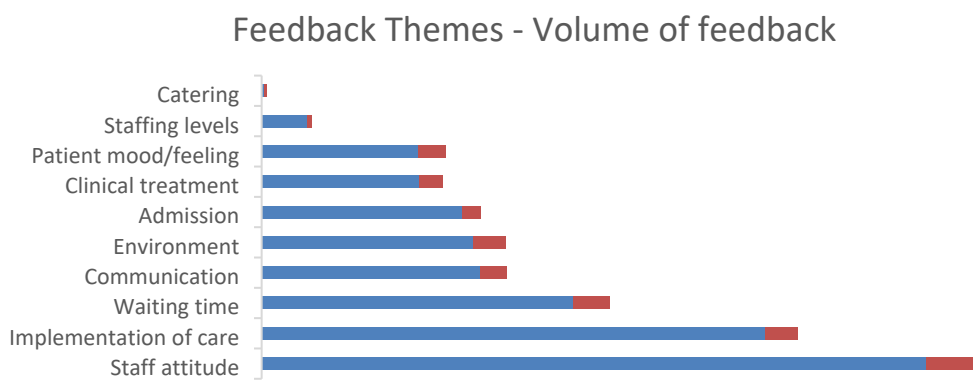
	• 90% of all outpatients are likely or very likely to recommend us to friends and family

4.	Activity analysis/achievement
	We will collaborate with patients to improve the patient experience by listening to and acting on what patients and their friends and family tell us would improve their experience. A key method for us to hear what patients are saying is through our survey programme which includes the Friends and Family Test (FFT), local surveys, and national surveys. We recognise that there are limitations to the insight we can gain from these sources alone and this year we have challenged ourselves to think more creatively about how we can hear from patients and carers in different ways such as through a real-time feedback opportunity. One such initiative has been to signpost patients directly to the Patient Experience Manager in person when they have feedback, rather than relying solely on the FFT or survey mechanisms. **Friends and Family Tests** The Friends and Family Test (FFT) gives patients who have received care through the Trust the opportunity to provide immediate feedback about their experience. Between April 2024 and March 2025, we received **37,893** responses to the FFT, with over **17,000** comments given showing high patient satisfaction from the **20.7**% of patients responding to us. We have not achieved our inpatient response rate target of **40%** and achieved **34.2%.** We have not achieved our outpatient response rate target of 20% and have achieved **17.5%.** We achieved our recommendation rate, with **99.6%** of all responding inpatients, and **95.3%** of all responding outpatients, recommending us to their friends and family for the period. The chart below shows the monthly breakdown by headline areas:



The most commonly raised themes brought up by patients are improvement opportunities and areas of positivity. The charts below present the themes for the reporting period, showing both the volume of feedback received and how the results relate to one another.





	Staff attitude	Implementation of care	Waiting time	Communication	Environment	Admission	Clinical treatment	Patient mood/feeling	Staffing levels	Catering
Area for Improvement	94	67	74	54	67	38	47	56	10	6
Positive Feedback	1351	1022	634	443	430	408	320	319	92	5

As with previous years, the majority of our patients are more than satisfied with the high standards of care they receive, citing the friendliness, helpfulness and professionalism of staff, excellence of clinical outcomes and overall very positive patient experience.

Patient feedback highlighted that the areas where experience could be improved most often related to how staff interacted with patients particularly in the context of waiting times. One example of learning from this feedback is the use of “you said we did” posters in our outpatient and MIU settings. As this is led by the clinical service, the approach may vary between different teams or specialties. The Minor Injuries Unit (MIU) specifically use this opportunity to share wait times, how they use triage to prioritise patients and how patients can escalate concerns about their waits in that context.

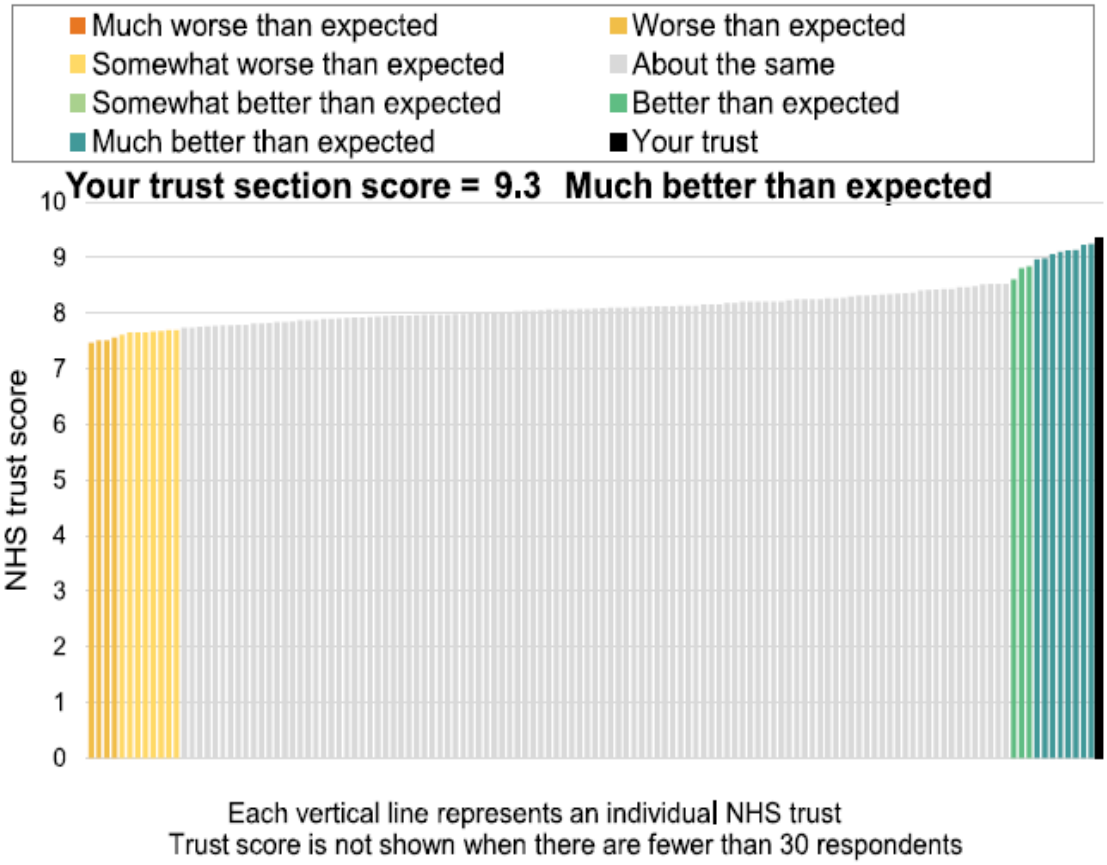
Patients noted that communication, attitude and the way they were treated during delays had significant impact on their overall experience. In addition, a common theme among suggested improvements relate to clarity and accessibility of written information provided during their care.

Patient feedback, both from FFT and real time patient experience surveys are routinely provided directly to ward and department managers on a monthly basis which include individual comments.. Each ward displays the FFT recommendation rates, response rates and some chosen comments for that ward for patients and staff to see.

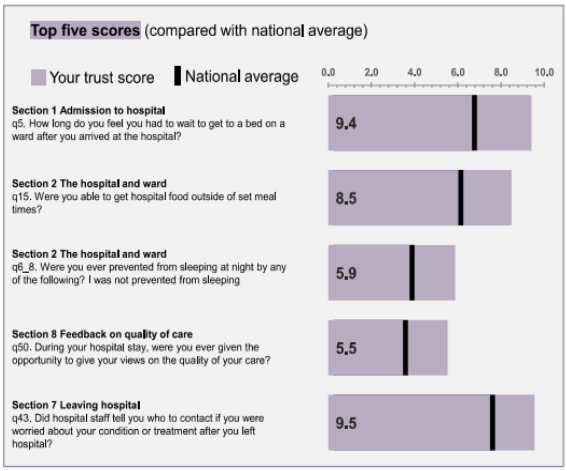
National Surveys

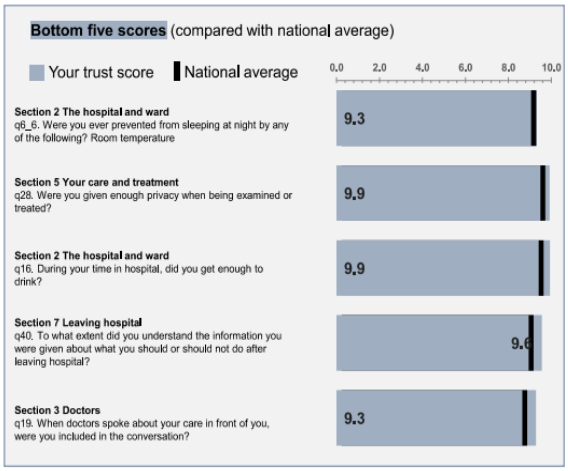
The Trust continues to participate in the Care Quality Commission’s National Patient Survey programme. This provides another opportunity to listen to what patients are saying about our services. Ahead of discussing this report we have received the results for the Adult Inpatient Survey 2023 and the Children and Young People Survey 2024.

For the Adult Inpatient Survey 2023, patients scored their overall experience whilst in the hospital as **9.3** out of 10. This is an excellent score and we are proud to have been recognised by our patients as the number one Trust in the country for overall experience.

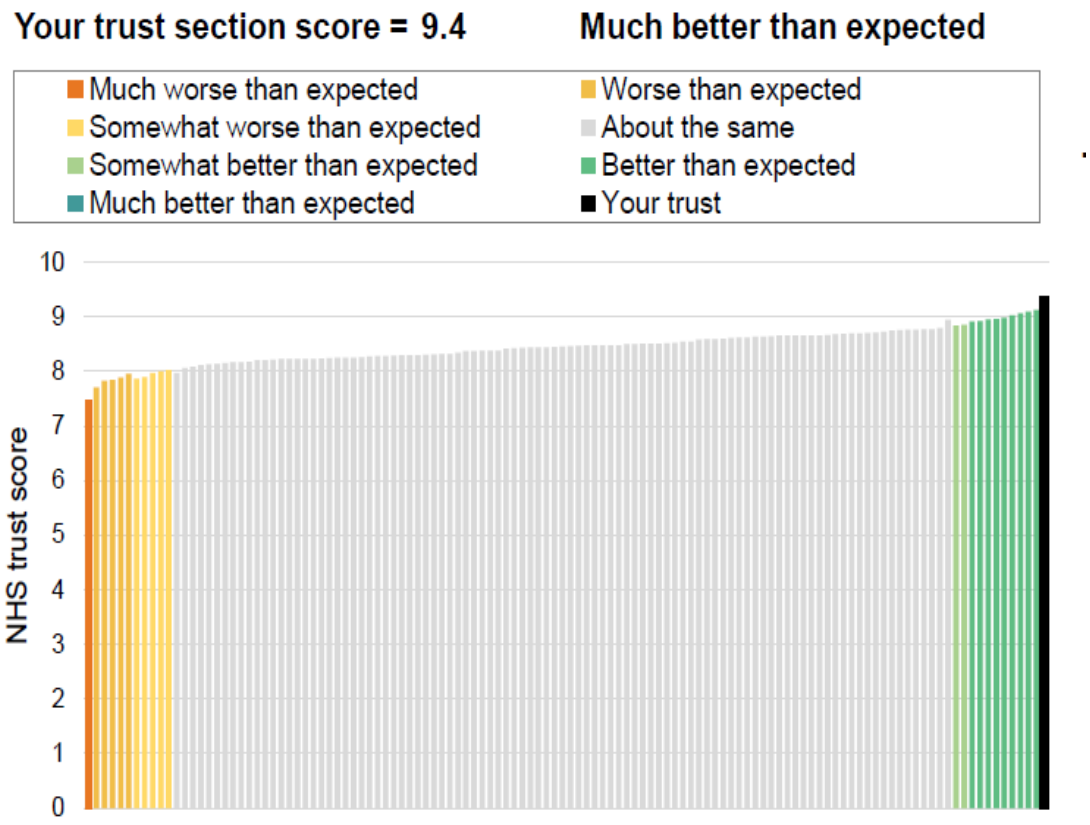


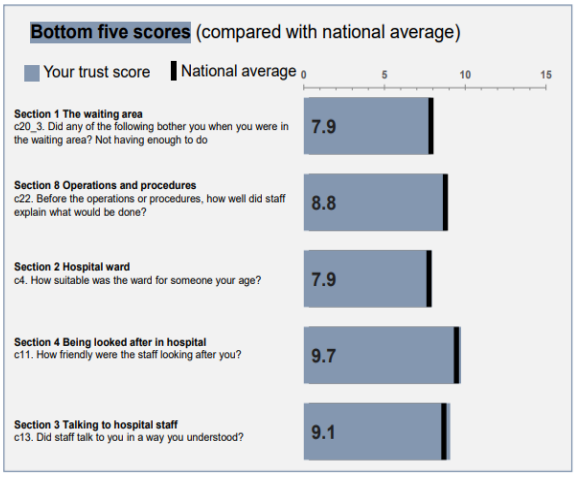
We understand that in order to continue to provide such a service we need to commit to our areas for improvement and these include promoting sleep on the ward, the information provided at the point of discharge and including our patients in their care further.





For the Children and Young People Survey 2024, we were equally proud to have been recognised by our patients as the number one Trust in the country.





Similarly our areas for improvement include the waiting area, the information provided about surgery and the way it was shared to include our patients in their care further.

For the Cancer Patient Experience Survey 2023, we were equally proud to have patients score their overall experience as **9.0** out of 10. This is an excellent score and no questions were scored below the expected range.

Website feedback
Alongside our survey programmes, we also receive feedback more and more through our linked websites, such as Care Opinion, and social media sites. Patient and carers share their thoughts and are replied to by the Patient Experience Manager, Chief Nursing Officer or Communications team to thank them for their feedback and invite them into a discussion on how their feedback can help develop services. Over the course of the period, 17 comments have been posted on the linked website with many more on social media sites.

Patient Story at Board
Stories can help build a picture of what it is like to be in receipt of our services and how care can be improved or best practice shared. It is a way of ensuring that individual experiences are shared to highlight an area of improvement that will impact on patients.

At every other public Board meeting, the Chief Nursing Officer and Chief Medical Officer invite a patient to share their personal story directly with the attendees. A staff story is shared instead when a patient story is not available. The Board are keen to hear the lived experience of those sharing their story and by listening to those in receipt of our services they gain a real insight into the direct thoughts and feelings of our patients.

Invitees are typically those patients who have raised complaints or written to the Chief Executive Officer as they provide a rich source of improvement opportunity.

From April 2024 to March 2025, we had two patients presented stories that were positive and very personal experiences of attending the breast reconstruction and facial palsy services. Both were based on compliments from the patients who wanted us to recognise what we had done well. Two further patient stories were unfortunately gathered but not shared as the patient was unable to attend, or technology issues were experienced. One of these was rescheduled at a future date.

Following these patient stories being shared the subsequent actions have been taken:
- A review of patient appointment letters, and communication on the day, into the eye clinic to manage expectations about waiting times and how diagnostics follow sequential steps which can't be sped up in the current setup of the clinic
- A communication plan has been introduced to ensure that referring doctors are aware of the facial palsy service and what it offers to patients.
- A process was commissioned to build on the exemplary care provided by domestic and catering staff providing meals. This process aimed to build on food options and the service provided at mealtimes.

Patient Advice and Liaison Service (PALS)
PALS has continued to grow busier, demonstrating its importance as a support for patients, carers, families and staff. The service aims to help resolve low-level concerns quickly and provide advice, support and signposting for patients, family,

and carers as well as staff.

During the period of 1 April 2024 to 31 March 2025, there were **278** PALS enquiries which is an increase of **20%** from last year:

- **183** of these were dealt with as issues to be resolved (five of these were referred as a formal complaint or an accompanying concern to a formal complaint).
- **95** of these were for advice and information

The majority of these enquiries were related to communication errors (lack of information or incorrect information) about appointments and treatment. Themes were mixed where patients recognised their issues as communication, treatment and behavioural concerns. These themes were triangulated, discussed and addressed at 'Learning From' meetings with the leadership triumvirates.

Complaints

The NHS constitution and NHS Complaints Regulations 2009, clearly set out the rights of patients about raising complaints and expectations on how these should be managed. As a Trust, we take this duty very seriously. We want to know when someone is unhappy with the treatment or service they have received. This means we can put things right and learn from the experience of our service users.

The Trust has an integrated service – Complaints and PALS - to manage complaints, concerns and feedback in accordance with its Complaints Policy. This service is made up of one full time member of staff who manages the complaints, PALS and overall patient experience service. This member of staff also provides guidance, training and support to staff.

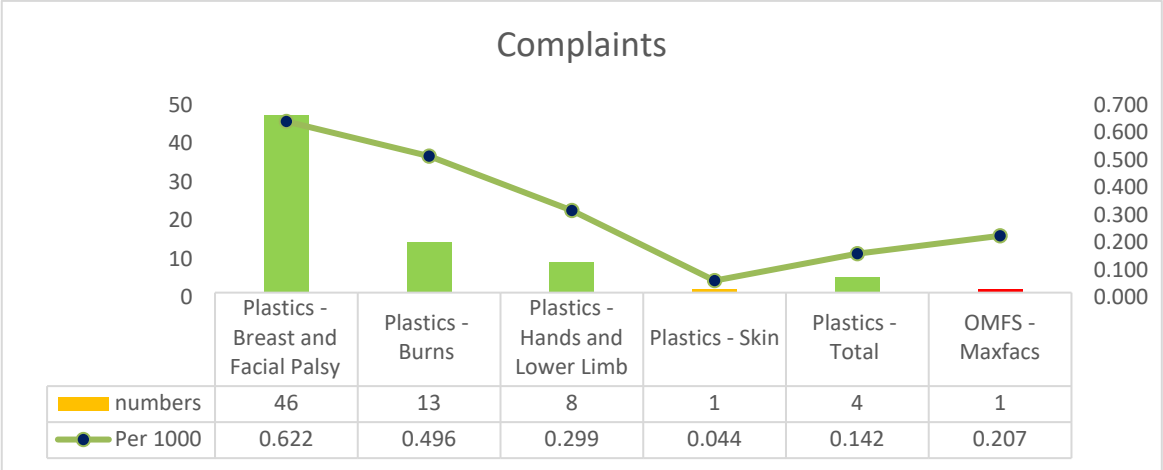
Being a single person team has some limitations on the service such as not being able to tend to two cases at the same time. This can have implications on the continuity of service during very busy periods and prospective cover arrangements need to be agreed in the next period.

From 1 April 2024 to 31 March 2025 we received **73** formal complaints, which is an increase of **12%** from the previous year (**65** complaints) and aligns to local and national trends of increasing complaints being received.

Throughout this period, the Trust has undergone significant change in the setup of teams and services. Four Directorates have been launched, each with a leadership team triumvirate of a Clinical Director, Head of Nursing and General Manager. This activity has seen some services changed processes and procedures whilst simultaneously increasing patient numbers. During this period of transformation, there has undoubtedly been an increase in the volume of feedback, concerns and complaints received.

The Trust acknowledged **97%** of all new cases received in three working days and closed **90%** of all new cases in forty (40) working days. This is a slight improvement on both results from the previous period and achieves the targets set of 90% for the period. Where timeframes cannot be met, the complainant will be informed and a suitable timeframe agreed.

It is difficult to confirm the potential reasons for delays as during this period the complaints process was significantly changed more than once. The current version of the process has been in place since January 2025 and is being monitored by the Patient Experience Manager and Chief Nursing Officer.



	Plastics - Breast and Facial Palsy	Plastics - Burns	Plastics - Hands and Lower Limb	Plastics - Skin	Plastics - Total	OMFS - Maxfacs
numbers	46	13	8	1	4	1
Per 1000	0.622	0.496	0.299	0.044	0.142	0.207

The chart above shows the number of complaints as a proportion of activity (the total number of inpatient and outpatient contact). To enable comparison with other trusts, figures are presented per 1000 contacts rather than as standalone numbers. This results in a total of **73** complaints for the period, corresponding to a rate of **0.322** complaints per 1000 contacts. With the creation of directorates this period activity numbers can only be assured where the bar presented is green. Ross Tilley and Community Diagnostic Centre (CDC) numbers have not been captured in the same manner for the period and reflect the risk associated to the activity number with a different colour bar. The amber bar reflects that practice to capture the numbers has changed once in the period, the red bar reflects that practice has changed more than once in the period.

We take all negative feedback very seriously and have reviewed our complaints process throughout the year to make sure that it is properly considered in a timely manner. At the outset of the period, our Chief Executive considered every complaint personally before a response was sent. This was then delegated to an Executive Lead (Chief Nursing Officer, etc.) during the period. The Directorate Leadership Triumvirates also review every complaint in their area and lead on the investigation conducted.

Parliamentary and Health Service Ombudsman (PHSO)
A complainant may refer their complaint to the PHSO if they do not feel that the Trust has responded to all of their concerns or they are unhappy with the way in which we have dealt with their complaint.

The PHSO gives the Trust the opportunity to ensure that all local resolution has taken place to try and resolve the issues and will give an independent view on the complaint.

The outcome of a PHSO investigation may result in a complaint being fully

upheld, partly upheld or not upheld.

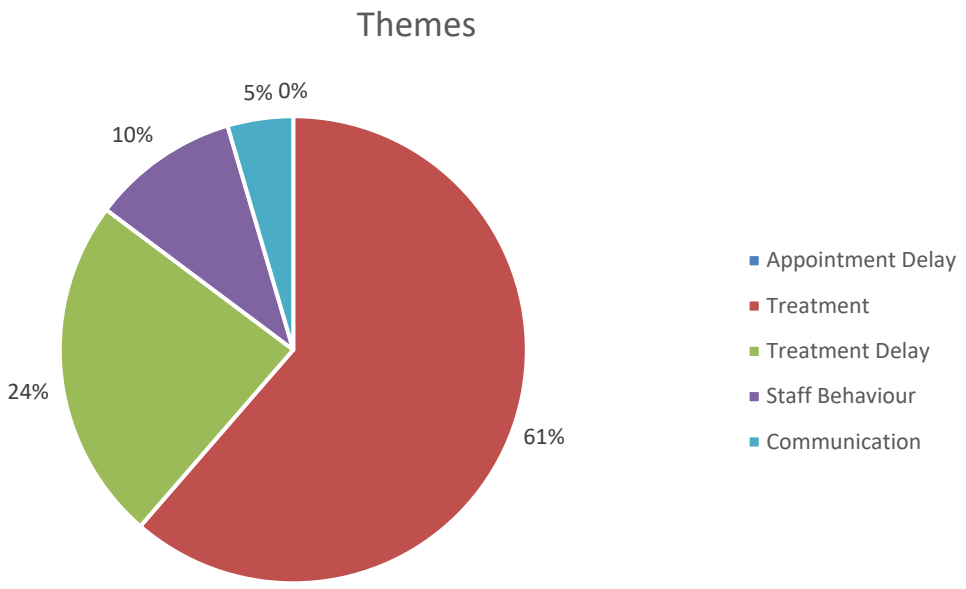
There were no new cases referred to the PHSO in this period.

'Learning From' and triangulation
The ultimate purpose of any feedback provided to QVH is that we will learn the lessons from it. Sometimes the lessons are to keep doing what you are doing, in the form of a compliment, and other times it is to tell us where changes can be made for service improvement.

Understanding this has allowed the structural changes within the Trust to adopt a systems based approach to review the feedback in the same manner as the Patient Safety Incident Response Framework (PSIRF). This does not look to attribute blame to events and seeks to remove any stigma by identifying improvement opportunities in a methodical standardised way.

Triangulation of all sources of feedback is a key part of learning from patient experience and brings together the available information to really understand what is going on. The Patient Experience Manager is involved in all PALS queries, local resolutions, formal complaints, claims, FFT responses and violence prevention and reduction investigation.

As a result of having such access to these datasets, thematic and systemic analysis can be performed and discussed with Directorate Leadership Triumvirates allowing for a more consistent and grounded view of complaints to be disseminated across the Trust. This has improved the communication and standardisation of the process to respond and learn from patient feedback. It may not be possible from one dataset in isolation, due to the relatively low numbers, to find statistically significant themes. Using these collective datasets allows for a larger sample size to assist the analysis.



	The chart above shows the themes of complaints for the period. Structuring them in this manner allows for standardisation across the different datasets to allow for deep analysis. Treatment as a theme, for example, breaks down further into communication about the treatment, execution of the treatment and consent of the treatment. Claims that are then received about treatment can be considered alongside the execution or consent of treatment complaints, as necessary. During the course of this period, the Patient Experience Manager and the Directorate Leadership Triumvirates have met quarterly to discuss the results of triangulation in 'Learning From' meetings. Where findings are Trust wide, ad hoc meetings are called to discuss topics and understand if there is a suitable forum or working group within existing governance structures to pick up on this. The result of each 'Learning From' meeting is a trust and directorate action plan. Training needs for individuals, for example, are always captured on directorate action plans. Trust action plans, for example, capture team training on values and customer service as well as process/procedural changes. Each complaint is seen as an opportunity to reflect, learn and make improvements in the areas that matter most to our patients, and the people important to them. Examples of learning and changes in practice that have arisen in response to complaints are set out below: • We seek feedback from complainants every time a complaint is closed. Whilst we have not received any formal feedback some complainants have anecdotally shared they are not satisfied with the process and as a result we have redefined the process. Further improvement in this area is a quality priority for the next period. • Feedback has told us that where hybrid clinics operate (both face to face and telephone appointments), it is possible that telephone appointments have been missed or run late. As a result the clinical staff have been trained to minimise this risk and a review will be conducted in the summer of 2025 to determine if this has been effective. If not, a new procedure will be developed for the management of these hybrid clinics. • Evidence from successful claims suggests that we could improve the reporting incidents and errors through our incident reporting framework when things have gone wrong. There is evidence of two cases in this period that were not reported and this may mean we don't learn from these experiences effectively or follow through on the Duty of Candour requirements at the time of the incident. The Duty of Candour policy is being revisited in the next period for improved clarity and will be cascaded to improve practice. • Signposting for patients through NHS 111 has led to them attending MIU when it is the wrong facility for their care needs. This has led to the patient being transferred when we cannot treat. As a result criteria has been set for what the MIU can accept and the ICB have been engaged to work with NHS 111 and the network to disseminate this information. • Patients who need assessment for trauma may not always require a procedure, but communication has meant this has not always been clear. This can lead to frustration when the patient arrives expecting treatment. As a result we have engaged with the Trauma Network to help them

	understand how trauma clinics at QVH operate and what patients can expect. • Variance in the discharge process between different surgical treatment areas has led to patient confusion around discharge plans. To respond to that we have improved communication about what to expect when admitting the patient. Nursing staff also now ensure that they confirm with patients how they are getting home and explore options for transport with them. For medical staff, actions from directorate action plans are fed into their appraisal process which requires an annual discussion of any complaints to occur between them and their medical supervisor. We also try to share actions back to staff, their patients and their families to show them how we are learning from patient feedback. Some of the ways we do this are by: • Direct feedback to the patient e.g. via meetings, complaint letters, telephone calls • Request for assistance from the person providing feedback e.g. to join a project, meeting or discussion group • 'You said – we did' noticeboards at department level • Posters and signage around the Trust • Creation and development of new groups and forums • Monthly reporting • Trust annual report All new staff have received a condensed session about customer care and handling concerns at the Trust induction programme and a training leaflet was enhanced to accompany this training. This is in addition to the induction programme newly provided on the Trust's vision and values.

5.	**Involvement & Engagement**
	The patient experience vision and objective are inherent in all QVH does. The Trust Key Strategic Objectives (KSO), start with KSO1 simply being "Outstanding Patient Experience". Our five year strategy sets our refreshed organisation vision, values, strategic objectives, future focus and direction. It includes our ambitions for our patient services and the key enablers to help us deliver our strategy. We are proud that it has been shaped and co-produced with over 3,000 patients, volunteers, staff, health and care partners and a wide variety of stakeholders across Kent, Surrey, Sussex and beyond. You can read all about it here **Patient Safety and Experience Sub-Committee (PSESC)** As part of the governance developments within the Trust over the period, the Patient Experience Group has ceased and replaced by the PSESC. The group meet monthly, chaired by the Chief Nursing Officer, and are the key forum for patient representation and participation. The group is a formal assurance

group comprised mainly of Trust staff, patient representatives and Healthwatch representatives.

SPESC is a Sub-Committee of the Board's Quality & Safety Committee which reports directly into the Board. The group collaboratively work together to deliver on key patient centred metrics based on the Trust Key Strategic Objectives (KSO), focusing on KSO1 Outstanding Patient Experience and Patient Led Assessment of the Care Environment (PLACE) inspection.

The group supports and challenges the decision making process within the Trust to steer the patient experience and verify the vision and values are being followed. Sitting within the scope of SPESC are working groups that deliver on agreed priorities and regularly feedback on outcomes and actions. One such group this period is the additional needs working group; this builds on, and brings together, previous forums the Trust had on dementia, learning disabilities and many more to standardise an approach that our patient representatives agree and can make sure suit all our patients and their needs.

SPESC has received quarterly reports on complaints, FFT feedback, patient experience reports, Healthwatch reports and national surveys. The committee has received updates on key projects which affect patient experience, including the outpatient improvement programme.

One highlight of the period was the improved PLACE inspection results that were received. These showed a dramatic improvement in the food, dementia and disability categories from the previous period. This spots the effort of new services likes volunteers helping to serve food on wards and further actions and improvements have since been discussed to better scores next period.

The outputs from SPESC are discussed at the Quality and Safety Committee to provide assurance to them and the Board.

Complaints
The NHS complaints standards set out a single vision for staff, patients, carers and their families of what should happen when someone raises a complaint. They promote accountability and openness, leading to better communication to create change and service improvement.

In accordance with these standards the trust is continuously working to promote a learning culture which welcomes complaints. It empowers and develops colleagues to have the skills, experience and responsibility to be confident in handling complaints in a timely manner.

At the outset of a complaint the necessary support is discussed with each complainant to understand how assistance can be provided. The most common support asked for is a regular update throughout the process to know what stage work is at and remaining timeframes.

The complaints process also supports colleagues throughout the process to assist them in providing successful resolutions with their insight and expertise.

	When a complaint response is provided the process is reviewed with a survey. Asking the complainant how they feel about the different components of the complaint process. Information about reopened cases and PHSO complaints could help us to identify improvement opportunities in the complaints process and complaint handling. We have not received a survey response to any complaint. We have had anecdotal feedback through liaising directly with patients who have complained such as during a Patient Story to Board. The lack of responses to surveys has been reviewed and is thought to be a result of providing only an electronic option. As a result a paper survey was introduced for closed complaints from February 2025 and a range of options will be introduced in the next period.

6.	**Learning from Experience**
	The introduction of new Directorates and triumvirates led to a review and overhaul of reporting requirements and processes. This has inevitably meant that there has been some development of the reporting suite and processes during this period which have impacted on short term efficiency and effectiveness for longer term improvement. The result has been that this period has been a very challenging time for all within the Trust as they balance their outputs and outcomes in the context of significant change. Specifically within the Safety and Patient Experience Team a full review of the structure and content of reports was undertaken, working with the triumvirates in respect of what would be the most useful for them. This has resulted in new, and new look reports which have been updated and developed month on month, with information from other specialty areas included and learning wider across the services. It has also seen some of the standard channels to the wider Trust, such as the Joint Hospital Clinical Governance meeting, being replaced by new governance structures and interim measures put in place for the period whilst the new structures were implemented.

7.	**Recommendations**
	The Patience Safety and Experience Team will continue to respond to any changes introduced, ensuring that the data provided is useful and wholly reflective of what is required to enhance shared learning and take advantage of improvement opportunities. All future plans and targets that are addressed in the next section need to be considerate of the current NHS landscape and ongoing transformation. Service level, Trust wide and National changes are all ongoing and any plans must be agile and reflective that work is subject to change.

8.	**Future plans and targets**

	We have a lot to be proud of and celebrate from the past 12 months. It has been a year of significant change and progress, stretching ourselves with new innovative programmes of work whilst sustaining our services to a high standard. We successfully delivered on all of our objectives and as we look to build on this year over the next 12 months. Looking ahead, QVH has set clear goals to improve patient experience further: 1. Revisiting the Patient Experience and Public Engagement Strategy to ensure alignment with the Trust's long-term strategy. 2. Reducing the timeframe for complaints resolution from 40 to 30 working days. 3. Increasing FFT response rates to at least 25% across the Trust. 4. Enhancing 'learning from' analysis to create a more complete picture of safety and patient experiences. Progress against these objectives will be reviewed and shared with leadership teams, including the Executive Board and the Patient Safety and Experience Sub-Committee.

9.	**Conclusions and assurance**
	Despite challenges and changes overall, patient feedback remains strongly positive. The Safety and Patient Experience Team has played a key role in analysing feedback, identifying areas for improvement, and ensuring patient voices are heard. In doing so we are better equipped to make meaningful improvements for our patients and staff as a Trust. By focusing on transparency, engagement, and continuous improvement, QVH remains committed to providing outstanding care and ensuring every patient feels valued and listened to.

10.	**Report approval and governance**
	This report will be reviewed and approved by the following committees/sub-committees as follows: 1. The Safety and Patient Experience Sub-Committee 2. Executive Leadership Team 3. Quality and Safety Committee

Report cover-page					
References					
Meeting title:	Board of Directors				
Meeting date:	10/07/2025		**Agenda reference:**	**48-25**	
Report title:	Research & Innovation Annual Report 2024/25				
Sponsor:	Tamara Everington, Chief medical officer				
Author:	Mary Mason, Mohamed Elalfy, Research & Innovation Team				
Appendices:	None				
Executive summary					
Purpose of report:	The Research and Innovation Annual report is presented as a summary of activity during 2024-25				
Summary of key issues	Despite a reduction in recruitment volume this year, QVH's research delivery remained strategically aligned, well governed, and adaptable. The closure of high-volume studies without immediate replacement affected annual totals, but critical steps have been taken to diversify the portfolio and expand delivery models into primary care. With new studies open, strengthened workforce investment and a new Research and Innovation strategy aligning us with community and system partners, the foundations are now in place for renewed growth and resilience in 2025/26				
Recommendation:	The Board is asked to note the report				
Action required	Approval	Information	Discussion	**Assurance**	Review
Link to key strategic objectives (KSOs):	KSO1: *To deliver outstanding care*	KSO2: ***To innovate and improve***	KSO3: *To be an excellent employer*	KSO4: *To deliver sustainable services*	KSO5: ***To collaborate with others***
Implications					
Board assurance framework:	None				
Corporate risk register:	None				
Regulation:	N/A				
Legal:	None				
Resources:	None				
Assurance route					
Previously considered by:	ELT Quality & safety committee				
	Date:	27/05/25 03/06/25	Decision:	Submit Trust Board	
Next steps:					

Queen Victoria Hospital
NHS Foundation Trust

Research & Innovation

Annual Report

Report covering the period from
April 2024 to March 2025

Document Control:
Executive sponsor: Tamara Everington, Chief Medical Officer

Authors: Mary Mason, Mohamed Elalfy, Research & Innovation team

Date: 21.05.25

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1.	Executive Summary
	Despite a reduction in recruitment volume this year, QVH's research delivery remained strategically aligned, well governed, and adaptable. The closure of high-volume studies without immediate replacement affected annual totals, but critical steps have been taken to diversify the portfolio and expand delivery models into primary care. With new studies open, strengthened workforce investment and a new Research and Innovation strategy aligning us with community and system partners, the foundations are now in place for renewed growth and resilience in 2025/26.

2.	Introduction
	Since our last annual report, there have been significant changes in the QVH Research and Innovation space. The Trust Research & Innovation Strategy was published in November 2024. Work is already underway to implement this strategic vision for collaborative and multidisciplinary research aimed at '*Improving Lives Together'.* Key to delivery of the strategy is clinical leadership throughout the organisation which offers patients the opportunity to '*Be part of research'.* The strategy recognises the need for strong governance, estate and staff resource to support quality research outputs and addressing these areas is our priority. Delivering research and innovation must be aligned with broader strategy, priorities and values for QVH and the wider health and care system. Our ambition is that partnership to mutual advantage with academia, the commercial and third sector will unlock opportunity for innovative approaches that help address health inequalities. This has been a year of transition for the whole Research and Innovation Team. It is important to give credit to the team and research collaborators across the organisation. They have sustained research delivery and maintained financial balance though this year whilst also helping build our future vision. This gives us a sound platform for future success.

3.	Service aim, objectives and expected outcomes
	Historically, QVH has had a world-class reputation built on ground breaking innovation and research. In recent years research has focussed largely on NIHR (National Institute for Health and Care Research) portfolio non-commercial research. Research & Innovation can help improve outcomes and experience for patients both at QVH and in the wider NHS. Quality research will help us address challenges and inequalities in our current service model. Research & innovation needs to be delivered in collaboration across sectors allowing us to impact the wider health economy and helping to deliver services more effectively. Research and Innovation (R&I) at QVH is performance-monitored by our local Research Delivery Network (RDN), and by the R&I Governance Group. Research activity is tracked regularly by the RDN via an interactive online system (EDGE). During 2024/5, the key objectives monitored by the Governance Group and the CRN which were set out for 2024/5 included: • Continue to increase the number of Portfolio studies that we undertake

- Develop feasibility review process to improve reliability and accuracy

Sussex Integrated Care System's (ICS) *'Improving Lives Together through Research Strategy'* notes research prioritises health including prevention, healthy ageing, improving patient outcomes and sustainable healthcare. Our work during this year has provided a foundation for this work at QVH with a successful bid to broaden our research portfolio in collaboration with Primary Care, providing us with proof of concept for the partnership work ahead in 2025/6.

Throughout 2024/5 we have set up academic partnerships with the University of Sussex Engineering Faculty and the University of Bath Chemistry Faculty to foster translational research opportunities at the interface of technology and clinical care. Additionally a formal partnership with Sussex Health and Care Research Network has enabled access to a range of regional infrastructure and support systems critical to engagement, capacity-building, and delivery. These partnerships align well with the Sussex ICB ambitions.

4. Activity analysis/ achievement

During 2024/25, QVH supported a total of 14 active research studies, including 5 that closed to recruitment and 2 which were newly opened in March 2025. This was a slight reduction from 2023/24. Historically a focus on research reflective of the specialist nature of the Trust has reduced the pool of opportunity open to us.

While overall research activity was maintained across QVHs core clinical areas, total participant recruitment declined compared to the previous year. This was primarily due to the closure of two large-scale, high-recruiting studies. Despite this, important foundational work was undertaken to support portfolio diversification and long-term sustainability, including expanded engagement with primary care and targeted infrastructure investment.

Of the five studies that closed, three met or exceeded their recruitment targets. The remaining two did not reach their planned sample sizes — one fell slightly below target, while the other was closed early at the sponsor's request, as the global recruitment target was met ahead of schedule.

Table 1 **- Study Characteristics**

Category	Number
Total active studies	14
New studies opened	3
Studies closed to recruitment	5
Commercial studies	2
Non-commercial studies	12

Table 2 **- Recruitment by Specialty**

Specialty	Participants	No. of Studies
Plastics	256	8

Radiology	113	1
Anaesthetics	151	1
Corneo	13	2
Maxillofacial	2	2

Non- portfolio Studies - In addition to NIHR Portfolio activity, QVH supported a non-portfolio research study in facial palsy, led by one of our Advanced Facial Therapists. Sponsored by the Trust, the study recruited 56 participants across two work streams and successfully met its recruitment target. This reflects QVH's commitment to enabling clinician-led, home-grown research beyond the NIHR framework.

Governance

A restructure of the R&I leadership function was undertaken, enhancing the Trust's strategic alignment with research activity. This included:

- Increased Board-level and senior leadership engagement.
- The Chief Medical Officer formally assuming responsibility for executive sponsorship of Research and Innovation.
- Strengthened governance mechanisms and clearer accountability structures, ensuring R&I is embedded within wider clinical and corporate governance frameworks.
- A new quality management system is in review including feasibility elements as per our objective for this year. Changes in personnel have identified gaps which we are now working through into 2025/6.

As part of our governance framework review to identify protocol breaches, a potential issue regarding the loss of research records in an historical study within the corneo plastic unit was exposed. No patients were affected. An investigation is ongoing and will be reported via the Research and Innovation Governance group when concluded.

Research Workforce Development

QVH continued to support the professional development of research delivery staff, recognising training and accreditation as critical to sustainable research growth and governance. Examples include :

New roles or strategic appointments:

- Dedicated Clinical Academic appointed to develop internal capacity and investigator-led research with skills in methodology development and statistical analysis
- Bid and secured for an in-year feasibility programme for 2025/6 collaborating with primary care and enabling delivery in specialties where the Trust has not previously conducted research.

Training and development:

- Clinical Research Practitioner (CRP) accreditation submitted for one member of the research delivery team, reflecting a commitment to professional standards and recognition in non-registered research roles.

	• Associate Principal Investigator (PI) Scheme - Two physiotherapists successfully completed the NIHR Associate Principal Investigator (PI) Scheme during 2024/25, supporting the development of a broader research culture within the clinical workforce. **Infrastructure** Several developments represent a step change in how research is operationalised at QVH, creating a solid foundation for future growth and strengthen the enabling environment for research at QVH. A new laboratory space dedicated to research has been identified on site. Groundwork is underway, alongside development of a quality management system to ensure *Good Clinical Practice* and regulatory compliance. This facility is expected to enhance our ability to host early-phase or translational studies and support investigator-led research in the long term. The next phase of the project is subject to confirmation of additional funding for fit-out and activation. A strategic decision has been taken to pursue charitable funding for a dedicated clinical research facility and laboratory which also supports educational attainment, recognising the need for fit-for-purpose infrastructure and skilled staff to support our expanding ambitions. We secured a REDCap license, providing a robust and secure digital platform for data capture in both sponsored and hosted research. We are currently engaging with the IT department to develop and deploy this resource.

5.	**Involvement & Engagement**
	Involvement – staff members or patients/ carers actively involved in annual work streams, including: **Involvement in identifying priorities –** Our clinical academic and senior consultant researcher in burns joined a James Lind Priority setting partnership; over 2 years over 200 people involved in caring for people with burns or, those who have been injured by burns identified the top ten priorities for burn care research. The output will be used by funders to allocate future grant funding. **Honorary Roles –** Clinical Academic for Burns chairs the Research Committee of the British Burns Association and is vice chair of the research committee of the ISBI. Other clinicians sit on the BAPRAS council and the BSSH. The Lead Research Nurse sits on the NRES ethics committee **Research outputs** are routinely presented at national and international conferences. Overall, 97 academic papers have been published by staff at QVH in the last financial year including a landmark paper in the Lancet Global. **Local Collaboration with East Grinstead Primary Care Network** To bring research closer to the community and diversify its research portfolio, QVH established a new collaboration with the Primary Care Network (PCN) in East Grinstead. This strategic partnership aims to:

	• Expand into clinical specialties not previously served by the Trust's research portfolio • Improve access to research for the local population in community and primary care settings • Leverage the PCN's integration with Research Delivery Network support structures, increasing capacity and reach **Partnership with Sussex Health and Care Research Network -** QVH formally confirmed its partnership with the Sussex Health and Care Research Network. As part of this partnership, QVH now benefits from**:** • The Academic Career Training Hub, supporting the development of early-career researchers and clinician-academics. • Access to the Clinical Trials Unit (CTU), enabling enhanced support for study design, approvals, and delivery. • Integration with the Research Engagement Network (REN), which supports wider awareness and involvement in research across Sussex. • Direct collaboration with the Public and Community Involvement and Engagement (PCIE) Team, to ensure research at QVH is shaped by patient experience, community priorities, and inclusive practices. These partnerships with primary care, regional research networks and the wider Sussex system mark a significant step forward in broadening the reach and relevance of QVH's research, laying the groundwork for more co-produced, community-connected, and academically robust research activity across our portfolio. **Academic Partnership with University of Sussex Engineering Faculty -** QVH also initiated an exploratory collaboration with the University of Sussex Engineering Faculty to foster translational research opportunities at the interface of technology and clinical care. Discussions are underway to explore how clinical and engineering teams can collaborate on research that meets mutual innovation and impact goals. **Academic Partnership with University of Bath Chemistry Faculty -** QVH has entered into Academic partnership with the University Of Bath Faculty Of Chemistry through the ESPRC Impact accelerator account award to collaborate on a revolutionary skin cancer drug delivery project. Prof Toby Jenkins visited QVH and met Skin cancer surgeons and the CEO. Plans are for an MRC / ESPRC bid in Q4 2025 with *in-vitro* research taking place in our new research lab and first in man trials 2028. This emerging academic partnership reflects QVH's commitment to multidisciplinary innovation and lays the groundwork for future collaborative research that combines clinical insight with engineering expertise.

6.	**Learning from Experience**
	As noted previously, our ability to join a large number of NIHR clinical trials is limited by our tertiary referral specialist nature. However, our new research strategy will support the development of local research including application for research grants with our partners and collaborators.

7.	Recommendations
	Key recommendations relate to areas already translated into actions for the forthcoming year. These include extending our research portfolio to further align with the national and local prevention and wider health ambitions. Strengthening our governance and optimising our research and innovation portfolio by securing dedicated space with options to offer collaborative research alongside our community partners

8.	Future plans and targets
	In 2025/6 our priorities are: **Governance**: An executive led Research and Innovation Steering Group will be established and meet monthly to drive the ambitions of this strategy **Leadership:** Strengthened research and innovation leadership and staffing model that is able to support and drive the ambition of this strategy. **Home grown research**: We will foster a culture of home-grown research that leverages the unique strengths and expertise of our organisation and is developed within a governance framework that keeps us outward facing. **Collaboration**: We will continue to work with our patients, community and partners to understand future ambitions and opportunities. We will establish sustainable partnerships with academic institutions, industry, and other NHS organisations.

9.	Conclusions and assurance
	2024/5 has been a pivotal year within the NHS reinforcing the need for Research and Innovation to support the ever changing healthcare landscape. The aim is to deliver improved patient outcomes in a clinically effective way whilst balancing the need for innovation and research to achieve sustainable healthcare with financial balance and efficiency. The Trust has laid the foundations for many key national priorities including collaboration across systems optimising the benefits of collaborative research opportunities that meet the wider determinants of health, not just those that sit within our areas of national and regional specialisms. The work done in 24/25 to develop and begin implementation of our research & innovation strategy has set our forward vision. The secure foundation of portfolio work and existing research outputs from QVH gives a solid grounding for progress. The early development of practical research partnerships based on both specialist expertise and novel collaborations has opened up opportunities for innovation aligned to shared health and care objectives.

10.	Appendices
	None

11.	Report approval and governance
	Report to be approved at Executive Leadership Team meeting 27/5/25 prior to sight at Quality & Safety Committee 3rd June 2025

Report cover-page					
References					
Meeting title:	Board of Directors				
Meeting date:	10/07/2025	**Agenda reference:**	**48-25**		
Report title:	Appraisal & Revalidation Annual Report 2024/25				
Sponsor:	Tamara Everington, Chief Medical Officer				
Author:	Abdi Sulaiman, Medical Workforce Manager Tamara Everington, Chief Medical Officer				
Appendices:	Annex A - Professional standards: framework for quality assurance and improvement (FAQI) – Annual Report 2023-2024				
Executive summary					
Purpose of report:	To provide assurance to the Board, evidencing compliance with the Responsible Officer's (RO) statutory functions. Report on performance in relation to those functions; to update the Board on the progress since 2023/24 annual report; to highlight current and future issues and to present action plans to mitigate potential risks. This report forms part of the Chief Medical Officer's duties as Responsible Officer (RO).				
Summary of key issues	**Achievements** •Successfully embedding the L2P (app) appraisal platform post implementation •Improved clinical engagement with appraisals and benefit from outputs •Increased appraiser engagement & compliance with competency documentation **Challenges** •Turnover of staff supporting appraisal and revalidation including the RO • Improving timeliness of appraisals and revalidation preparation				
Recommendation:	That the Board **notes and ratifies** Annex A, Section 4 Statement of Compliance confirming it is compliant with the regulations, as recommended by the Quality & safety committee.				
Action required	**Approval**	Information	Discussion	Assurance	Review
Link to key strategic objectives (KSOs):	KSO1: *To deliver outstanding care*	**KSO2:** ***To innovate and improve***	KSO3: *To be an excellent employer*	KSO4: *To deliver sustainable services*	KSO5: *To collaborate with others*
Implications					
Board assurance framework:	KS02				
Corporate risk register:	None				
Regulation:	The Medical Profession (Responsible Officers) Regulations, 2010 as amended in 2013' and 'The General Medical Council (Licence to Practice and Revalidation) Regulations Order of Council 2012'				
Legal:	As above				
Resources:	This annual report was produced using existing resources.				
Assurance route					
Previously considered by:	ELT Quality & safety committee				
	Date:	27/5/25 03/06/25	Decision:	Approved	
Next steps:					

Report to:	Board of Directors
Agenda item:	48-25
Date of meeting:	10 July 2025
Report from:	Tamara Everington, Chief medical officer
Report author:	Tamara Everington, Chief medical officer Abdi Sulaiman, Medical Workforce Manager
Date of report:	21 May 2025
Appendices:	Annex A - Professional standards: framework for quality assurance and improvement (FAQI) – Annual Report 2023-2024

Appraisal & Revalidation Annual Report 2024/25

Introduction

To provide assurance to the Trust Board, evidencing compliance with the Responsible Officer's (RO) statutory functions. Report on performance in relation to those functions; to update the Board on the progress since 2022/23 annual report; to highlight current and future issues and to present action plans to mitigate potential risks. This report forms part of the Chief Medical Officer's duties as Responsible Officer.

Summary

Strong year for appraisal and revalidation with completion of all actions. Delivering clinical excellence in a safe environment requires an ongoing focus on performance and personal development, appraisal and revalidation. Development of the behaviour framework and learning support functions are key to this.

Achievements

- Successfully embedding L2P app post implementation
- Improved clinical engagement with appraisals and benefit from outputs
- Increased appraiser engagement and compliance with competency documentation
- SAS Doctors becoming medical appraisers

Challenges

- Turnover of staff supporting appraisal and revalidation including the RO
- Improving timeliness of appraisals and revalidation preparation
- Monitoring of inequality and behaviours

Recommendation

That the Board **notes** and **ratifies** Annex A, Section 4 Statement of Compliance confirming it is compliant with the regulations, as recommended by the Quality & safety committee.

Annex A

Professional standards: framework for quality assurance and improvement (FAQI) – Annual Report 2023-2024

Previously titled

A Framework of Quality Assurance (FAQ) for Responsible Officers and Revalidation – Annual Board Report and Annual Statement of Compliance

Covering reporting period
1 April 2024 – 31 March 2025

This framework will help responsible officers and organisations to provide assurance that their professional standards processes meet the relevant statutory requirements and support quality improvement.

This report sets out the information and metrics that a designated body is expected to report upwards, to assure their compliance with the regulations and commitment to continual quality improvement in the delivery of professional standards.

Section 1 – Qualitative/narrative
Section 2 – Metric
Section 3 – Summary and conclusion
Section 4 – Statement of compliance

Section 1: Qualitative/narrative

1A – General

The board of Queen Victoria Hospital NHS Foundation Trust can confirm that:

1A(i) An appropriately trained licensed medical practitioner is nominated or appointed as a responsible officer.

Action from last year:	Recruitment of a permanent CMO post Q1 2024
Comments:	Tamara Everington, GMC No. 4032698, GMC registered professional with licence to practice was appointed to the role as Chief Medical Officer and therefore Responsible Officer for the organisation on 01.10.2024
Action for next year:	RO responsibilities are included within scope of the CMO role.

1A(ii) Our organisation provides sufficient funds, capacity and other resources for the responsible officer to carry out the responsibilities of the role.

Yes / No:	Yes
Action from last year:	Optimise L2Ps reporting functionality maximising efficiency. Continue collaborating with L2P tailoring a system fit for QVH needs.
Comments:	During the year the team has continued to collaborate with L2P looking at various reports that can be extracted from the platform. There has been ongoing discussion around optimization of the educational role component.
Action for next year:	Explore the possibility of automating reports to be disseminated across triumvirates to ensure they support compliance with appraisals.

1A(iii)An accurate record of all licensed medical practitioners with a prescribed connection to our responsible officer is always maintained.

Action from last year:	Continue using GMC portal as an accurate record of all licensed medical practitioners with a connection to QVH.
Comments:	The GMC Connect portal is used to securely record doctor details both into and out of QVH. Frequent monitoring of starter and leavers reports ensure accuracy is maintained.
Action for next year:	Continue using GMC portal; maintain current process for updating of starters and leavers to ensure accuracy.

1A(iv) All policies in place to support medical revalidation are actively monitored and regularly reviewed.

Action from last year:	Complete policy revision for ratification by Local Negotiation Committee (LNC).
Comments:	The LNC ratified the Medical Appraisal, Revalidation and Remediation Policy. This was approved and published on 4 January 2024. Changes included L2P electronic system and Medical Appraisal Guide 2022 (AoMRC).
Action for next year:	Timetabled for next renewal date January 2027.

1A(v) A peer review has been undertaken (where possible) of our organisation's appraisal and revalidation processes.

Action from last year:	None – awaiting further guidance from South East Higher Level Responsible Officer Team, NHS England – South East following postponement in 2020.
Comments:	RSM internal audit commissioned for 25/26 to conduct a review of job planning, rostering and appraisal for the medical and dental workforce.

Action for next year:	Following internal audit, to look at findings and improve processes.

1A(vi) A process is in place to ensure locum or short-term placement doctors working in our organisation, including those with a prescribed connection to another organisation, are supported in their induction, continuing professional development, appraisal, revalidation, and governance.

Action from last year:	Revise process ensuring appraisal date is booked 2 months prior to appraisal due date. RO to monitor appraisal completion data for short-term staff at quarterly meetings.
Comments:	The medical workforce administrator regularly reviews outstanding appraisals or appraisals due to expire and flags to the RO fortnightly. With the RO steer, the appraisal compliance is in excess of 90%. Ongoing work to proactively refine process.
Action for next year	By Q4 end to have 95% compliance on in date appraisals

1B – Appraisal

1B(i) Doctors in our organisation have an annual appraisal that covers a doctor's whole practice for which they require a General Medical Council (GMC) licence to practise, which takes account of all relevant information relating to the doctor's fitness to practice (for their work carried out in the organisation and for work carried out for any other body in the appraisal period), including information about complaints, significant events and outlying clinical outcomes.

Action from last year:	Revise L2P guidance mandating documents for uploading to L2P i.e. complaints, significant events, datix reports, MPITs.
Comments:	Ongoing as and when updates occur.
Action for next year:	Ensure appraisal supports completion of audits and declaration of interests updates on ESR including detail around scope of work.

1B(ii) Where in question 1B(i) this does not occur, there is full understanding of the reasons why and suitable action is taken.

Action from last year:	Complete missed appraisals by end of Q1 24/25. As part of new organisational rewiring, Business Units will be responsible for supporting appraisal performance and will provide additional support to doctors arriving without a previous appraisal.
Comments:	New Medical workforce support structure. Reviews and intervention needed with regards to performance, particular achievements and PDP

Action for next year:	Continue to champion achievements and putting in place early interventions where possible

1B(iii) There is a medical appraisal policy in place that is compliant with national policy and has received the Board's approval (or by an equivalent governance or executive group).

Action from last year:	Continue with current process. Policy renewal date January 2027
Comments:	The Joint Local Negotiating Committee approved the Medical Appraisal, Revalidation and Remediation Policy, ratified by the Finance & Performance Committee and published in January 2024. Changes incorporated use of electronic sytem and reference to Medical Appraisal Guide (AoMRC) 2022. The electronic system has streamlined the allocation of appraiser process.
Action for next year:	Continue with current process. Policy renewal date January 2027

1B(iv) Our organisation has the necessary number of trained appraisers[1] to carry out timely annual medical appraisals for all its licensed medical practitioners.

Action from last year:	Recruit additional 2 appraisers, expressions of interest from SAS, selected senior managers, and consultants with more than 1 year in role. Seek to attract individuals with recent experience of the training pathway and reflective practice.
Comments:	Several expressions of interests both from new consultants and also SAS doctors, 3 new SAS doctors have attended their MIAD training. To begin appraising in Q3 with early supervision in line with policy.
Action for next year:	Continue to promote appraisal training

1B(v) Medical appraisers participate in ongoing performance review and training/ development activities, to include attendance at appraisal network/development events, peer review and calibration of professional judgements (Quality assurance of medical appraisers or equivalent).

Action from last year:	Additional presentations planned for 2024/25 including GMC on Good Medical Practice 2024 update. RO to review additional leadership support of a named clinical appraisal lead. Evaluate post appraisal data and identify development, training needs.
Comments:	Engagement and training meetings for appraisers held. Clinical appraisal lead to be looked at 25/26 due to new appointment of CMO and clinical leadership model being evaluated
Action for next year:	Implement and embed new clinical leadership model

[1] While there is no regulatory stipulation on appraiser/doctor ratios, a useful working benchmark is that an appraiser will undertake between 5 and 20 appraisals per year. This strikes a sensible balance between doing sufficient to maintain proficiency and not doing so many as to unbalance the appraiser's scope of work.

1B(vi) The appraisal system in place for the doctors in our organisation is subject to a quality assurance process and the findings are reported to the Board or equivalent governance group.

Action from last year:	Planned correlation of post appraisal data with PROGRESS audit outcomes. Share outcomes with individual appraisers. Complete annual PROGRESS audit sampling appraisals from each appraiser.
Comments:	Appraiser feedback for CPD shared and discussed with consideration for improvements. PROGRESS to be set up formally in 25/26.
Action for next year:	Continue to share feedback and complete PROGRESS audit sampling appraisals from each appraiser

1C – Recommendations to the GMC

1C(i) Recommendations are made to the GMC about the fitness to practise of all doctors with a prescribed connection to our responsible officer, in accordance with the GMC requirements and responsible officer protocol, within the expected timescales, or where this does not occur, the reasons are recorded and understood.

Action from last year:	Ensure revalidation portfolios are completed at least 1 month before revalidation due date.
Comments:	Meetings held throughout the year, revalidation portfolios reviewed by RO and with recommendations made on time. L2P has increased visibility of upcoming revalidations with reminders sent to doctors in line with expected timescales. Any delays recorded on L2P. L2P has replaced a manual process with an efficient system whilst maintaining quality.
Action for next year:	Ensure revalidation portfolios are completed at least 1 month before revalidation due date.

1C(ii)GMC recommendations are confirmed promptly to the doctor and the reasons for the recommendations, particularly if the recommendation is one of deferral or non-engagement, are discussed with the doctor before the recommendation is submitted, or where this does not happen, the reasons are recorded and understood.

Action from last year:	Maintain current process.
Comments:	All doctors received confirmation of the revalidation recommendation on the day. Confirmation of either a positive recommendation or deferral due to insufficient evidence sent from medical workforce. In exceptional circumstances, when a deferral is mandated the RO will discuss this with the individual.

Action for next year:	Continue with confirmation on same day and RO to discuss with individual if deferral is mandated.

1D – Medical governance

1D(i) Our organisation creates an environment which delivers effective clinical governance for doctors.

Action from last year:	We will continue to work with teams to share information on compliments, complaints, involvement in incidents and similar items for the medical appraisal process.
Comments:	There is good sharing of information including cascade from the Patient Experience Manager and Risk Team supporting doctors' appraisal discussions and professional development.
Action for next year:	Ensure the effective sharing of clinical governance to business units continues during organisational rewiring.

1D(ii) Effective systems are in place for monitoring the conduct and performance of all doctors working in our organisation.

Action from last year:	Maintain current process.
Comments:	Effective systems are in place to support informal and formal conduct and performance review. Maintaining High Professional Standards (MHPS) investigations have been conducted in line with guidance.
Action for next year:	Continue with current process and as part of the organisation's rewiring, strengthen and support clinical leads and clinical directors MHPS knowledge and skills. Review training needs and data capture process.

1D(iii) All relevant information is provided for doctors in a convenient format to include at their appraisal.

Action from last year:	Collaborate with patient experience manager, risk and medical education teams to scope providing an annual data pack to doctors.
Comments:	Information is supplied but the plan to provide packs is in progress. Due to the change in structures and teams there was a delay in this action.
Action for next year:	Implement and embed annual data packs

1D(iv) There is a process established for responding to concerns about a medical practitioner's fitness to practise, which is supported by an approved responding to concerns policy that includes arrangements for investigation and intervention for capability, conduct, health and fitness to practise concerns.

Action from last year:	Continue to follow our agreed policies and procedures.
Comments:	The Trust's process for responding to concerns is set out in its policies and based on the national 'Maintaining High Professional Standards (MHPS)' and GMC guidance.
Action for next year:	Continue to follow agreed policies

1D(v) The system for responding to concerns about a doctor in our organisation is subject to a quality assurance process and the findings are reported to the Board or equivalent governance group. Analysis includes numbers, type and outcome of concerns, as well as aspects such as consideration of protected characteristics of the doctors and country of primary medical qualification.

Action from last year:	Continue with current procedures.
Comments:	The Chief People Officer supports the CMO in responding to concerns. Issues are discussed with the GMC Employment Liaison Officer and if required PPA (NCAS) - NHS Resolution. Regular meetings with GMC Employment Liaison Officer take place at least 4 times per year. A non-executive board member oversees any MHPS investigation. Numbers and types of investigations are reported to the Board.
Action for next year:	Continue with current procedures and ensure analysis of protected characteristics and country of primary medical qualification are included.

1D(vi) There is a process for transferring information and concerns quickly and effectively between the responsible officer in our organisation and other responsible officers (or persons with appropriate governance responsibility) about a) doctors connected to our organisation and who also work in other places, and b) doctors connected elsewhere but who also work in our organisation.

Action from last year:	Continue with current process and monitor compliance.
Comments:	The Trust's process for transferring information and concern meet with NHS England's Information flows to support medical governance and responsible officer statutory function guidance, commonly known as MPIT or RO references. Requests are actioned within 10 days.
Action for next year:	Continue with current procedures

1D(vii) Safeguards are in place to ensure clinical governance arrangements for doctors including processes for responding to concerns about a doctor's practice, are fair and free from bias and discrimination (reference GMC governance handbook).

Action from last year:	Improve OMMT compliance rate from 77.94%. Roll out Active Bystander training sessions in 2024.
Comments:	Raising Concerns (Whistle Blowing) Policy, Freedom to speak up service and the Disciplinary policy for medical and dental staff continue to adhere to national MHPS and GMC / NHSE guidance on managing concerns. The CMO manages concerns supported by the Chief People Officer, and the Employee Relations team ensures processes are free from bias and discrimination.
Action for next year:	Continue to follow agreed policies and procedures

1D(viii) Systems are in place to capture development requirements and opportunities in relation to governance from the wider system, for example, from national reviews, reports and enquiries, and integrate these into the organisation's policies, procedures and culture (give example(s) where possible).

Action from last year:	None specified; new statement
Comments:	FTSU, active bystander training rolled out with support from Employee Relations. Neurodiversity awareness training offered and well received. Ongoing work to support inclusivity through the Cultural Transformation Steering Group led by the CEO and CMO.
Action for next year:	Progress insights and learning through cultural workstreams to support recognition of individual needs and inclusivity

1D(ix) Systems are in place to review professional standards arrangements for all healthcare professionals with actions to make these as consistent as possible (reference Messenger review).

Action from last year:	Consider a process to ensure middle level leadership receive appropriate management training. Cross-reference training needs to job plans. Review clinical directors appraisals ensuring PDPs consistently reflect the needs of the role.
Comments:	At induction, Library services offer support to individuals with regular links to articles that may be relevant to their professional practice. The audit team share all new national guidance outputs from inquiries and action plans arising from that. Particular relevance of the infected blood enquiry with an action plan monitored by quality and safety committee. Prospective audit plan agreed with each service and directorate.
Action for next year:	Continue to embed processes to ensure development and promote management courses – exploring making this mandatory for new managers

1E – Employment Checks

1E(i) A system is in place to ensure the appropriate pre-employment background checks are undertaken to confirm all doctors, including locum and short-term doctors, have qualifications and are suitably skilled and knowledgeable to undertake their professional duties.

Action from last year:	Continue to current processes and monitor compliance
Comments:	All doctors employed by QVH including the medical and dental Bank are subject to the NHS mandatory pre-employment recruitment checks prior to appointment via the Trac recruitment system ensuring visibility and consistency. During the year, identity document validation technology (IDVT) was implemented; digital checks to documents providing an extra layer of clarity on individual documentation. At interviews, in addition to the standard clinically based questions; questions based on the Trust's values are included. Assurance is provided that successful applicants are able to converse and understand medical terminology at an appropriate level in English. Employment references follow a set format and include past employer and most recent Responsible Officer declaration. The Trust adheres to the National Health Service (Appointment of Consultants) Regulations: Good Practice Guidance 2005 when appointing consultants ensuring assurance.
Action for next year:	Continue current processes and monitor compliance.

1F – Organisational Culture

1F(i) A system is in place to ensure that professional standards activities support an appropriate organisational culture, generating an environment in which excellence in clinical care will flourish, and be continually enhanced.

Action from last year:	Embed Freedom to Speak Up Service and QI methodology to drive improvement.
Comments:	The organisation's vision and values support a culture whereby clinical care flourishes and is continually enhanced. The Trust's Freedom to Speak up Guardian Service enables staff to discuss matters relating to patient care and safety, whistleblowing, bullying and harassment, and work grievances. Processes ensure immediate escalation of any issues relating to patient or employee safety to a member of the Trust's board. In Q1 2024, the Trust launched an external guardian service offering information and emotional support in a strictly confidential, non-judgmental manner. The Trust has now procured a formal Continuous Improvement system incorporating a new behavioural framework.
Acton for next year:	Continue to embed Freedom to Speak Up Service and continuous improvement methodology to drive improvement.

1F(ii) A system is in place to ensure compassion, fairness, respect, diversity and inclusivity are proactively promoted within the organisation at all levels.

Action from last year:	None; new statement in report template.
Comments:	The Learning & Development and Medical Education teams support the Trust in delivering training to ensure compassion, fairness, respect, diversity and inclusivity are proactively promoted within the organisation at all levels. Introduction of the Oliver McGowan mandatory training to support people with a learning disability or autism to access effective support and safe, compassionate and informed care. Active Bystander training has been rolled out in 2024 to empower staff to challenge poor behaviours bringing about change through the reinforcement of messages defining the boundaries of unacceptable behaviour. The Trust has completed a visions and values refresh.
Action for next year:	Continue to promote courses in line with the ethos of the organisation

1F(iii) A system is in place to ensure that the values and behaviours around openness, transparency, freedom to speak up (including safeguarding of whistleblowers) and a learning culture exist and are continually enhanced within the organisation at all levels.

Action from last year:	None specified; new statement
Comments:	Patient Safety Incident Response Framework (PSIRF) supports an open learning culture. Tell Edmund and the external Freedom to Speak Up Guardian processes support the Trust in ensuring that staff have a number of options to support them in expressing any concerns.
Action for next year:	Embed behavioural framework, identify training needs to support doctors make positive change.

1F(iv) Mechanisms exist that support feedback about the organisation' professional standards processes by its connected doctors (including the existence of a formal complaints procedure).

Action from last year:	Continue with policies and processes. Review case outcomes.
Comments:	The Dignity and Respect at Work Policy and Procedure, Maintaining High Professional Standards in the Modern NHS (MHPS) and Handling Complaints & Concerns Policy procedures exist and enable feedback about the Trust's professional standards processes. During the year, an active claim demonstrated this process is functioning.
Action for next year:	Continue with policies and processes. Review case outcomes.

1F(v) Our organisation assesses the level of parity between doctors involved in concerns and disciplinary processes in terms of country of primary medical qualification and protected characteristics as defined by the Equality Act.

Action from last year:	None specified; 2024-2025 report new statement.
Comments:	The Workforce Disability Equality Standard (WDES) and the Workforce Race Equality Standard (WRES) report assesses the overall parity by protected characteristics for staff, however not reported by staff group. For disciplinary processes, we ensure equity when dealing with concerns and our policies are clear about this.
Action for next year:	The Trust does not record primary medical qualification and will investigate how this can be captured going forward for assessing level of parity.

1G – Calibration and networking
1G(i) The designated body takes steps to ensure its professional standards processes are consistent with other organisations through means such as, but not restricted to, attending network meetings, engaging with higher- level responsible officer quality review processes, engaging with peer review programmes.

Action from last year:	Continue with process and networking opportunities
Comments:	To ensure the Trust's professional standards processes are consistent with other organisations the RO attends regular South East region Responsible Officer & Appraisal Lead Network meetings.
Action for next year:	Continue with process and networking opportunities

Section 2 – metrics

Year covered by this report and statement: 1 April 2024 to 31 March 2025.
All data points are in reference to this period unless stated otherwise.

2A General

The number of doctors with a prescribed connection to the designated body on the last day of the year under review. This figure provides the denominator for the subsequent data points in this report.

Total number of doctors with a prescribed connection on 31 March 2025	153

2B – Appraisal

The numbers of appraisals undertaken, not undertaken and the total number of agreed

exceptions is as recorded in the table below.

Total number of appraisals completed	155
Total number of appraisals approved missed	21
Total number of unapproved missed	9

2C – Recommendations

Number of recommendations and deferrals in the reporting period.

Total number of recommendations made	28
Total number of late recommendations	0
Total number of positive recommendations	28
Total number of deferrals made	7
Total number of non-engagement referrals	0
Total number of doctors who did not revalidate	0

2D* – Governance –

Total number of trained case investigators	
Total number of trained case managers	
Total number of new concerns registered	
Total number of concerns processes completed	
Longest duration of concerns process of those open on 31 March	
Median duration of concerns processes closed	
Total number of doctors excluded/suspended	
Total number of doctors referred to GMC	

**Unknown at this time, review of training needs and data capture process required to be embedded in 2025/26.*

2E – Employment checks

Number of new doctors employed by the organisation and the number whose employment checks are completed before commencement of employment.

Total number of new doctors joining the organisation	16
Number of new employment checks completed before commencement of employment	13

2F – Organisational culture

Total number claims made to employment tribunals by doctors	1
Number of these claims upheld	0
Total number of appeals against the designated body's professional standards processes made by doctors	0
Number of these appeals upheld	0

Section 3 – Summary and overall commentary

This comments box can be used to provide detail on the headings listed and/or any other detail not included elsewhere in this report.

General review of actions since last Board report
Strong year for appraisal and revalidation with completion of all actions. **Achievements** • Successful procurement and implement of electronic appraisal system L2P • Clinical engagement with appraisals has improved • Increased appraiser engagement with improved competency documentation • SAS Doctors becoming medical appraisers **Challenges** • Appraiser number constraints • Turnover of staff supporting appraisal and revalidation including the RO • Improving timeliness of appraisals and revalidation preparation
Actions still outstanding:
None
Current issues
• Ongoing recruitment of medical appraisers • Monitoring of inequality and behaviours

Actions for next year (replicate list of 'Actions for next year' identified in Section 1):
1A(i) RO responsibilities are included within scope of CMO role. 1A(ii) Explore the possibility of automating reports to be disseminated across triumvirates to ensure they can maintain the compliance of appraisals 1A(iii) Continue using GMC portal; maintain current process for updating of starter and leavers to ensure accuracy. 1A(iv) Timetabled for next renewal date January 2027. 1A(v) Following internal audit, to look at findings and improve processes following that 1A(vi) By Q4 end to have 95% compliance on in date appraisals 1B(i) Ensure audits are completed and declarations of interests are updated on ESR as well as scope of work 1B(ii) Continue to champion achievements and putting in place early interventions where possible 1B(iii) Continue with current process. Policy renewal date January 2027. 1B(iv) Continue to promote appraisal training 1B(v) Implement and embed new clinical leadership model 1B(vi) Continue to share feedback and complete annual PROGRESS audit sampling appraisals from each appraiser 1C(i) Ensure revalidation portfolios are ready for review by RO at least 1 month before revalidation due date. 1C(ii) Continue with confirmation on same day. RO to discuss with individuals if deferral is mandated. 1D(i) Ensure the effective sharing of clinical governance to business units continues during organisational rewiring. 1D(ii) Continue with current process and as part of the organisation's rewiring, strengthen and support clinical leads and clinical directors in MHPS knowledge and skills. 1D(iii) Implement and embed annual data packs 1D(iv) Continue to follow agreed policies. 1D(v) Continue with current procedures and ensure analysis of protected characteristics and country of primary medical qualification are included. 1D(vi) Continue with current procedures 1D(vii) Continue to follow agreed policies and procedures 1D(viii) Progress insights and learning through cultural workstreams to support recognition of individual needs and inclusivity 1D(ix) Continue to embed processes to ensure development and promote management courses – consider making this mandatory for new managers 1E(i) Continue current processes and monitor compliance. 1F(i) Continue to embed Freedom to Speak Up Service and continuous improvement methodology to drive improvement 1F(ii) Monitor and improve compliance. 1F(iii) Embed behavioural framework, identify training needs to support doctors make positive change. 1F(iv) Continue with policies and processes. Review case outcomes. 1F(v) The Trust does not record primary medical qualification and will investigate how this can be captured going forward for assessing level of parity. 1G(i) Continue with process and networking
Overall concluding comments:
The Trust continues to develop its strategy for the future and organisational culture is a vital part of this. Delivering clinical excellence in a safe environment requires a continued focus on performance and personal development. Appraisal and revalidation as well as the behaviour framework are key to this.

Section 4 – Statement of compliance

The Board/executive management team have reviewed the content of this report and can confirm the organisation is compliant with The Medical Profession (Responsible Officers) Regulations 2010 (as amended in 2013).

Signed on behalf of the designated body

[(Chief executive or chairman (or executive if no board exists)]

Official name of the designated body	Queen Victoria Hospital NHS Foundation Trust
Name:	Abigail Jago
Role:	Acting Chief Executive Officer
Signed:	
Date:	

Report cover-page					
References					
Meeting title:	Board of Directors				
Meeting date:	10/07/2025	**Agenda reference:**	**49-25**		
Report title:	Finance & performance committee assurance report				
Sponsor:	Peter O'Donnell, committee Chair				
Author:	Peter O'Donnell, committee Chair Ellie Simpkin, Governance manager				
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	- The Trust has had a good start to the year with operational and financial performance and key projects broadly in line with targets and timetables. The operational and financial outlook however looks very challenging. - Some good progress has been made to deliver the Trust's efficiency programme 2025/26 however, there is still a material gap to the overall Cost Improvement Programme (CIP) target. Contingency plans are also being considered. As anticipated, delivery of the financial plan will become increasingly challenging for the Trust throughout 2025/26 and may adversely impact on operational delivery. The committee asked for more information of the CIP activity to date and the developing plans and contingencies. - Cancer performance has been highlighted as area of challenge for the Trust going forward due to the increase in the number of skin cancer referrals. - Although the Trust's Community Diagnostic Centre (CDC) activity increased in month one, the outlook is that it remains behind plan. Action is being taken to address the underperformance in some modalities. - The Electronic Patient Record programme (EPR) is broadly tracking to plan, the next few months will be critical to ensure go live in November 2025. Action is also being taken to improve the Trust's response to Freedom of Information of Act requests within 20 working days. - The committee has reviewed the Trust's 2024 NHS staff survey results. The experiences of staff who declare a disability and staff feeling able to speak up have been identified for improvement and are areas of focus for the Executive team. - There are several risks to the delivery of the Bognor CDC programme, including capital spend and external stakeholder factors, meaning that the project is currently red/amber. - A contractor has been appointed to deliver the new build East Grinstead CDC and the programme continues to be rated green/amber.				
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:** *To deliver outstanding care*	**KSO2:** *To innovate and improve*	**KSO3:** *To be an excellent employer*	**KSO4:** *To deliver sustainable services*	**KSO5:** *To collaborate with others*
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: 49-25
Date of meeting: 10 July 2025
Report from: Peter O'Donnell, committee Chair
Report author: Peter O'Donnell, committee Chair
Ellie Simpkin, Governance manager
Date of report: 01 July 2025
Appendices: None

Sub-committee assurance report
Finance & performance committee – 30 June 2025

Key agenda items

- **Integrated Quality and Performance Report (IQPR) – month 1 (including month 2 finance update)**
- **Major project updates**
- **Efficiency Programme Update**
- **Estates assurance - critical infrastructure delivery**
- **Staff survey results and action planning**
- **Workforce Disability Equality Standards and Workforce Race Equality Standards annual reports 2024/25**
- **Gender Pay Gap report 2024/25**
- **Ethnicity Pay Gap report 2024/25**
- **Information governance assurance**
- **Information Management & Technology (IM&T) assurance**
- **Organisational Risk Register**

Alert

- Some good progress is being made to deliver the Trust's efficiency programme 2025/26, however, there is still a material to the overall Cost Improvement Plan (CIP) target. Contingency plans are also being considered. As anticipated, delivery of the financial plan will become increasingly challenging for the Trust throughout 2025/26 and may adversely impact on operational delivery. The committee has asked for more information of the CIP activity to date and the developing plans and contingencies.
- Cancer performance has been highlighted as area of challenge for the Trust going forward due to the increase in the number of skin cancer referrals. Consideration is being given to how the increase in demand can be managed.
- Although the Trust's Community Diagnostic Centre (CDC) activity increased in month one, the outlook is that it remains behind plan. Action is being taken to address the underperformance in some modalities.

- There are several risks to the delivery of the Bognor CDC programme, including capital spend and external stakeholder factors, meaning that the project is currently red/amber. The project is unlikely to complete in this financial year and capital allocated will need rephasing.
- Work continues at pace to deliver the Trust's Electronic Patient Record (EPR) programme. Training modules have been established and progress is being made on developing core system functionality, however, due to the complexity of the programme and some delays in process mapping the programme is currently rated as amber. The committee has asked for further detail on the critical path for the EPR.
- Action is being taken to improve the Trust's response to Freedom of Information of Act requests within 20 working days. Compliance will be monitored through the Trust's monthly IQPR going forward.
- The committee has reviewed the Trust's 2024 NHS staff survey results. The experiences of staff who declare a disability and staff feeling able to speak up have been identified for improvement and are areas of focus for the Executive team.
- The Trust's Workforce Race Equality Standards (WRES) Report 2024/25 shows that black and minority ethnic (BME) staff are over four times as likely to experience discrimination compared to white staff. The committee notes the ongoing work to improve the experiences of BME staff including the Trust's culture transformation steering group, Equality, Diversity and Inclusion champions and workshops to hear the lived experience of staff.
- The Workforce Disability Equality Standards (WRES) Report 2024/25 has reported an increase of 9.1% in disabled staff who felt pressure to come to work (22.7% in 2023/24 to 31.8% in 2024/25). The committee has suggested that further analysis is needed to understand the reasons for this and the proportionality of the results.
- The Trust's gender pay gap has grown for 2025, driven by a greater number of men in more senior admin roles among our Agenda for Change (AfC) workforce and Board, alongside senior male clinicians earning top of grade and bonus payments relative to our total workforce. The committee has highlighted the importance of ensuring that recruitment processes are attracting diverse candidates. The Trust's mean ethnicity pay gap has increased from -20.79% in 2024 to -22.95% in 2025 in favour of BME staff. The WDES, WRES and gender pay gap and ethnicity pay reports will be presented to the Board in September 2025 for oversight and discussion.

Assure

- The Trust met its planned month one performance against the 2025/26 operational targets for urgent and emergency care, referral to treatment and cancer and financial targets and month 2 is also tracking to plan.
- Temporary staffing use has decreased in month one, with substantive roles being filled and turnover decreasing which has resulted in a lower vacancy rate.
- The East Grinstead CDC programme continues to be rated green/amber. A contractor has been appointed to deliver the new build. Information sessions for local residents will be taking place in July 2025.
- Progress continues on addressing the Trust's critical estates infrastructure. The committee was pleased to note that the Trust has been awarded £1.4m of additional funding to replace a boiler system. Demolition of the old medical photography unit to remove the Reinforced Aerated Autoclaved Concrete (RAAC) is underway and expected to be complete by the end of July 2025.

Advise

- The committee received an update on the Trust's NHS England Data Security and Protection Toolkit self-assessment submission, noting that requirements have changed significantly for 2024/25. A remedial action plan is in place for some elements which will be monitored by the Executive Leadership Team.

Risks discussed and new risks identified

- The committee has reviewed the organisational risks relevant to its remit. The highest scoring risk is related to the Trust not being able to deliver the full value of the cost improvement plan for 2025/26 (current score of 20).
- A risk of the spread of fire due to lack of fire compartmentalisation has been added to the register. The committee asked that the risk is reviewed to clarify the extent of the risk and the mitigations in place.
- The committee suggested the risk relating to the management of Trust's cash flow is considered further.

Recommendation

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