Bundle Public Board 9 July 2026

Agenda attachments

- A - Front cover PUBLIC
- B - Membership
- C - Register
- D- Agenda public- 09 July 2026 FINAL

27.26 Welcome, apologies and declarations of interest
Angela McNab, interim Trust Chair

28.26 Draft minutes of the public meeting held on 14 May 2026
Angela McNab, interim Trust Chair
Approval
- PUBLIC Board meeting- 14 May 2026 DRAFT V2

29.26 Matters arising and actions pending from previous meeting
Angela McNab, interim Trust Chair
Review
- 29-26 PUBLIC Matters arising

30.26 Patient story
Liz Blackburn, acting Chief nursing officer
Discussion

31.26 Chair's report
Angela McNab, interim Trust Chair
Assurance
- 31-26 Chairs report July 2026 FINAL

32.26 Chief executive's report
Abigail Jago, acting Chief executive officer
Assurance
- 32-26 CEO Board Report 9 July 26

33.26 Integrated quality and performance report
All executive directors
Assurance
- 33-26 (FC) IQPR M1
- 33-26.1 Final for Board Trust IQPR_M1 2026_27Report

34.26 Quality and safety assurance
Jo Emmanuel, Non-executive director
Assurance
Quality annual reports 2025-26:
Learning from Deaths
Safeguarding (Adult and Children)
Infection Prevention and Control
Patient Experience
Appraisal & Revalidation annual report 2025-2026
Liz Blackburn, acting Chief nursing officer
Tamara Everington, Chief medical officer
- 34-26 Quality & safety assurance report June FINAL
- 34-26.1 (FC) Annual Learning from Deaths Report 2025-26
- 34-26.2 Annual Learning from Deaths Report 2025-26
- 34-26.3 (FC) Safeguarding annual report 2025-26
- 34-26.4 Safeguarding Annual Report 2025-26
- 34-26.5 (FC) Infection prevention control annual report 2025-26
- 34-26.6 Infection prevention control annual report 2025-2026
- 34-26.7 (FC) Patient Experience Annual Report 2025-2026
- 34-26.8 Patient Experience Annual 2025-2026
- 34-26.9 (FC) Appraisal and Revalidation front cover 2025-26
- 34-26.10 Appraisal revalidation - annex-a-QVH-2026 (002)

35.26 Financial, workforce and operational performance assurance
Jagjit Dosanjh-Elton, Non-Executive Director
Assurance
35-26 Finance & performance assurance report June FINAL

36.26 Strategy and culture assurance
Jo Emmanuel, Non-Executive Director
Assurance
36-26 Strategy & culture assurance report June 2026 FINAL

37.26 Audit and risk assurance
Jagjit Dosanjh-Elton, Non-executive director and committee Chair
Assurance
Audit & risk committee annual report 2025/26
37-26 Audit & risk assurance report June 2026 FINAL
37-26.1 Audit and Risk Annual Report 2025-26 FINAL

38.26 Bi-annual safe staffing and nursing workforce review
Liz Blackburn, acting Chief nursing officer
Assurance
38-26 Bi annual Safe Staffing and Nursing Workforce Review

39.26 Bi-annual digital update
Tamara Everington, Chief medical officer
Assurance
39-26 Digital Strategy Update for Board

40.26 Board Assurance Framework
Jamie O'Callaghan, interim Company secretary
All executive directors
Assurance
40-26 Board Assurance Framework (BAF) Board July 2026
40-26.1 BAF summary updated 02 July 2026
40-26.2 BAF001 template ACCESS V4
40-26.3 BAF002 template CYBER v1
40-26.4 BAF003 template DIGITAL V4
40-26.5 BAF004 template ESTATES V5
40-26.6 BAF005 template FINANCE V3
40-26.7 BAF006 template LEADERSHIP CAPACITY V4
40-26.8 BAF007 template PEOPLE V4
40-26.9 BAF008 template QUALITY V6
40-26.10 BAF009 template REGULATION V2
40-26.11 BAF010 template SUSTAINABILITY AND STRATEGY V4

41.26 Annual review of Standing Orders, Standing Financial Instructions and Scheme of Delegation & Reservation of Powers
Jamie O'Callaghan, interim Company secretary
Approval
41-26 (FC) SO's, SoD RoP, SFI's
41-26.1 Standing orders 2026-27 DRAFT V1
41-26.2 RoP SoD revised format 2026-27 DRAFTV1
41-26.3 Standing financial instructions 2026-27 DRAFT V1

42.26 Company Secretary's report
Jamie O'Callaghan, interim Company secretary
Assurance / Approval
42-26 Company secretary's report
42-26.1 NRC ToR 2026-27 DRAFT V1

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

44.26 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 qvh.corporategovernance@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.

Angela McNab, interim Trust Chair

Queen Victoria Hospital
NHS Foundation Trust

Business Meeting of the Board of Directors

Thursday 09 July 2026

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

MEMBERSHIP
BOARD OF DIRECTORS
July 2026

Members (voting):

Interim Trust Chair	-	Angela McNab
Senior Independent Director	-	Kalee Talvitie-Brown
Non-Executive Directors	-	Jagjit Dosanjh-Elton
	-	Jo Emmanuel
	-	Nick Page
Acting Chief Executive Officer	-	Abigail Jago
Chief Medical Officer	-	Tamara Everington
Acting Chief Nursing Officer	-	Liz Blackburn
Interim Chief Finance Officer	-	Ross Dunworth

In full attendance (non-voting):

Associate Non-Executive Directors	-	Aleema Shivji
	-	Vivek Chaudhri
Chief People Officer	-	Helen Edmunds
Chief Operating Officer	-	Kirsten Timmins
Acting Chief Strategy Officer	-	Kathy Brasier
Interim Company Secretary	-	Jamie O'Callaghan

Annual declarations by directors 2026/27

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 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)								
Angela McNab Interim Trust Chair	Non executive director / Vice Chair of Kent and Medway Integrated Care Board Non executive of Dimensions UK Ltd	Shareholder (less than 5%) in Rapid Health	Nil	Nil	Nil	Nil	Nil	Member of Independent Reconfiguration Panel (NDPB) - Advisory
Jagjit Dosanjh-Elton Non-Executive Director	Non-executive director for Social Investment Business Foundation Non-executive director for The Social Investment Business Limited Non-executive director for Public Relations Communications Association Limited Director 100% Shareholder of Ingenious Exec Limited	Nil	Nil	Trustee for TB Alert	Nil	Nil	Sister works as Chief Nurse at Guys and St Thomas Trust. Brother in law works as a Cardiac Consultant at Pembury Hospital Kent	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

Nick Page Non-Executive Director	Mid & South Essex NHS Foundation Trust: Non-executive director Berkshire & Surrey Pathology Services (contractual JV): Non-executive director Institute of Chartered Accounts in England & Wales: Council Member Chartered Institute for Archaeologists Esher Cricket Club Ltd: Director/Charity Trustee Esher Cricket Club Trading Ltd: Director Carrington Place, Esher, Management Company Ltd: Director Willow Property Management Ltd: Director Willow Investment Holding Ltd: Director	Mid & South Essex NHS Foundation Trust:	Nil	Nil	Nil	Nil	Nil	Nil
Kalee Talvitie-Brown Non-Executive Director	Nil	Nil	Nil	Chair of the Corporate Advisory Group, Evelina Children's Hospital Charity.	Nil	Nil	Nil	Nil
Abigail Jago Acting Chief Executive Officer	Nil	Nil	Nil	Nil	Nil	Nil	Nil	Nil
Liz Blackburn Acting Chief Nursing Officer	Nil	Nil	Nil	Nil	Nil	Nil	Nil	Nil

Kathy Brasier Acting Chief Strategy Officer	Nil	Nil	Nil	Nil	Nil	Nil	Nil	Nil
Ross Dunworth Interim Chief Finance Officer	Shareholder and Director: Whireparish Financial Services Ltd	Nil	Nil	Nil	Nil	Nil	Nil	Nil
Helen Edmunds Chief People Officer	Nil	Nil	Nil	Nil	Nil	Nil	Nil	Nil
Tamara Everington Chief Medical Officer	Nil	Nil	Nil	Nil	Nil	Azets (Trust's external auditor) support with annual tax return including evaluation of pension tax liability	Nil	Nil
Kirsten Timmins Chief Operating Officer	Nil	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	Co-Chair, Peace Direct (charity)	Nil	Nil	Nil	Nil
Vivek Chaudhri Associate Non-Executive Director	Director of Global AI Leaders Network Director of Purposeful AI NED, East London NHS Foundation Trust (ELFT) NED, National Highways	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 Board member of the trust under given circumstances known as the "fit and proper person test". By completing and signing an annual declaration form, QVH Board members confirm their awareness of any facts or circumstances which prevent them from holding office as a member of QVH NHS Foundation Trust Board.

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							
Angela McNab Interim Trust Chair	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Jagjit Donsanjh-Elton 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
Nick Page Non-Executive Director	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Kalee Talvitie-Brown 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
Ross Dunworth Interim Chief Finance Officer	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Liz Blackburn Acting 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
Kathy Brasier Acting Chief Strategy 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 09 July 2026
10.00-12.00

Agenda: session held in public		
WELCOME		
27-26	**Welcome, apologies and declarations of interest** *Angela McNab, interim Trust Chair*	
STANDING ITEMS		**Purpose**
28-26	**Draft minutes of the public meeting held on 14 May 2026** *Angela McNab, interim Trust Chair*	*Approval*
29-26	**Matters arising and actions pending from previous meetings** *Angela McNab, interim Trust Chair*	*Review*
30-26	**Patient Story** *Liz Blackburn, acting Chief nursing officer*	*Discussion*
31-26	**Chair's report** *Angela McNab, interim Trust Chair*	*Assurance*
32-26	**Chief Executive's report** *Abigail Jago, acting Chief executive officer*	*Assurance*
PERFORMANCE		
33-26	**Integrated quality and performance report** *All executive directors*	*Assurance*
COMMITTEE ASSURANCE REPORTS		
34-26	**Quality and safety assurance** *Jo Emmanuel, Non-executive director* **Quality annual reports 2025-26:** - **Learning from Deaths** - **Safeguarding (Adult and Children)** - **Infection Prevention and Control** - **Patient Experience** - **Appraisal & Revalidation annual report 2025-2026** *Liz Blackburn, acting Chief nursing officer* *Tamara Everington, Chief medical officer*	*Assurance / Approval*
35-26	**Financial, workforce and operational performance assurance** *Jagjit Dosanjh-Elton, Non-Executive Director*	*Assurance*

36-26	**Strategy and culture assurance** *Jo Emmanuel, Non-Executive Director*	*Assurance*
37-26	**Audit and risk assurance** *Jagjit Dosanjh-Elton, Non-executive director and committee Chair* - **Audit & risk committee annual report 2025/26**	*Assurance*
ANNUAL REPORTS		
38-26	**Bi-annual safe staffing and nursing workforce review** *Liz Blackburn, acting Chief nursing officer*	*Assurance*
39-26	**Bi-annual update on digital strategy** *Tamara Everington, Chief medical officer*	*Assurance*
GOVERNANCE & RISK		
40-26	**Board Assurance Framework** *Jamie O'Callaghan, interim Company secretary* *All executive directors*	*Assurance*
41-26	**Annual review of Standing Orders, Standing Financial Instructions and Scheme of Delegation & Reservation of Powers** *Hugh Cronshey, Deputy director strategic financer* *Jamie O'Callaghan, interim Company secretary*	*Approval*
42-26	**Company Secretary's report** *Jamie O'Callaghan, interim Company secretary*	*Assurance / Approval*
MEETING CLOSURE		
43-26	**Any other business (by application to the Chair)** *Angela McNab, interim Trust Chair*	*Discussion*
MEMBERS OF PUBLIC		
44-26	**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 qvh.corporategovernance@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.* *Angela McNab, interim Trust Chair*	

	Minutes (DRAFT)	
Meeting:	**Board of Directors (session in public)** **10.00-12 noon 14 May 2026** **Learning and Development Centre, QVH**	
Present:	Angela McNab (AM)	Interim Trust Chair (voting)
	Jagjit Dosanjh-Elton (JDE)	Non-executive director (voting)
	Peter O'Donnell (POD)	Non-executive director (voting)
	Shaun O'Leary (SOL)	Non-executive director (voting)
	Russell Hobby (RH)	Non-executive director (voting) [MS Teams]
	Abigail Jago (AJ)	Acting Chief executive officer (voting)
	Simon Marshall (SM)	Interim Chief finance officer (voting)
	Tamara Everington (TE)	Chief medical officer (voting)
	Liz Blackburn (LB)	Acting Chief nursing officer (voting)
	Kirsten Timmins (KT)	Chief operating officer (voting)
	Helen Edmunds (HE)	Chief people officer (non-voting)
	Aleema Shivji (AS)	Associate Non-executive director (non-voting)
	Vivek Chaudhri (VC)	Associate Non-executive director (non-voting)
In attendance:	Jamie O'Callaghan (JO)	Interim Company secretary (minutes)
	Louise Rogers (LR)	Advanced care specialist (for patient story item)
	Jacqui Marshall-Dibble	AuditOne (Observer for well-led review)
	Jackie Doherty (JD)	Freedom to Speak Up Guardian (FTSU item)
Apologies:	Jo Emmanuel (JE)	Non-executive director (voting)
Members of the public:	8 governors and one member of the public (for patient story)	

01-26	**Welcome, apologies and declarations of interest** The Chair opened the meeting welcoming members of the Board and those observing the meeting. The Chair acknowledged that this was the final Board meeting for SOL, POD and RH and placed on record her sincere thanks for their significant contribution to the Trust. The Chair reminded those observing the meeting that they were not invited to participate in discussions and that there would be an opportunity to ask questions at the end of the meeting. Apologies were received from JE. There were no declarations of interest other than those already recorded on the register of interests.
02-26	**Draft minutes of the public meeting held on 13 March 2025** The Board agreed that the minutes of the public Board meeting held on 13 March 2026 were a true and accurate record and approved them on that basis, subject to a minor amendment raised by KT.
03-26	**Matters arising and actions pending from previous meetings** Action 1 (Company secretary's report). The Board noted that the first draft of the handbook was completed and due to go through the approval process and be shared with staff. This action will be closed. Action 2 (Sexual safety and violence prevent and reduction) The Board noted that the update was presented to the Strategy and Culture committee in April 2026. This action will be closed.

	Action 3 (Quality impact assessments). The Board noted that the report was presented to the Quality and Safety committee in May 2026. This action will be closed. Action 8 (Estates). The Board noted that a discussion was held at the Board seminar in April 2026. This action will be closed. The Board noted that there were four further open actions which are not due until June 2026. The Board noted the verbal and written updates for the actions.
04-26	**Patient story** The Board welcomed LR and the patient to the meeting to share his experience of the Trust's laser scar treatment service. LR outlined the development of the service, noting that it was launched in March 2025, has treated over 100 patients and represents an important step forward in the management of complex scarring. The patient described his experience of care, reflecting on a long clinical history with the Trust. He spoke positively about the professionalism of staff and the impact of the laser treatment in improving flexibility and scar appearance. TE asked the patient whether, reflecting on his earlier care, there was anything that could have been done differently. The patient explained that earlier experiences had taken place in a different clinical context and that there was little that could have been done differently at that time. KT asked whether there were further opportunities to improve the service. The patient highlighted the value of clear information at the outset, including the use of visual materials to support understanding of outcomes and clearer communication regarding the incremental nature of treatment. SOL asked whether the patient would have felt able to provide feedback outside of the Board setting. The patient reflected that while he had strong informal relationships with staff, formal feedback routes were less clear and could be strengthened. AJ noted that the service represented a successful example of innovation, with strong patient outcomes and experience, and thanked LR and the team for their work in developing the service. The Board recognised the service as a strong example of patient-centred care. The Board thanked the patient for sharing his experience.
05-26	**Chair's report** AM presented the report to the Board, highlighting the following: - Progressing the Trust's strategic partnership remains the Board's key priority, with ongoing engagement with the RSASP Group - The Non-Executive Director recruitment process is underway and interviews are scheduled for early June 2026 - This Board meeting marks the final Board meeting for POD, SOL and RH and she placed on record her sincere thanks for their contribution - A Board seminar took place in April 2026 focusing on Board development, CQC preparedness and the strategic partnership

	- The Council of Governors election process is underway and results are due to be declared in June 2026 The Board **noted** the contents of the report.
06-26	**Chief Executive's report** AJ presented the report to the Board, highlighting that: – A business continuity incident occurred over the weekend due to a power surge, with temporary loss of systems. Patient care was maintained safely and systems restored promptly. Thanks were extended to IT and the on-call manager. A lessons learned exercise will be undertaken – The year had been challenging and turbulent; however, the Trust sustained high quality patient care, delivered strong patient feedback and achieved its financial plan – Progress has been made in the strategic partnership, development at Bognor and strengthening system relationships – There has been continued progress in digital, including EPR rollout, and in the use of health inequalities data – Operational performance has been mixed, with an overall stable position across KSOs and a continued focus on elective recovery and financial sustainability – Staff survey results show a reduction in morale and increased fatigue, which will be a key area of focus AJ reported that this was SM's final Board meeting and thanked him for his contribution. The Board echoed their thanks, noting the achievement of breakeven and progress in financial performance and the Bognor programme, which is transitioning into primary care. Board members discussed the strategic partnership, noting progress in developing relationships and alignment across Royal Surrey NHS Foundation Trust and Ashford and St Peter's Hospitals NHS Foundation Trust. SOL highlighted wider system changes and the importance of maintaining oversight as arrangements embed, with an opportunity to review progress in due course. The Board **noted** the contents of the report.
07-26	**Staff survey results 2025** HE presented the report to the Board. She highlighted that: – The response rate was 56%, broadly in line with the previous year – There has been a reduction in staff recommending the Trust as a place to work, with engagement, morale and fatigue identified as key areas of focus – There has been a reduction in staff confidence to speak up – Improvements were noted in relation to physical violence, including patient to staff and staff to staff incidents – A workshop is planned with the Executive team to focus on areas for improvement The Board discussed the report. Board members noted the value of the benchmarking included and queried comparisons with Royal Surrey NHS Foundation Trust and Ashford and St Peter's Hospitals NHS Foundation Trust. It was highlighted that while benchmarking well in some areas, continued focus is required as the organisation depends on its people. Variation across teams was acknowledged and the importance of sharing learning from high performing areas was noted.

	Board members highlighted leadership visibility and communication as key themes and suggested focusing on a small number of priorities including visibility, psychological safety and fatigue. The link between staff engagement and continuous improvement was emphasised. Board members raised potential disengagement amongst younger staff as an area for consideration and noted that leadership visibility must be meaningful. The importance of visibility being felt by staff, alongside maintaining psychological safety and ensuring staff feel heard, was emphasised. The Board **noted** the contents of the report.
08-26	**Bi-annual assessment of addressing health inequalities** Liz presented the report to the Board. She highlighted that: - A dashboard has been developed to support understanding of health inequalities and to promote this as everyone's business - Progress has been made in developing data and insight, with further work required to translate this into measurable outcomes - A focus is being placed on embedding health inequalities into the IQPR to support regular monitoring - Further work is required in relation to ethnicity data and PAS optimisation to ensure consistent data capture and understanding - Priorities include improving access for patients with additional needs Board members welcomed the progress made and the development of the dashboard, but emphasised the need for greater clarity on priorities, actions and measurable impact. Queries were raised regarding the collection of data on pre-existing disabilities. It was noted that this is not currently captured consistently and further work will be undertaken to explore this and report back. Board members highlighted the importance of moving from insight to action, including addressing the deprivation gradient and DNA rates, with a focus on outcomes. The importance of reasonable adjustments and ensuring systems support effective sharing of patient information was noted. SOL praised the significant improvement since last year but challenged what the next steps would be, noting a lack of specificity on priorities and queried what targeted actions would be taken in relation to the deprivation gradient and how demonstrable improvement would be achieved, including when measurable targets would be set. **ACTION LB.** The Board **noted** the contents of the report.
09-26	**Integrated quality and performance report** The Executive team presented the report to the Board, highlighting that: - The Trust delivered its 2025/26 financial plan, reporting a breakeven position supported by additional funding - Cancer performance standards, including the Faster Diagnosis Standard and 62-day performance, were achieved at year end - RTT performance remains below plan, with patients waiting over 52 and 65 weeks and actions in place to improve validation and waiting list management - Operational performance remains mixed, with strong delivery in urgent and emergency care and diagnostics, but challenges remain in elective pathways - Key risks include delivery of RTT standards, CDC activity performance and digital programme timelines, including PAS

	The Board discussed the report. SOL queried cancer performance targets, noting a lack of clarity on what has been met, exceeded and not delivered and requested clearer articulation in future reporting. **ACTION KT** Board members noted improvements across a number of metrics and positive trends in performance. POD queried the waiting list trajectory and level of confidence in recovery, noting performance has remained below 85% for some time. KT reported that theatre utilisation has improved in recent months but remains below target. Actions are in place including addressing day of surgery cancellations, improving start and finish times and optimising use of theatres through specialty level review. KT noted there remain risks to delivery within the current timeframe, with some improvements expected to take longer to realise. The Chair noted the concerns raised and confirmed that the Board would expect to see a clear trajectory to target in areas of underperformance, with updates through the Finance and Performance committee. **ACTION KT** In response to a query regarding VTE compliance, LB reported that the reduction was linked to changes following EPR implementation. Targeted actions have been implemented, including use of dashboards and focused training, with performance improving to 89% in April and further improvement expected. No increase in VTE incidents has been identified. The Board **noted** the contents of the report.
10-26	**Business plan 2026/27** SM presented the report to the Board, noting that it had previously been approved at an extraordinary Board meeting and was now presented for ratification. - The plan has been accepted by NHS England with two conditions, with further work expected to address these - The cost improvement programme remains significant, with c.£5m identified and further schemes to be developed with partners - Delivery will require continued financial control and oversight - The activity plan forms a key component of delivery - Capital remains constrained, with clarity expected in the coming weeks, including in relation to the estates safety fund VC raised the planning assumptions. KT confirmed that planning for next year has been scrutinised through the Finance and Performance committee. The Board noted the challenges and risks associated with delivery of the plan. The Board **ratified** the business plan for 2026/27 as previously approved at its extraordinary meeting.
11-26	**Quality and safety committee assurance** RH presented the report to the Board, highlighting that: - The committee has provided assurance on quality and safety matters - Progress has been made in relation to health inequalities recording and development of the dashboard - Work continues to address key quality and safety priorities, including policy compliance

	The Board **noted** the contents of the report.
12-26	**Financial, workforce and operational performance assurance.** POD presented the report to the Board, highlighting that: - The committee had commended the executive team on progress in delivering the 2025/26 plan in a challenging context - The committee continues to have oversight of performance against waiting time targets, including the 65 week position - There is financial risk associated with the delay to the East Grinstead CDC build - The committee has supported the handover of the Bognor CDC The Board **noted** the contents of the report.
13-26	**Strategy and culture assurance** POD presented the report to the Board, highlighting that: - There is a significant programme of activity underway in relation to the strategic partnership - The committee is focused on maintaining momentum in delivery through to September 2026 - There is a need to increase focus on the wider strategic agenda alongside current priorities The Board **noted** the contents of the report.
14-26	**Freedom to Speak up annual report** The Freedom to Speak Up Guardian presented the report to the Board, highlighting that: - Concerns continue to be raised through the Freedom to Speak Up service - Feedback from the staff survey suggests that staff are not reluctant to speak up, but there is a perception of futility in some cases Board members noted that reporting levels are higher than comparator organisations and queried whether this was a positive indicator. Board members queried the proportion of staff who felt they had not been listened to and sought further insight. It was noted that this can reflect feedback loops not being completed, or where outcomes cannot be shared. POD highlighted the relationship with leadership visibility and the role of managers, noting that where staff feel able to raise concerns locally, escalation may be less required. SOL queried how assurance is gained that concerns relating to management are triangulated with wider people processes and whether themes reflect known issues. It was confirmed that themes are shared where possible, with regular engagement with the Executive team, and that triangulation is undertaken through wider reporting. The Board **noted** the contents of the report.
15-26	**Guardian of Safe Working report** TE presented the report to the Board in the absence of the Guardian of Safe Working who had sent her apologies to the meeting. TE highlighted that the report reflects updates aligned to national changes and noted the importance of having robust HR processes in place to support compliance, including in relation to rest periods.

	TE confirmed that an 11-hour rest period between shifts is in place and that the 10 point plan is being overseen. SOL thanked the team for the report, noting that these reports have been coming to the Quality and Safety committee and that significant improvements have been seen. The Board **noted** the contents of the report.
16-26	**QVH Strategy 2025-2030: 2025/26 year 1 delivery & Key Strategic Objectives 2026/27** KB presented the report to the Board. JE asked whether more specific measures could be included within the employer metrics. KB confirmed that this would form part of the further development of the IQPR pack for next year and that greater specificity would be provided on how elements of the KSOs are reflected. AS commented on the approach to the development of the objectives. The Board **approved** the Key Strategic Objectives for 2026/27.
17-26	**Board Assurance Framework** JOC presented the report to the Board, highlighting that no key changes had been made to update scores, mitigations or controls and that greater discussion had taken place at the relevant committees. JOC also noted that a cyber-risk was being developed for inclusion within the Board Assurance Framework. SOL commented that JOC's perspective in the Company Secretary role was helpful in bringing a fresh review of the Board Assurance Framework. The Board **noted** the contents of the report
18-26	**Company secretary's report** JOC presented the report to the Board and highlighted the following key points. - The Trust has complied with its NHS provider licence conditions for 2025/26. Compliance with the Code of Governance continues to improve, with one area of non-compliance relating to remuneration, which will be disclosed in the Annual Report. - The draft Annual Governance Statement has been reviewed by the Audit and Risk Committee and concludes that no significant control issues have been identified. Internal audit provided reasonable assurance overall during the year. - The annual review of committee terms of reference has been completed, with minor updates made. The Modern Slavery Statement for 2025/26 was presented and confirmed as compliant with statutory requirements. The Board: – **Noted** that the Trust has complied with its standard NHS provider licence for 2025/26 – **Noted** the area of non-compliance with the Code of governance for NHS provider trusts – **Noted** the update related to the Annual governance statement 2025/26 – **Approved** the committee terms of reference as appended – **Approved** the Modern slavery statement for 2025/26 as appended
19-26	**Any other business (by application to the Chair)**

	There was no further business and the meeting closed.
20-26	**Questions from members of the public** ***Question*** *Staff survey - recommend as a place to work decreased which is a concern. The survey response rate for bank workers has declined - is there a reason for this?* ***Response*** *There has been a 20% reduction in the number of bank workers over the past year. 60% of bank workers also have permanent roles and would have answered the survey as substantive member of staff.* ***Question*** *Staff survey - were some aspects of the staff survey results for RS/ASP better than QVH?* ***Response*** *Yes.* ***Question*** *Has NHSE now been disbanded?* ***Response*** *NHSE is in a period of transition. Changes to staffing are taking place but the disbanding NHSE and the transfer of powers of the DHSC requires a change in legislation which is yet to take place.* ***Question*** *Is there an update on the plans to abolish CoGs following yesterday's King speech?* ***Response*** *There is no further update as yet. More information will be shared as it becomes available.*

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**
5	March 2026	144-26	GP engagement	Holistic report on Trust wide GP engagement to be presented to the Strategy and culture committee	**TE, KB**	**June 2026***	April 2026: Item scheduled on the agenda for the June 2026 Strategy and culture committee meeting June 2026: Report presented to the June 2026 Strategy and culture committee and an overview is included in the committee assurance report to Board. Action closed.	**Closed**
6	March 2026	147-26	Provider Capability Assessment	Update on Provider Capability Assessment gaps and actions to be presented to the Audit and risk committee	**AJ**	**June 2026***	April 2026: Item scheduled on the agenda for the June 2026 Audit and risk committee meeting. June 2026: Report presented to the June 2026 Audit and risk committee and an overview is included in the committee assurance report to Board. Action closed.	**Closed**
7	March 2026	148-26	65 week waits	Share trajectory to reach zero 65 week waits with the Finance and performance committee	**KT**	~~**June 2026***~~ **September 2026**	May 2026: Forecast for Q1 shared and discussed at the May 2026 Finance and performance committee. The trajectory for the remainder of 2026/27 will be shared with the committee for discussion at the June 2026 meeting. July 2026: The trajectory for the remainder of 2026/27 is in progress and will be shared at the next Finance and Performance Committee.	**Pending**
1	May 2026	08-26	Bi-annual assessment of addressing health inequalities	Update to be provided outlining the targeted actions that will be taken in relation to the deprivation gradient and how demonstrable improvement will be achieved including when measurable targets will be set.	**LB**	**July 2026***	July 2026: Through the development of the Trust health inequalities dashboard, the data identifies areas of unwarranted variation in access and attendance across deprivation and ethnicity cohorts, with patients from the most deprived communities being approximately five percentage points more likely to wait over 18 weeks than those from the least deprived areas. We recognise that this is a complex area requiring improvement. A pilot programme of work is planned at one of our spoke sites targeting areas of known deprivation. This activity will focus on analysing the drivers of patient 'Did Not Attend' by deprivation, including appointment timing, specialty, access issues and booking processes. Findings will be used to pilot interventions, including enhanced reminders and flexible booking arrangements for patients from the most deprived groups.	**Pending**
2	May 2026	09-26	Integrated quality and performance report	Clearer articulation of cancer performance (what has been met, exceeded and not delivered) to be included in future reporting.	**KT**	**July 2026***	July 2026: the IQPR now details cancer performance by each metric. Action closed.	**Closed**
3	May 2026	09-26	Integrated quality and performance report	Clear trajectory to target in areas of underperformance to be included in future reporting, with updates through the Finance and Performance committee.	**KT**	**July 2026***	July 2026: action being undertaken to recover areas of underperformance detailed in the IQPR and monitored by the Finance and performance committee. Updates included in assurance reporting to Board. Action closed.	**Closed**

Report cover-page					
References					
Meeting title:	Board of Directors				
Meeting date:	09/07/2026	**Agenda reference:**	**31-26**		
Report title:	Chair's report				
Sponsor:	Angela McNab, interim Trust Chair				
Author:	Angela McNab, interim 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	• Progressing the Trust's strategic partnership remains the Board's key priority, with significant decisions due to be considered by partner Boards later in July. • Nick Page and Kalee Talvitie-Brown joined the Board as Non-Executive Directors on 1 July 2026. Kalee has been appointed Senior Independent Director and Nick has been appointed Chair of the Finance and Performance Committee. • The Board records its thanks to Peter, Shaun and Russell, whose terms of office as Non-Executive Directors concluded on 30 June 2026. • The QVH Star Awards will take place on 10 July 2026, providing an opportunity to recognise and celebrate the contribution of colleagues across the Trust. • The Council of Governors has concluded the governor recruitment and election process and welcomed new public, staff and stakeholder governors.				
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 of Directors
Agenda item:	31-26
Date of meeting:	09 July 2026
Report from:	Angela McNab, interim Trust Chair
Report author:	Angela McNab, interim Trust Chair
Date of report:	01 July 2026
Appendices:	None

Chair's report

Introduction

This report provides an update on my activities since the last Board meeting and highlights key areas of focus for the Board of Directors and the Council of Governors.

The report also reflects the Board's continued focus on progressing the Trust's strategic partnership and the important decisions that will be considered later this month. It includes an update on changes to Board membership following the appointment of new Non-Executive Directors, highlights opportunities to recognise and celebrate the contribution of our staff, and outlines recent developments within the Council of Governors, including governor appointments and elections

Board of Directors

Progressing the Trust's strategic partnership remains the Board's key priority, with a clear focus on securing the long term sustainability and resilience of our services. During this period, I have continued to work closely with Abigail and colleagues from across the Trust, alongside our partner organisations, to develop the proposed partnership arrangements and supporting governance framework.

A number of significant milestones are scheduled during July, including public meetings of the respective Boards to consider the next phase of the proposed arrangements. The Trust will also hold an extraordinary public meeting of the Board of Directors on 23 July 2026, at which the Board will be asked to consider the Memorandum of Understanding, arrangements for the first six months of leadership and governance, and the proposed timeline for partnership appointments. As this important programme of work progresses, the Board remains committed to ensuring that robust governance, due diligence and stakeholder engagement continue to underpin decision making.

The recruitment process for Non-Executive Director roles has now concluded. Following approval by the Council of Governors at its extraordinary meeting on 10 June 2026, I am pleased to welcome Nick Page and Kalee Talvitie-Brown, who joined the Board as Non-Executive Directors on 1 July 2026. Both bring significant experience and expertise, and I look forward to the contribution they will make as we continue to deliver the Trust's strategic objectives. Kalee has also been appointed as Senior Independent Director and Nick has been appointed Chair of the Finance and Performance Committee.

I would also like to again place on record my sincere thanks to Peter, Shaun and Russell, whose terms of office as Non-Executive Directors concluded on 30 June 2026. On behalf of the Board, I thank them for their commitment, leadership and contribution to the Trust. Each has made a significant impact through their stewardship, challenge

and support, and we are grateful for the expertise and dedication they have brought to the organisation during their time in office.

Staff Recognition
As I write this, preparations are underway for the QVH Star Awards on 10 July. The awards are a wonderful opportunity to celebrate the dedication, skill and compassion of our colleagues, and I am looking forward to hosting my first ceremony as Chair. Alongside Abigail, I will be proud to present the Chair and Chief Executive Award for Outstanding Contribution, recognising an individual or team that has made an exceptional impact on our patients, colleagues and the wider Trust. The awards provide an important opportunity to recognise and celebrate the outstanding contribution that staff make every day in delivering high-quality care and services across QVH.

Council of Governors
I continue to hold regular meetings with the Lead and Deputy Lead Governor to discuss key issues and provide assurance on matters relating to the Council of Governors.

An extraordinary meeting of the Council of Governors was held on 10 June 2026 to consider the recommendations of the Appointments Committee arising from the Non-Executive Director recruitment process. In accordance with their statutory responsibilities, governors approved the appointments recommended by the Appointments Committee. I would like to thank governors for their engagement and contribution throughout the process.

As noted in my previous report, a number of public and staff governors reached the end of their terms of office in June 2026 and a recruitment and election process was undertaken to fill these vacancies. I am pleased to report that this process has now concluded. I would like to welcome Robin Graham, Terry Holding, Suzy O'Hara, Glynn Roche and Robert Tamplin to the Council of Governors as public governors. Together they bring a broad range of experience and perspectives from public service, business, governance and community engagement, which will support the Council in fulfilling its statutory responsibilities.

Staff governor elections were contested, with eight candidates standing for three vacancies. Following the election, I am pleased to welcome Jo Deamer, Dental Training Specialist, and Amy Hinz, Quality and Compliance Lead for Perioperative Services, as staff governors. Together they bring valuable experience and insight from across the Trust and will play an important role in representing the interests of staff within the Council of Governors.

Following the recent local government elections, I am pleased to welcome Councillor Yvonne Gravely to the Council of Governors as stakeholder governor representing West Sussex County Council. I look forward to working with her and to the contribution she will make to the Council's work.

I would also like to congratulate those governors who were re-elected for a further term of office and thank all governors whose terms of office concluded during the year for their commitment and contribution to the Trust. Their support, challenge and engagement have played an important role in helping the Council fulfil its responsibilities.

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

Report cover-page					
References					
Meeting title:	Board of Directors				
Meeting date:	09/07/2026	**Agenda reference:**	**32-26**		
Report title:	Chief Executive Officer (CEO) report				
Sponsor:	Abigail Jago, Acting Chief Executive Officer				
Author:	Kathy Brasier, Deputy Chief Strategy Officer Allison Hunter, Strategy Support Officer				
Appendices:	None				
Executive summary					
Purpose of report:	To update on key developments, achievements and risks since the last Board meeting.				
Summary of key issues	QVH has started 2026/27 with strong quality, urgent care and year to date financial performance. However, the Trust is experiencing challenges in planned care delivery including Referral to Treatment (RTT) and cancer performance against plan. These challenges are driven by a combination of increased demand in Sleep, Skin and Oral and Maxillo Facial Surgery services, capacity constraints within Plastic Surgery and the need to strengthen operational grip and control across some care pathways. Enhanced operational oversight is in place supported by strengthened leadership and a clear focus on improving patient access and recovering performance. The Trust also remains focused on strengthening staff experience and engagement, recognising this as fundamental to delivering outstanding care for patients. Progress against the Trust's strategic programmes remains on track and aligned with the ambitions of the NHS 10 Year Health Plan. This includes delivery of the Community Diagnostic Centre and implementation of the new Patient Administration System. Work to progress the proposed Strategic Partnership continues at pace and remains on track. Key organisational risks remain the delivery of the financial plan, recovery of planned care access standards and ongoing estates related challenges. Nationally, resident doctors have accepted a new pay deal, bringing an end to the planned programme of industrial action.				
Recommendation	The Board is asked to **NOTE** the contents of the report.				
Action required	Approval	**Information**	Discussion	Assurance	Review
Link to key strategic objectives (KSOs):	**KSO1:**	**KSO2:**	**KSO3:**	**KSO4:**	**KSO5:**
	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:	All				
Organisational risk register:	All				
Regulation:	None				
Legal:	None				
Resources:	Resource impact as identified within the report.				
Assurance route					

Report to:	Board Directors
Agenda item:	32-26
Date of meeting:	09 July 2026
Report from:	Abigail Jago, Acting Chief Executive Officer
Report author:	Abigail Jago, Acting Chief Executive Officer Allison Hunter, Strategy Support Officer Kathy Brasier, Deputy Chief Strategy Officer
Date of report:	June 2026
Appendices:	None

Chief Executive Officer (CEO) report

Alert

- **Financial Position**: QVH remains on track at M2 against the financial plan. However there remains financial risk in 2026/27 due to a gap in the Better Value Cost reduction programme. Work is ongoing led by the Interim Chief Finance Officer to develop and deliver schemes to close the remaining gap.
- **Planned Care Performance** is challenged in a number of key areas, including overall waiting list size, the percentage of patients treated within 18 weeks (61.37% against a plan of 62.4%) and the number of patients waiting over 52 weeks. Whilst the Trust achieved its month 1 52 week position (230 patients), pressure remains within a number of services particularly Plastic Surgery. Cancer Performance is also below plan and recovery actions are in place. The current position reflects a combination of increased demand, capacity constraints in some specialities and the need to strengthen operational grip and control across some care pathways. Improving performance remains a key focus, supported by enhanced oversight, strengthened leadership capacity and improvements in waiting list management. Diagnostic performance (DMO1) is below trajectory for month one driven primarily by increased demand for Sleep Services, whilst Diagnostic Imaging remains on track.
- **Organisational Risk**: Key organisational future risks remain the delivery of the financial plan, recovery of planned access standards and ongoing estates related challenges. Whilst overall risk scores remain broadly unchanged focus continues on accelerating risk mitigation.

Assure

- **Quality Account and Annual Reports and Accounts** have been approved by the Board in line with national requirements. The Annual Governance Statement concluded that no significant control issues were identified during the year reflecting sustained progress made to address the financial control and governance issues identified in 2024/25.
- **Capital Delivery**: The Trust successfully delivered its 2025/26 capital programme. Substitution schemes were progressed at year end to mitigate the impact of slippage within the East Grinstead Community Diagnostics Centre (CDC) build programme. Delivery of the 2026/27 capital programme is progressing within the expected financial envelope and will support further reduction in high level estates risks, alongside accelerating the next phase of the Trust's digital transformation programme. The Patient Administration System (PAS) replacement programme remains subject to funding uncertainty and continues to be closely monitored.
- **Delivery of Key Strategic Objectives**: The Trust continues to make progress against its Key Strategic Objectives during 2026/27. Directorate triumvirate teams are developing aligned and deliverable objectives, translating strategic priorities into clear operational actions and outcomes across services.

- **Major Projects:** Delivery of the Community Diagnostic Centre remains on track with an anticipated opening date of October 2026. The programme will increase diagnostic capacity and improve access for local patients.
- **Strategic Partnership:** Progress towards the implementation of the proposed Strategic Partnership remains on track. Assurance processes continue across all organisations.
- **Urgent and Emergency Care** performance remains strong and consistently above national standards

Advise

- **National Oversight Framework (NOF):** QVH's Quarter 4 National Oversight Framework (NOF) position was 42nd out of 134 providers. Referral to Treatment (RTT) performance was the principal factor influencing this position, with sickness absence and staff survey results also contributing. It should be noted that, excluding the impact of Deficit Support Funding, QVH would have been positioned within Segment 1. Performance improvements were seen in productivity and Clostridioides difficile measures during the period. The 2026/27 framework introduces revised metrics with a greater emphasis on delivery against plan, including elective recovery, productivity, financial performance and workforce indicators.
- **Resident Doctors' Pay Deal:** Planned industrial action by Resident Doctors represented by the British Medical Association (BMA) has been stood down following acceptance of a national pay deal. This is a positive development for the NHS and reduces the risk of further disruption to patient care and service delivery.

National and Local Updates

National NHS Policy and Operating Environment

UK Health Bill: The UK Health Bill continues its passage through Parliament and, if enacted, will introduce significant changes to NHS structures, including the abolition of NHS England and the transfer of functions to the Department of Health and Social Care. While the detailed implications for QVH remain subject to parliamentary approval, the proposed changes are expected to further strengthen national performance, productivity and accountability requirements across NHS providers.

10-Year Health Plan: National focus remains on implementation of the NHS 10-Year Health Plan, with particular emphasis on productivity, financial sustainability, elective recovery, neighbourhood health services and digital transformation. The Trust's strategic priorities, including the Community Diagnostic Centre, Patient Administration System implementation and strategic partnership development, remain closely aligned to these national ambitions.

Resident Doctor 10-Point Plan: NHS organisations continue to implement the Resident Doctor 10-Point Plan, which seeks to improve working lives, training experience and retention. QVH continues to perform strongly in this area, with positive feedback from resident doctors and strong assessment results. Work is ongoing to further enhance the experience and wellbeing of resident doctors within the Trust.

Surrey and Sussex Cancer Alliance Annual Review 2025-26

The Surrey and Sussex Cancer Alliance Annual Review 2025/26 highlights continued progress in earlier diagnosis, pathway improvement and innovation, delivered through strong system partnership working. Key developments include increased rates of early-stage diagnosis, targeted screening programmes, streamlined pathways and new tools to support clinical teams. The report also demonstrates a continued focus on personalised care and

improving patient experience. QVH will continue to work closely with Cancer Alliance partners to support delivery of national cancer ambitions and improve outcomes for patients

NHS Oversight Framework (NOF)
The NHS NOF for 2026/27 introduces a more transparent and rules based approach to assessing provider performance, combining delivery against a defined set of metrics with an assessment of organisational capability. There is stronger emphasis on elective recovery, including RTT performance, productivity, workforce and outcomes. Within this context QVH 2025/26 Q4 position shows the Trust remains in segment 3 despite a delivery score that would otherwise place it in a stronger position. This reflects the combined impact of RTT performance pressures and financial constraints rather than underlying quality concerns.

For 2026/27 QVH is no longer in receipt of Deficit Support Funding and will therefore be assessed solely on its performance against NOF measures. The revised framework reinforces the importance of sustained improvements to planned care, access, productivity, workforce indicators and financial delivery throughout 2026/27

Quality and Safety
A targeted recovery programme commenced in May 2026 to review open historical incidents through weekly review meetings. This has resulted in a reduction in the number of open incidents, with themes, learning and actions being identified and shared across the organisation.

Compliance with policy review and renewal processes has improved significantly, with compliance levels now at 92%, demonstrating strengthened governance, oversight and accountability.

Venous Thromboembolism (VTE) compliance remains below the national target of 95%. Following review by the Chief Nursing Officer and Chief Medical Officer, the assessment criteria have been refined to ensure appropriate exclusions are applied. Further training is planned to increase staff awareness, improve the quality of assessments and support sustained improvement in compliance.

Staff Survey
Following publication of the 2025 NHS Staff Survey results, Executive Directors met with all directorates and corporate teams to review the findings and agree priority actions to improve staff experience. Areas of focus include engagement, communication, leadership visibility, speaking up, and staff health and wellbeing.

Action plans have been developed across teams and will be monitored throughout the year to support sustained improvement in staff experience and organisational culture.

The Management Essentials programme and Resilience and Change Management workshops continue to be delivered, alongside targeted coaching interventions where required. These actions are informed by culture reviews and form part of the Trust's ongoing commitment to leadership development, staff engagement and organisational effectiveness.

Staff Engagement
A staff engagement workshop was held on 23 June and attracted 107 attendees, including a strong clinical representation. Colleagues participated in discussions across seven themes: partnerships, digital, estates, continuous improvement, the Better Value Programme, research and innovation, and the Community Diagnostic Centre. The high levels of engagement demonstrated the commitment of colleagues to shaping the future direction of the Trust and supporting delivery of our strategic ambitions.

Celebrating our QVH Team
I am always proud to recognise the achievements of our colleagues and the difference they make for patients, communities and the wider NHS. The following examples highlight the expertise, commitment and values demonstrated by teams across QVH and the external recognition they have received.

Values in Practice (VIP) Award Winners
The Values in Practice (VIP) Awards recognise colleagues who demonstrate our values and help foster a positive and supportive culture across the Trust.

Our April winner, Alex Cash, Consultant Orthodontist, was recognised for embodying the value of *being supportive and challenging over staying comfortable*. He was nominated for his commitment to team wellbeing, creating an inclusive environment where colleagues feel valued, able to speak up and supported to develop.

Our May winner, Greg Livanos, Senior Information Analyst, was recognised for *succeeding together over achieving alone*. He was nominated for his collaborative approach, supporting colleagues in a largely virtual environment and helping build capability across the team.

Nominations have also been received for the Trust's annual Star Awards, with winners due to be announced at the event on Friday 10 July.

Celebrating Our Workforce
Since the last Board, we have had the opportunity to recognise and celebrate many of the professions and teams that make QVH such a special place to work, including International Nurses Day and Operating Department Practitioner Day (12 May), International Clinical Trials Day and International HR Day (20 May), Biomedical Science Day (4 June), National Healthcare Estates & Facilities Day (17 June) and National Children's Nurses' Day (30 June). Each of these occasions has highlighted the expertise, dedication and commitment of our colleagues, demonstrating the breadth of skills and professions that work together to deliver outstanding care for our patients. My sincere thanks go to every member of staff for the contribution they make to our organisation every day.

Regional recognition for digital transformation at QVH
Our Electronic Patient Record (EPR) and Electronic Prescribing and Medicines Administration (EPMA) teams were named runners-up in the Digital Transformation category at the 2026 South East Digital Skills Development Network Awards in May. This recognises the successful implementation of our Archie EPR system and the collaborative approach to its delivery and ongoing optimisation.

QVH colleagues recognised at Buckingham Palace
Four colleagues, Mohamed El-Belihy, Consultant Dental & Maxillofacial Radiologist; Nisa Pinto, Lead Sleep Physiologist and Service Manager; Edline Madzivanyika, Senior Management Accountant; and Rainer Halsall, Site Practitioner, were invited to a Royal Garden Party at Buckingham Palace, recognising their contribution to public service and their communities.

National recognition for support to the Armed Forces community
As part of the ongoing engagement with Defence partners, we hosted a visit from Joint Hospital Group South East on 21 May. The visit provided an opportunity to share more about the Trust, meet our RAF nurses and highlight the important role they play, including hearing positive feedback from a former QVH placement student

In June, QVH was awarded the Defence Employer Recognition Scheme (ERS) Silver Award for 2026, recognising our support for the Armed Forces community, including reservists, veterans and military families. This reflects our ongoing commitment, including signing the Armed Forces Covenant, achieving ERS Bronze and becoming Veteran Aware accredited. The award will be formally presented on 1 July.

Connection with Teams
I have enjoyed continuing to visit and connect with a variety of teams across the period. Visits included spending time with the Workforce Team who are doing great work to digitise services in line with the NHS analogue to digital ambition. This included an informative conversation with Jo Walls, Trust Rostering Lead who was sharing the work underway to digitise roster and rota analysis which will support teams to effectively utilise information to support rostering and ensure best use of resources. Julie Field, Workforce Services Team Leader, shared work underway to support staff in the use of the Manager Self Service digital application that has been implemented in recent months. Finally, Employee Relations Advisors Stefi Flint and Renoskha Nogar who were sharing how they are seeing an increased benefit in cases from managers and staff being able to utilise the Trust Behaviours Framework.

Interim Chief Finance Officer
I would like to welcome Ross Dunworth, Finance Director at Royal Surrey NHS Foundation Trust, who joined us as Interim Chief Finance Officer on 1 June 2026, working across both organisations. This arrangement will strengthen financial leadership and oversight, support closer collaboration, and maintain a strong focus on delivery for our patients and staff.

The Deputy Chief Finance Officer and Deputy Director of Strategic Finance will continue to lead day-to-day operations, ensuring continued stability and continuity.

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

Report cover-page			
References			
Meeting title:	Board of Directors		
Meeting date:	09/07/2026	**Agenda reference:**	**33-26**
Report title:	Integrated Quality and Performance Report Month 1		
Sponsor:	Abigail Jago, acting Chief executive officer		
Author:	Ashley Hunt, Deputy Chief Operating 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 2026/27		
Summary of key issues	**KSO1** - The Trust has entered 2026/27 below trajectory for key access standards, having finished M12 below the planned Month 1 position for 2026/27, which has contributed to the current position alongside ongoing outpatient capacity constraints, pathway flow challenges and demand growth. RTT performance is 61.37% against a plan of 62.4%, with performance impacted by increased demand within Sleep and OMFS services. The >65 week position stands at 34 patients, predominantly within Plastics, particularly breast reconstruction pathways. The Trust achieved the 52-week position in M1 at 230 patients, however there is a deterioration risk into M2 driven by Plastics and OMFS services being off plan. The overall RTT waiting list size remains above plan, requiring focused validation to mitigate further growth. Cancer performance is below plan in M1, with FDS at 76.7% (plan 81.7%) and 62-day performance at 71.4% (plan 75.7%), reflecting reduced Head & Neck outpatient capacity alongside diagnostic and treatment constraints. Diagnostic performance is also below trajectory, with DM01 at 87.7% and waiting times for sleep diagnostics extending to approximately 20 weeks due to increased demand for overnight diagnostics. Urgent and Emergency Care performance remains strong and consistently above national standards. Overall, the position reflects demand and capacity pressures within Plastics, Sleep and OMFS pathways at the start of the year, with recovery required to return performance to plan. **KSO 2** – Research, innovation and continuous improvement activity continues to progress in line with the Trust's strategic objectives. Development of the Research, Innovation and Education Centre is underway, with agreed principles focused on improving accessibility for staff, strengthening collaboration and supporting engagement with academic and commercial opportunities. The Trust has secured National Institute for Health Research (NIHR) funding and further opportunities are being pursued, alongside investment in clinical research capability and partnerships with academic organisations. The QVH Way continuous improvement programme is now progressing into its sustain phase, with over 80 staff trained in improvement methodologies and increasing application of these approaches to operational and quality challenges. Activity to refresh improvement huddles and expand experience-based co-design is supporting front line teams to identify and deliver improvements in patient care. Draft quality priorities for 2026/27, aligned to outcomes, health inequalities and patient experience, are in development alongside the audit plan, providing a clear framework for ongoing quality improvement and assurance. Overall, work under KSO2 is supporting the development of a stronger improvement culture and enhanced capability to deliver sustainable quality improvement.		

	KSO 3 – Workforce performance in M1 remains stable overall, with a number of improving indicators alongside some ongoing areas of pressure. Staff in post are slightly above plan and vacancy rates remain below target at 6.8%, although pressures persist in key clinical areas including Plastics, Theatres and the Canadian Wing. Time to hire has improved significantly to an average of 25.7 days, supporting workforce stability, while bank and agency usage have reduced, indicating improved efficiency. Sickness absence remains above the 3% target at just over 4%, with sustained levels of long-term absence continuing to impact operational resilience, particularly within theatres, therapies and support services. Turnover has increased slightly to 11.3%, with higher levels in Corporate and clinical divisions. Appraisal compliance has reduced marginally to 82.3%, remaining below the 90% target, although the number of long overdue appraisals has improved. Mandatory training compliance remains above target at 90.5%, with some variation across key modules. Overall, the workforce position is stable, with improvements in recruitment and temporary staffing usage, however sustained sickness absence and areas of vacancy continue to present challenges. **KSO 4** – The Trust reported a Month 1 deficit of £0.248m, slightly ahead of the planned deficit of £0.252m, with a cash position of £14.1m, reflecting a stable in-month financial position. Income performance is aligned to plan, although there remains some volatility due to activity assumptions and underperformance in areas including the Community Diagnostic Centre, Plastics and daycase activity, partially offset by increased sleep outpatient activity. Pay expenditure is above plan, driven by pay awards and the partial delivery of efficiency schemes, while non-pay expenditure is favourable due to reduced spend across Digital, Estates and Theatres. Delivery of the Better Value Programme is on plan for M1, although further acceleration is required to support delivery of the full year requirement. Capital and transformation programmes continue to progress, including the Community Diagnostic Centre, estates infrastructure schemes and the digital transformation programme; however, there remain delivery risks associated with programme dependencies, funding assumptions and system readiness, particularly in relation to PAS, Radiology and the Sussex Pathology Network. Overall, the financial position remains stable at this stage of the year, with continued focus required on delivery of activity, efficiencies and programme milestones to support the achievement of the Trust's breakeven position. **KSO5** – Strategic partnership development and system collaboration continue to progress, alongside delivery of key programmes such as Community Diagnostic Centre (CDC) and Single Point of Access (SPOA) pathways. Focus remains on strengthening engagement, integration and system-wide pathway development.				
Recommendation:	The Trust Board is requested to review the Month 1 IQ&PR position				
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:	BAF 1 – Outstanding patient Care. BAF 4- long term sustainability (the IAF supports the delivery of the Trust's strategy BAF5- compliance				
Corporate risk register:	The IQPR reflects the risks on the organisational risk register.				

Regulation:	ICS, NHS England, CQC			
Legal:	None			
Resources:	None			
Assurance route				
Previously considered by:	Finance & safety committee Quality & safety committee			
	Date:	June 2026	Decision:	Progress to Board
Next steps:				

Queen Victoria Hospital
NHS Foundation Trust

Queen Victoria Hospital

Integrated Quality and Performance Report

Month 1: April 2026

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-26	£0.25m (deficit)	£0.25m (deficit)	£0.01m	The Trust's Income and Expenditure position was in line with the planned in month	
RTT 18 Week Wait Performance	69.4%	Apr-25	62.4%	61.37%	61.85%	Not achieving target in month and Q1 looks challenged.	
Cancer 62 days	80%	Mar-26	71.8%	81.55%	88.41%	Achieving target. Common cause – no significant change	
% Overall FFT Recommendation Rate	90%	Apr-26	90%	94.80%	94.74%	Achieving target. Special cause - concerning variation.	
Trust sickness rate – Rolling 12 months	3%	Apr-26	4.00%	4.31%	4.19%	Not achieving target in month. Special cause - concerning variation.	

Major Project	This Month	Overall Status	Last Month	Summary
To deliver the Community Diagnostic Centre (CDC) programme at East Grinstead		On track		Steel works, roof and slab works completed. Work nearly completed on making the building watertight.
Strategic Partnership Transition and Implementation		On track		In line with good governance, shared planning and analysis processes need to be followed to ensure each Board has the necessary assurance in place in order to finalise next steps
To deliver the **Digital Transformation** Programme		In progress		3 out of 15 projects are currently red; PAS, SPN and Radiology system procurement. Resource risk.
To deliver the **Key Estates Infrastructure Projects (MRI scanner, RI&E Hub)**		On track		Task and finish groups set up for both MRI and RI&E Hub. Engagement with design company on MRI.

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 2026/27.

Alert

- **RTT performance** is 61.37% in M1 against a trajectory of 62.4% (-1%), reflecting a deterioration from M12, driven by sustained outpatient capacity constraints impacting pathway flow and recovery.
- **65 Weeks:** 34 patients remain over 65 weeks in M1, with ongoing risk due to continued late tertiary referrals (c.4 per month), increasing the backlog to 11 non-breast patients in M2.
- **52 Weeks:** Although 230 patients were reported in M1, the position is challenged, with significant growth in the 40–51 week cohort (825 to 1,160) indicating an escalating pipeline risk into 52-week breaches.
- **DM01:** Performance deteriorated to 87.7% in M1 (down from 88.89% in M12), with waiting times for sleep diagnostics increasing to approximately 20 weeks, reflecting demand outstripping capacity.
- **FDS:** Performance achieved 76.7% in M1 against a plan of 81.7%, driven by reduced Head & Neck workforce and outpatient availability. Recovery is expected from M2 as capacity is restored.
- **62 Day:** Performance fell significantly to 71.4% in M1 against a plan of 75.7% (down from 83.37% in M12), across all tumour sites reflecting system-wide capacity constraints.
- **31-day:** Performance declined to 83.8% in M1 against a plan of 85.4%, driven by sustained theatre capacity and Sentinel Lymp Node Biopsy (SLNB) limitations impacting treatment timeliness.

Assure

- Strategic Partnership development continues, through a period of shared planning, analysis, and assurance.
- Diagnostic performance is broadly on trajectory, with mitigating actions in place (e.g. pathway review and alternative diagnostic approaches).
- Financial performance is in line with plan for M1, with delivery of efficiency requirements supporting stability.
- Strategic programmes (CDC delivery, estates and digital transformation) are progressing and will support future capacity and pathway resilience.

Advise

- The steel framework installation, concrete flooring and roof has been completed at the East Grinstead Community Diagnostic Centre (CDC) site. Work is ongoing to make the building water-tight.
- The Trust is entering 2026/27 from a challenged starting position, requiring accelerated recovery to deliver operational trajectories.
- Priority focus is required on RTT delivery, with particular emphasis on reducing the 40–51 week cohort to prevent deterioration in long waits.
- Targeted response to demand growth (notably Sleep services) is required, including pathway redesign and capacity optimisation.
- Sustained grip on cancer pathways is required to maintain compliance, given limited resilience and dependency on diagnostics.
- Delivery confidence will depend on improving elective throughput, including theatre utilisation, CDC recovery, and diagnostic capacity alongside continued financial discipline.

Abigail Jago
Acting Chief Executive Officer

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

2026/27 Annual Objectives

1. Delivery of Access Targets (Referral to Treatment (RTT), Cancer, Urgent and Emergency Care (UEC), Diagnostics (DMO1) delivery, including the National Cancer Plan
2. Strategic Service Reviews for burns, prosthetics and breast in liaison with commissioners
3. Quality priorities: Health Inequality Did Not Attend (DNA) & Access, Patient Schools, Outcomes & Effectiveness measures

2026/27 Annual goals

1. RTT – 18 week performance to meet 69% by March 2027. Cancer – FDS performance to meet 80% throughout 2026/27. By March 2027, 31 day performance to meet 94% and 62 day performance to meet 80%. DM01 performance to meet 92% by March 2027. UEC performance to be maintained above 98% throughout 2026/27.
2. Sustained reduction in patients waiting over 52 weeks by 1%
3. Completion of service reviews and outcomes (burns - September 2026, prosthetics - October 2026, breast - March 2027)
4. Maintain leading national positions in the adult inpatient survey, children and young peoples survey and the national cancer patient experience survey
5. Achievement of above the national average for all 8 domains of the Patient-Led Assessments of the Care Environment (PLACE) inspection.

KSO1 EXECUTIVE SUMMARY

Queen Victoria Hospital
NHS Foundation Trust

General summary
Month 1 reflects a challenging starting position for delivery of the 2026/27 operational plan, with the Trust entering the year off trajectory for key access standards. Whilst there has been progress in reducing long waits, overall elective and cancer performance remains under pressure, presenting a delivery risk.

Delivery of Access Targets
- **RTT performance** declined by 0.5% in M12 and remains below trajectory in M1 at 61.37% against 62.4%, driven by constrained first outpatient capacity resulting in waits exceeding 18 weeks, alongside increased demand pressures including growth in Sleep referrals; recovery actions are focused on expanding capacity, implementing a Single Point of Access model and progressing Straight to Test pathways.
- There were 34 patients waiting over **65 weeks** in M1, including 6 non-breast cases, with backlog growth continuing into M2 (11 patients) driven by ongoing late tertiary referrals from other acute providers (c.4 per month) and data quality challenges impacting non-breast pathways.
- The Trust achieved the **52-week** position in M1 with 230 patients; however, deterioration is expected in M2–M3 due to Plastics backlog and Breast capacity constraints, with growth in the 40–51 week cohort (825 to 1,160) indicating increasing pipeline risk.
- **Diagnostic** (DM01) performance has declined due to sustained growth in demand for overnight sleep studies, resulting in extended waiting times (circa 20 weeks) and placing additional pressure on outpatient pathways.
- **Cancer FDS** performance in M1 was 76.7% against a plan of 81.7%, primarily due to reduced Head & Neck first appointment capacity during March and April, although performance is expected to recover in M2 as capacity is restored.
- **62-day** performance declined to 71.4% in M1 against a plan of 75.7%, driven by increased breaches across Skin, Head & Neck and Breast pathways, reflecting capacity constraints across diagnostics and treatment stages.
- **31-day** performance was 83.8% in M1 against a plan of 85.4%, with breaches concentrated in Skin and Breast pathways and primarily driven by ongoing theatre capacity (SLNB)limitations.

Key Risk Summary:
- Delivery risk to RTT recovery trajectory
- Emerging sustainability risk within cancer pathways
- Underlying demand and capacity constraints impacting performance

Quality Priority Delivery (Health Inequalities (HI), Did Not Attend (DNA) & Access, Patient Schools, Outcomes & Effectiveness measures)
Continued focus on reducing inequalities in access (DNA, deprivation, ethnicity) and improving pathway effectiveness.

Kirsten Timmins
Chief Operating Officer

Liz Blackburn
Acting Chief Nursing Officer

KSO1 BALANCED SCORECARDS

QUALITY & SAFETY METRICS

Queen Victoria Hospital
NHS Foundation Trust

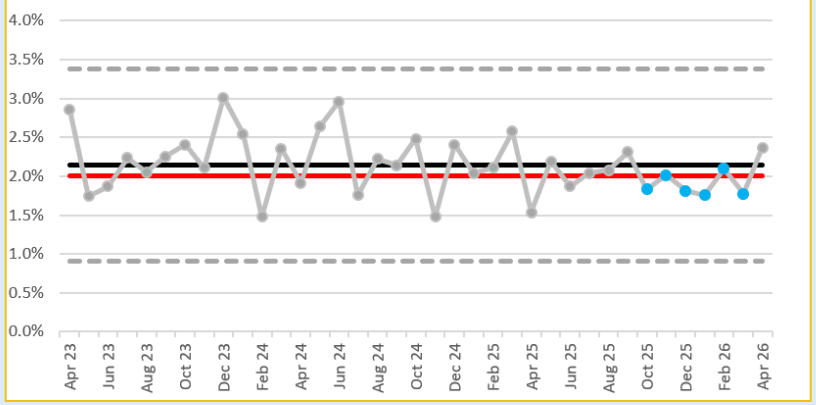
Metric	Latest Month	Target	Variation	Assurance	Actual	Actual Previous Month	Mean	LCL	UCL	Summary
Ethnicity recording	Apr-26	95%			85.12%	83.92%	81.26%	78.63%	83.89%	Special Cause - improving variation
Care Hours Per Patient Day (CHPPD)	Apr-26				11.5	11.1	13.29	10.23	16.35	Special Cause - concerning variation
Falls per 1,000 Occupied Bed Days	Apr-26	7			6.2	1.2	3.92	-3.45	11.28	Common cause - no signficant change
Hospital Aquired PU Per 1,000 Occupied Bed Days	Apr-26	0			1.2	1.2	0.75	-1.69	3.19	Common cause - no signficant change
% Complaints Responded On Time	Apr-26	90%			100.00%	72.73%	91.79%	64.84%	118.75%	Common cause - no signficant change
Safer Staffing Compliance	Apr-26	90%			100.00%	99.87%	99.66%	98.56%	100.75%	Common cause - no signficant change
% Overall FFT Recommendation Rate	Apr-26	90%			94.80%	94.74%	95.22%	94.42%	96.01%	Special Cause - concerning variation
% Overall FFT Response Rate	Apr-26	25%			21.66%	18.92%	20.42%	17.15%	23.69%	Common cause - no signficant change
Readmissions< 30 Days	Apr-26	2%			2.37%	1.77%	2.14%	0.90%	3.38%	Common cause - no signficant change
VTE Risk Assessment	Apr-26	95%			78.62%	76.38%	92.85%	82.67%	103.04%	Special Cause - concerning variation

Metric	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Apr-26
Number of Complaints	7	4	6	7	6	9	9	9	9	6	6	10	8	9	9
Number of Open CAS Alerts	0	0	0	0	0	1	0	0	0	1	1	2	1	1	1
Number of Patient Falls Incidents	2	4	1	5	4	5	4	1	2	2	2	1	3	1	5
Number of QVH Acquired Pressure Ulcers Cat. 2 and above	0	4	2	0	2	1	1	1	0	0	0	0	0	1	1
Never Events declared	0	1	0	1	0	0	0	0	0	1	0	0	0	0	0
Medication Incidents (No and low harm)	8	12	9	6	10	15	12	12	4	10	10	16	35	31	27
Medication Incidents (Moderate harm or above)	0	0	0	0	0	0	1	0	0	0	0	0	0	0	0
Internal Investigation declared	1	0	0	0	0	0	1	0	0	0	1	1	0	0	0
Patient safety incident investigations declared	0	0	0	0	1	0	0	0	0	0	0	0	0	0	0
Mortalities	0	1	1	0	0	1	0	0	0	0	0	0	0	0	0
Hospital Acquired CDI, MRSA, E.Coli, MSSA	1	1	0	1	0	1	0	0	0	0	0	0	0	0	0
Occupied Bed Days	893	991	781	848	800	933	704	739	860	778	676	799	721	821	806
Oliver McGowan Training Compliance	92.3%	91.8%	91.9%	91.5%	91.8%	92.2%	92.4%	92.9%	92.4%	93.1%	93.1%	93.7%	93.3%	93.6%	93.9%

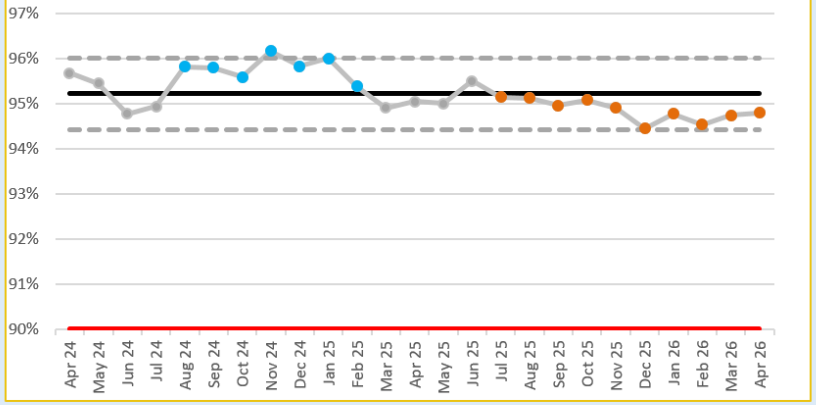
QUALITY & SAFETY METRICS

Queen Victoria Hospital
NHS Foundation Trust

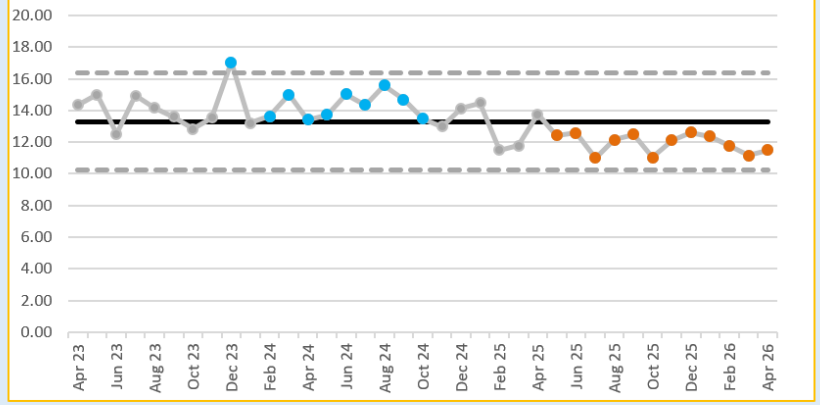
Readmissions< 30 Days



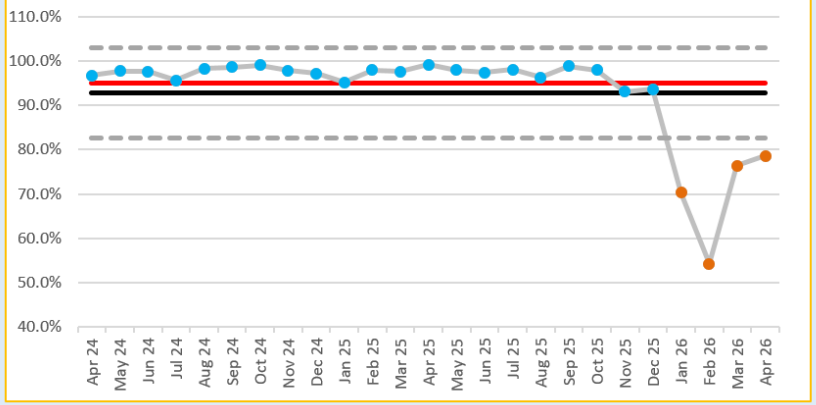
% Overall FFT Recommendation Rate



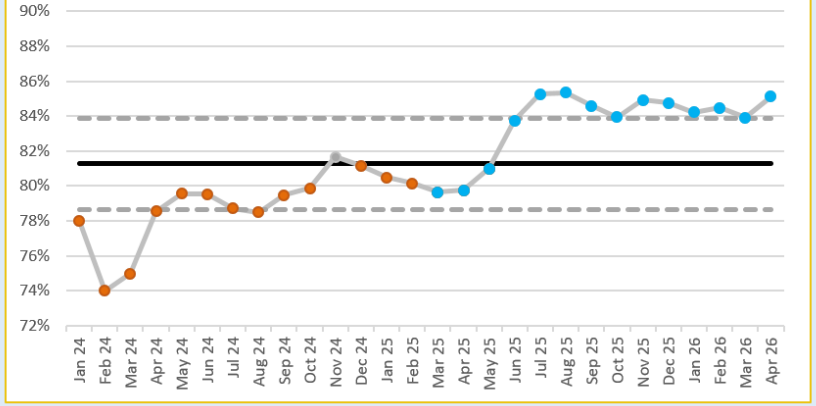
Care Hours Per Patient Day (CHPPD)



VTE Risk Assessment



Ethnicity Recording



Safer Staffing Compliance - Trust

	Planned staff			Actual staff			April 2026
DAY	RN	NA	HCA	RN	NA	HCA	
	3,714.50	115.00	1,311.00	3,714.50	115.00	1,311.00	*Total Hrs Planned and Actual*
				100.0%	100.0%	100.0%	*% Planned Hrs Met*
			5,140.50			5,140.50	*Total Hrs Planned & Actual - Combined reg & support*
						100.00%	*% Planned Hrs Met - Combined reg & support*
NIGHT	**Planned staff**			**Actual staff**			
	RN	NA	HCA	RN	NA	HCA	
	3,197.00	80.50	782.00	3,197.00	80.50	782.00	*Total Hrs Planned and Actual*
				100.0%	100.0%	100.0%	*% Planned Hrs Met*
			4,059.50			4,059.50	*Total Hrs Planned & Actual - Combined reg & support*
						100.00%	*% Planned Hrs Met - Combined reg & support*
Combined	**Planned staff**			**Actual staff**			
	RN	NA	HCA	RN	NA	HCA	
	6,911.50	195.50	2,093.00	6,911.50	195.50	2,093.00	*Total Hrs Planned and Actual*
				100.0%	100.0%	100.0%	*% Planned Hrs Met*
			9,200.00			9,200.00	*Total Hrs Planned & Actual - Combined reg & support*
						100.00%	*% Planned Hrs Met - Combined reg & support*

SPC Chart Key:

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

KSO1 AREAS OF FOCUS

Queen Victoria Hospital
NHS Foundation Trust

Area	Summary, impact, and actions
Ethnicity Recording	Ethnicity data completeness measures the proportion of patient records with a recorded ethnicity. Following targeted improvement work last year, completeness has increased and is currently stable at 84.74%. This remains below the 95% standard, and improving data completeness continues to be a priority to support robust inequalities analysis. Targeted areas for improvement include Outpatient Plastics, Maxillofacial and therapies. There will also be a focus on training development internally and with the Integrated Care Board (ICB).
Falls	Four inpatient falls noted within one clinical area and involving two patients. Full falls assessments completed and appropriate measures in place to support the further risk of falling. 1 fall within the theatres complex. All falls noted to result in low or no physical harm.
Pressure ulcers	One pressure ulcer caused by friction from medical device (splint). Wound completely healed within one week. All appropriate risk assessments and actions taken.
% Complaints Responded On Time	Nine patient complaints reported in month, general themes noted include communication and pathway concerns, all complaints are currently under investigation. 100% complaints were responded to within the 30 day timeframe.
Safer Staffing Compliance / Care Hours Per Patient Day (CHPPD)	Our safer staffing compliance is at 100%, and for 2026/27 the Care Hours per Patient Day (CHPPD) metric will be monitored as an additional metric. CHPPD measures the average number of care hours provided to each patient in a 24-hour period, over the past 12 months, there has been a reduction in the CHPPD noted. This reflects the bed reconfiguration and subsequent revised staff deployment with no impact noted to patient safety or quality.
Never Events	None
Mortalities	None
% Overall FFT (Friends & Family Test) Recommendation Rate	Overall FFT recommendation rate is 94.8% and above the national target of 90%.
Venous Thromboembolism (VTE) Risk Assessment	2% improvement noted in compliance with VTE at 78.6%. Review of assessment criteria in progress. Harm being monitored and no harm reported.
Mental Capacity Act (MCA)	The Task & Finish Group has closed with all change actions complete. A monthly audit has been established to monitor ongoing learning and continuous improvement which will continue to be overseen by the Chief Medical Officer (CMO).

KSO1 BALANCED SCORECARDS

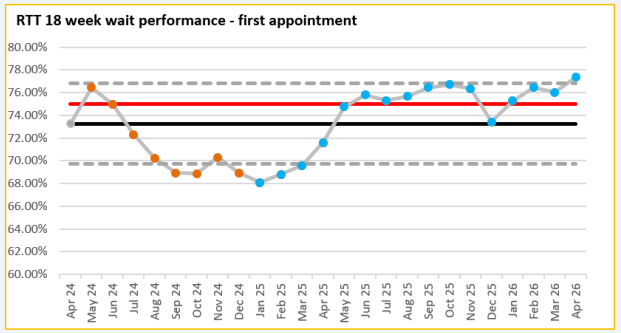
Queen Victoria Hospital
NHS Foundation Trust

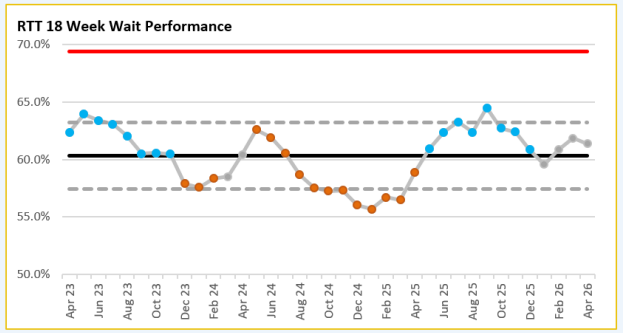
OPERATIONAL PERFORMANCE METRICS

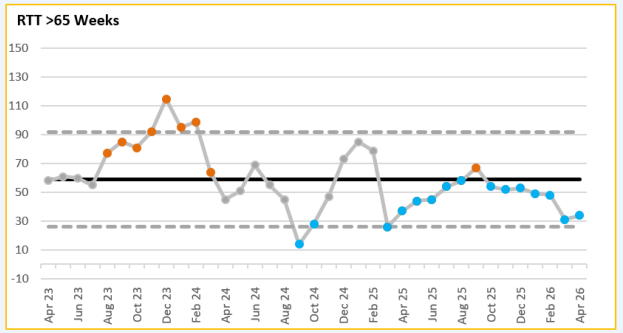
Metric	Latest Month	Target	Variation	Assurance	Actual	Actual Previous Month	Mean	LCL	UCL	Summary
RTT 18 week wait performance - first appointment	Apr-26	75.00%			77.34%	76.01%	73.27%	69.73%	76.82%	Special Cause - improving variation
RTT 18 Week Wait Performance	Apr-26	69.40%			61.37%	61.85%	60.32%	57.46%	63.19%	Common cause - no signficant change
RTT Waiting List	Apr-26	-			21,369	20,841	18632.65	17854.30	19410.99	Special Cause - concerning variation
RTT >40 Weeks	Apr-26	-			1,359	2,478	1458.84	1124.86	1792.82	Common cause - no signficant change
RTT >52 Weeks	Apr-26	-			230	226	383.41	310.33	456.48	Special Cause - improving variation
RTT >52 Weeks as a proportion of Waiting List	Apr-26	1.00%			1.08%	1.08%	2.08%	1.71%	2.44%	Special Cause - improving variation
RTT >65 Weeks	Apr-26	-			34	31	59.05	26.10	92.01	Special Cause - improving variation
CDC activity vs plan	Apr-26	100.00%			87.00%	61.58%	85.48%	42.98%	127.98%	Common cause - no signficant change
% Income Vs Plan	Apr-26	100.00%			94.23%	97.63%	99.59%	89.57%	109.61%	Common cause - no signficant change
Cancer 28 Day FDS	Mar-26	81.50%			83.37%	86.28%	82.09%	70.90%	93.28%	Common cause - no signficant change
Cancer 31 Days	Mar-26	94.00%			88.67%	82.26%	86.18%	76.18%	96.19%	Common cause - no signficant change
Cancer 62 Days	Mar-26	80.00%			81.55%	88.41%	77.62%	63.11%	92.13%	Common cause - no signficant change
Outpatient Productivity - Patient Initiated Follow Ups (PIFU)	Apr-26	2.00%			1.92%	1.72%	1.82%	1.27%	2.37%	Common cause - no signficant change
Outpatient Productivity - Missed Appointment Rate	Apr-26	4.00%				5.93%	5.31%	4.65%	5.96%	Common cause - no signficant change
Diagnostics 6 Week Wait Performance	Apr-26	92.00%			87.70%	88.89%	86.62%	78.77%	94.46%	Special Cause - improving variation
UEC 4 Hour Performance	Apr-26	98.00%			99.49%	98.69%	99.19%	97.70%	100.69%	Common cause - no signficant change
Theatre Productivity - % of Cancellations on the Day	Apr-26	5.00%			5.32%	4.89%	4.97%	1.24%	8.70%	Common cause - no signficant change
Theatre Elective Utilisation - QVH Site (Capped)	Apr-26	85.00%			80.25%	80.38%	82.11%	77.29%	86.94%	Special Cause - concerning variation
NHS App appointments available	Apr-26	70.00%			85.76%	85.02%	84.68%	83.03%	86.32%	Common cause - no signficant change

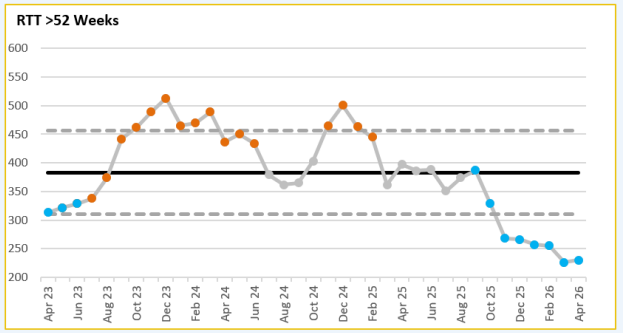
OPERATIONAL PERFORMANCE METRICS

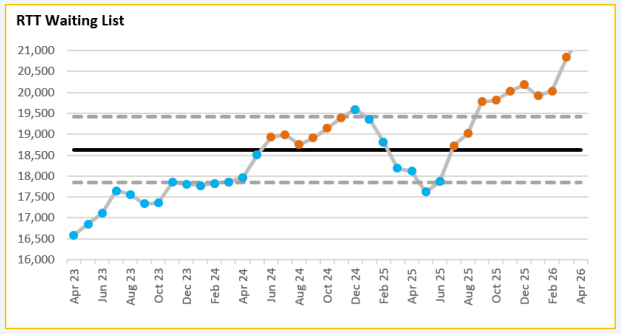
Queen Victoria Hospital
NHS Foundation Trust

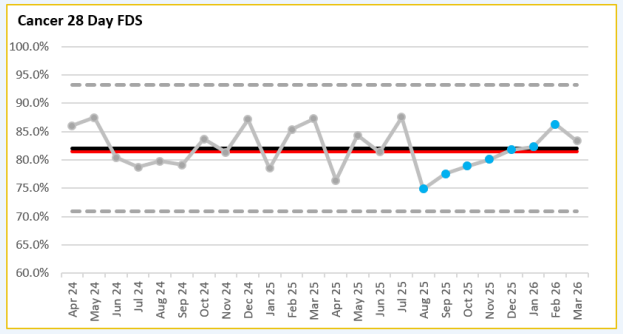


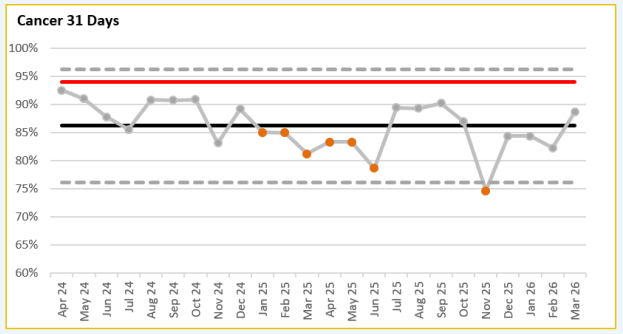


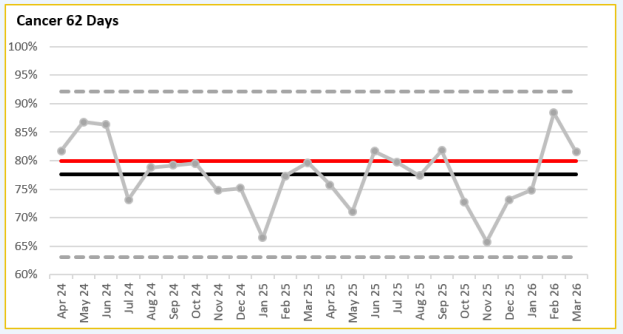


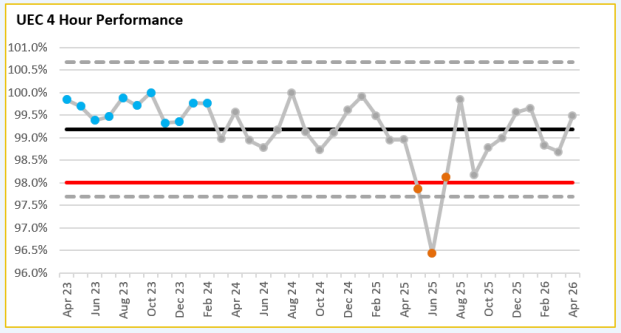


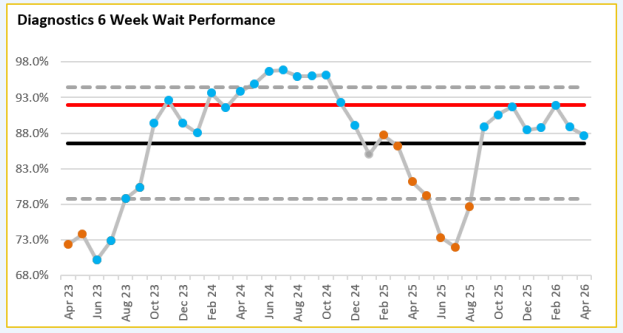


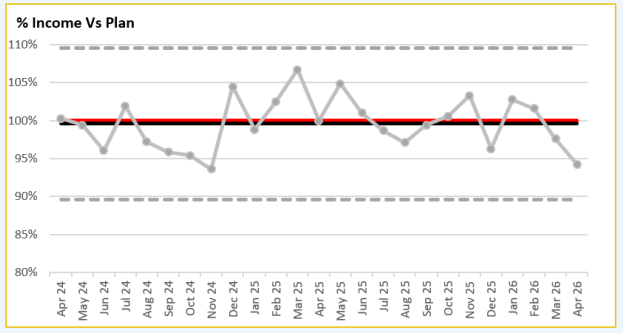


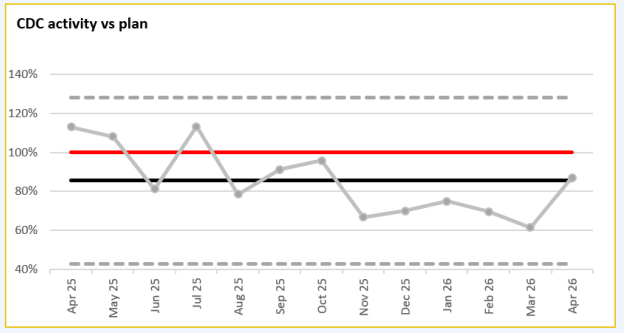












Trajectories- Operational performance

Queen Victoria Hospital NHS Foundation Trust

RTT	M1	M2	M3	M4	M5	M6	M7	M8	M9	M10	M11	M12
Waiting List Size	20,094	20,141	20,256	20,520	20,531	20,603	20,788	21,035	21,121	21,337	21,349	21,181
52ww (% of WL)	230 1.1%	226 1.1%	218 1.1%	215 1.0%	215 1.0%	210 1.0%	210 1.0%	210 1.0%	210 1.0%	210 1.0%	210 1.0%	210 0.99%
18 week wait Performance 1st appointment	75%	75%	75%	75%	75%	75%	75%	75%	75%	75%	75%	75%
18 week performance	62.4%	64.0%	63.2%	63.2%	63.3%	63.4%	65.0%	66.5%	66.0%	66.5%	67.3%	69.4%
Cancer (reported a month in arrears)	**M1**	**M2**	**M3**	**M4**	**M5**	**M6**	**M7**	**M8**	**M9**	**M10**	**M11**	**M12**
FDS	81.7%	81.4%	82.0%	82.0%	80.9%	80.0%	81.1%	81.3%	80.0%	80.0%	81.0%	81.5%
31 days	85.5%	87.2%	84.9%	87.6%	87.7%	89.1%	89.0%	88.0%	89.7%	90.8%	91.5%	94.0%
62 days	75.7%	75.9%	77.5%	77.8%	73.6%	78.4%	77.6%	77.9%	75.0%	72.4%	78.3%	80.0%
Diagnostics	**M1**	**M2**	**M3**	**M4**	**M5**	**M6**	**M7**	**M8**	**M9**	**M10**	**M11**	**M12**
Within 6 weeks	90.2%	90.8%	91.0%	91.3%	90.9%	91.1%	91.6%	91.1%	91.1%	91.7%	91.9%	92.0%
UEC	**M1**	**M2**	**M3**	**M4**	**M5**	**M6**	**M7**	**M8**	**M9**	**M10**	**M11**	**M12**
4 hr standard	98.3%	98.1%	98.1%	98.1%	98.6%	98.0%	98.4%	98.3%	98.4%	98.5%	98.3%	98.3%

Key

Performance achieved trajectory

Performance did not achieve trajectory

Benchmarking - Operational performance

Queen Victoria Hospital
NHS Foundation Trust

Group	Metric	Value	Latest Month	Specialist Rank	Specialist Rank (out of)	England Rank	England Rank (out of)
A&E / Minor Injury Unit	All 4 Hour Waits Performance	99.49%	Apr-26	1	3	3	139
Cancer Treatment	FDS Performance	83.44%	Mar-26	5	12	38	133
	31 days Performance	88.67%	Mar-26	12	13	12	134
	62 days Performance	81.55%	Mar-26	8	13	36	135
Diagnostics (DM01)	Under 6 Weeks Performance	88.89%	Mar-26	12	13	55	154
Referral To Treatment	Within 18 Weeks Performance	61.85%	Mar-26	12	13	121	150

Source: *NHS England Statistical Work Areas website; NHS Trusts Only - 'Community and Mental Health', 'Acute' & 'Specialist' English patients only so will be a sub-set of actual Trust performance figures (apart from A&E)*

KSO1 AREAS OF FOCUS

Queen Victoria Hospital
NHS Foundation Trust

Area	Summary, impact and actions
RTT> 65 week waits	• M1 position of 34 patients of which 28 are breast reconstruction, the remaining 6 (1 x Dermatology, 1x Facial Palsy, 3 x Skin and 1 x Orthodontics) are due to late referrals and pathway management issues. • Works continues to ensure appropriate allocation of long waiters with partners. • M2 forecast is 42 patients (39 Plastics and 3 OMFS). Work is underway to develop in year forecast.
RTT>52 week waits	• M1 delivery at 230 patients achieved in line with plan. M2 forecast is 260 patients vs plan of 226. Pressures within OMFS and plastics. • Forward look risk for delivery given increasing cohort of 40-51 week patients which is 6% greater than May 2025 • Mitigation: Targeted validation to minimise patient moving to 52 weeks cohort
RTT 18 Week Wait Performance	• M1 performance at 61.37% vs 62.4% trajectory. Drivers include the impact of non-delivery of year end position impacting 26/27 baseline position, first outpatient capacity constraints and pathway management challenges in some services. Waiting list recovery action plan in place to strengthen consistency of PTL oversight. • Risk to recovery trajectory to be mitigated by SPOA implementation, optimise Straight to Test pathways, increase outpatient capacity to reduce the wait for 1st appointments and strengthen PTL management
RTT Waiting List	• Waiting list at 21,369 vs plan of 20,094, reflecting continued growth driven by referral demand exceeding treatment capacity. • Demand and capacity models to be refreshed, pathway redesign to be undertaken as part of recovery plan.
Cancer 28 Day FDS	• M1 performance 71.67% against a plan of 81.7 % driven by Head & Neck first appointment capacity. • Capacity restoration planned from M2, with focus on first appointment standard and diagnostic turnaround.
Cancer 31 Days	• Performance in M1 impacted by treatment capacity constraints, particularly for specialist procedures within plastic surgery including Sentinel Lymph Node Biopsy for melanoma patents and immediate breast reconstruction.
Cancer 62 Days	• M1 performance of 71.4% against a plan of 75.7%. Gap reflects multi-stage pathway delays, including diagnostics, treatment and cross-provider pathways. Skin pathway action plan and review of spoke site capacity in progress.
Diagnostics 6 Week Wait Performance	• Current performance 87.7% vs trajectory of 90.1%, with increasing waiting times driven by Sleep overnight diagnostics. Work in progress to partially mitigate gap through home testing options where clinically appropriate.
Minor Injuries Unit (MIU) 4 Hour Performance	• Performance consistently above 98%, demonstrating stable performance position
% Income Vs Plan	• M1 income broadly aligned, with ~£0.1m adverse variance driven by 86% delivery in Plastics, 90% Maxillofacial and CDC, partially offset by over performance in sleep activity.

KSO1 AREAS OF FOCUS

Queen Victoria Hospital
NHS Foundation Trust

Area	Summary, impact and actions
% CDC activity vs plan	• M1 delivery at ~87% activity / 85% income, below plan with recovery expected in Q2 as additional pathways go live. Drivers include demand challenges. Additional pathway implementation in progress.
Theatre capped utilisation	• Separate slide

THEATRE UTILISATION

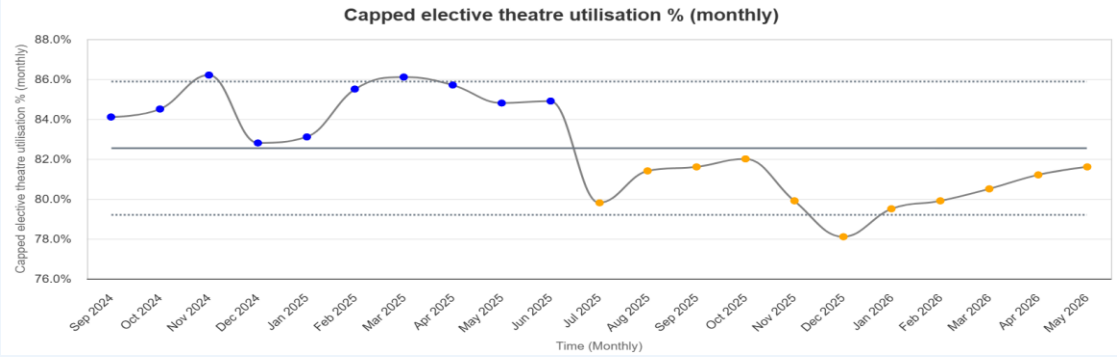
Queen Victoria Hospital
NHS Foundation Trust

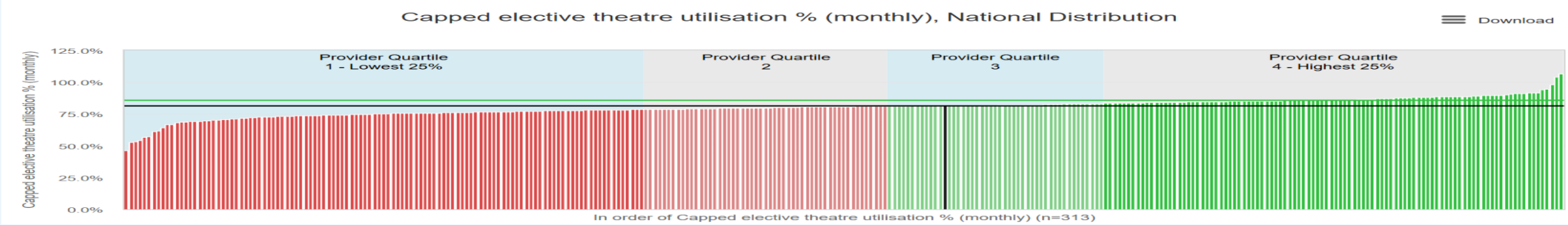
OPERATIONAL PERFORMANCE

- Utilisation improved from 77% (Nov 2025) to 81.6% (May 2026)
- Initial decline driven by data quality issues (ORSOS → Archie), now stabilised
- Improved data validation and operational oversight strengthening reporting accuracy
- Perioperative Flow & Productivity Programme chaired by Clinical Director with clear governance structure in place and focused workstreams to improve theatre utilisation
- Weekly specialty reviews with Maxillofacial and Corneo to review last weeks activity and identify actions to drive utilisation
- Monthly review of all cancellations on the day in place
- Standby patient pilot pathway launched June 2026 delivering additional activity on existing theatre lists. Ongoing PDSA cycle to further enhance the pathway.

Productivity - headline metrics	Data period	Site value	Peer average	National value	National value method	Chart
Capped elective theatre utilisation % (monthly)	May 2026	81.6%	N/A	81.3%	Provider median	

Queen Victoria Hospital (East Grinstead) Site — Select chart type: SPC

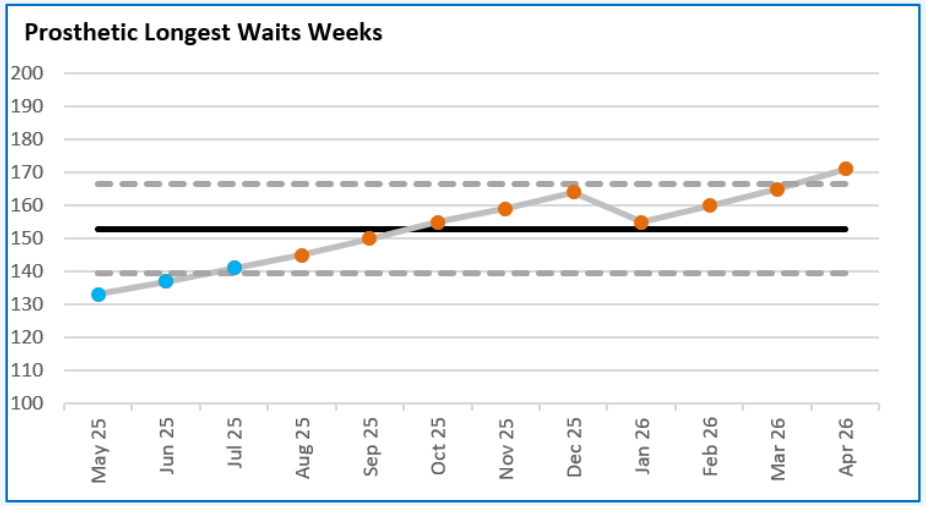


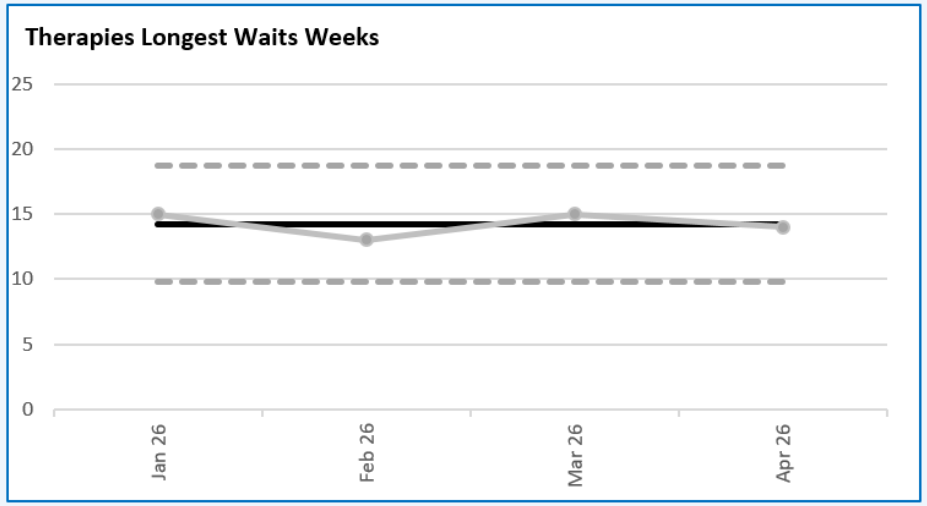


KSO1 BALANCED SCORECARD

Queen Victoria Hospital
NHS Foundation Trust

OPERATIONAL PERFORMANCE METRICS - Prosthetics and Therapies



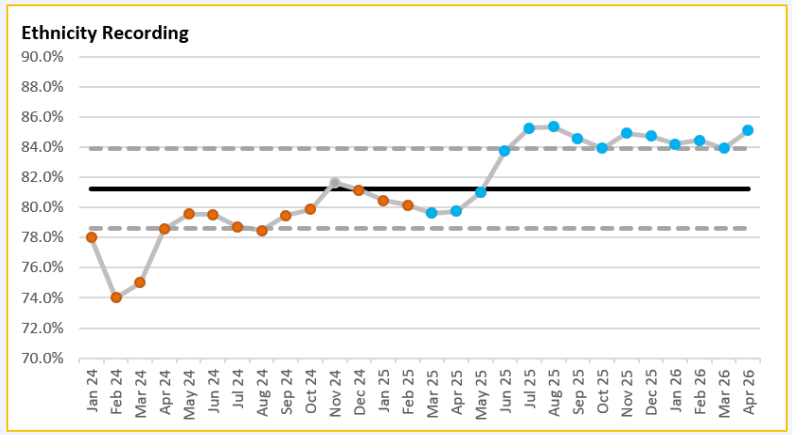


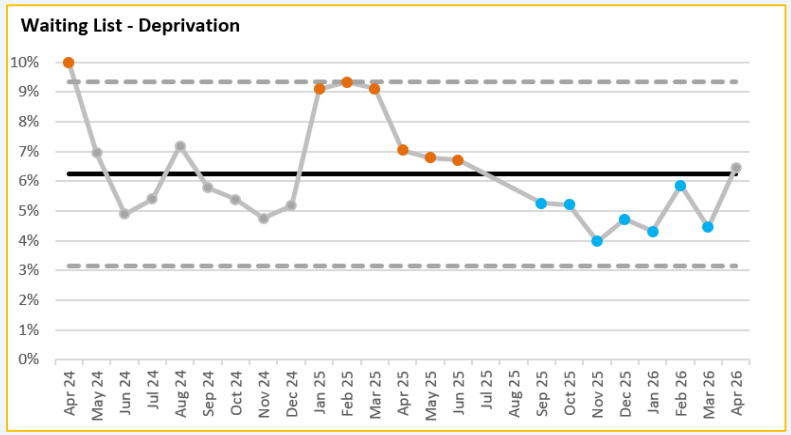
Area	Summary, impact and actions
Non-RTT Prosthetics longest week waits	At current rate of progression, longest wait will be c.250 weeks by June 2028.
Non-RTT Therapies longest week waits	At the end of Month M1, the Trust had 420 patients on the waiting list which was an increase from M12 for a first consultation within therapist led clinics, with the longest wait at 17 weeks. Caseload reviews and current recruitment drive ongoing to address capacity gap in vulnerable services inc. Speech and Language Therapy (SLT) and Hand therapy.

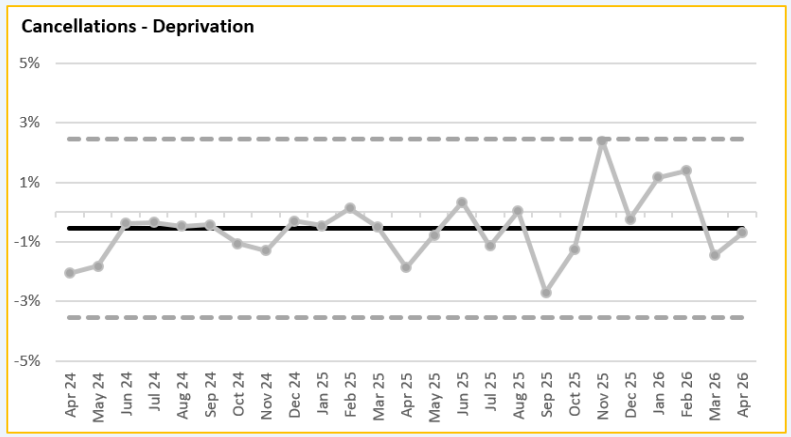
HEALTH INEQUALITIES PRIORITY PROGRESS

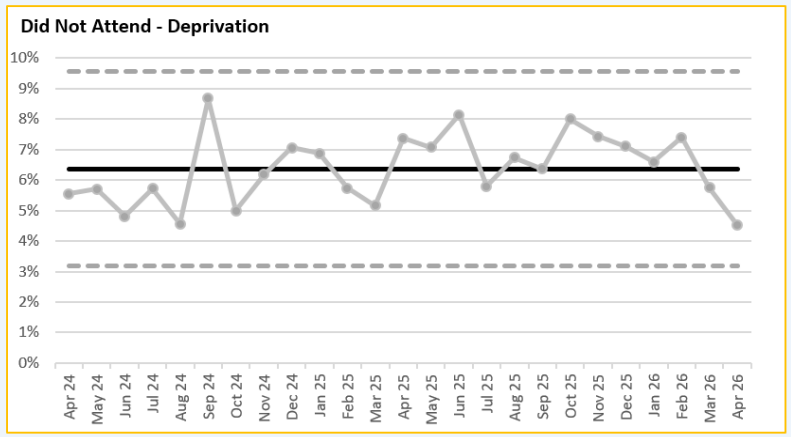
Queen Victoria Hospital
NHS Foundation Trust

M1 introduces a new suite of health inequalities metrics, establishing baseline positions and setting out what is being measured. Work to date has focused on developing the capability to report these measures, and during 2026/27 the focus will shift to understanding and reducing variation, with action-focused narrative to be provided from next month. Note that there are data quality issues with these metrics - Ethnicity is not known for new patients until they attend site and the Index of Multiple Deprivation depends on up-to-date post code information and mapping.









Metric - Apr-26	Black (M, N, P)	White (A, B, C)	Asian (H, J, K, L)	Mixed (D, E, F, G)	Other (R, S)	Not Assigned	Total
Did Not Attend - Ethnicity Groups rolling 6 months	9.28%	4.40%	6.07%	7.60%	6.33%	9.12%	5.36%

Area	Summary and actions
Ethnicity Data Improvement	Ethnicity data completeness measures the proportion of patient records with a recorded ethnicity. Following targeted improvement work last year, completeness has increased and is currently stable at 84.74%. This remains below the 95% standard, and improving data completeness continues to be a priority to support robust inequalities analysis.
Waiting List / Deprivation Variation	This metric measures the percentage point difference in patients waiting over 18 weeks between the most deprived (deciles 1 and 2) and least deprived (deciles 9 and 10) populations. The baseline position for M1 is approximately 5%, showing improvement from higher levels in the previous year. This means that patients living in the most deprived areas are around 5% more likely to be waiting over 18 weeks compared to those in the least deprived areas.
Patient-led Cancellations / Deprivation Variation	This metric looks at the number of percentage points between deciles 1 & 2 vs 9 & 10, who cancel their appointments. Patient cancellations only, not where QVH has cancelled. Although variation is limited in absolute terms, patients from more deprived groups show somewhat higher cancellation rates, which may be proportionally significant given the low overall rates.
DNA / Deprivation Variation	This metric measures the difference in DNA rates between the most and least deprived populations. The baseline position is approximately 4–6%, indicating a persistent gap in attendance between deprivation groups.
DNA / Ethnicity Variation (6 month rolling)	This metric measures variation in DNA rates across ethnic groups using a 6-month rolling period. The baseline shows notable variation, with rates ranging from 4.40% (White) to 9.28% (Black) against an overall average of 5.36%, indicating inequalities in attendance.

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

2026/27 Annual Objectives

1. Research, Innovation & Education Hub and strengthen academic and commercial partners
2. Ensure the QVH Way underpins all improvement and transformation programmes

2026/27 Annual goals

1. Delivery of Research & Innovation strategic plan year 2
2. Delivery of a Continuous Improvement (CI) in-house targeted training programme

KSO2 EXECUTIVE SUMMARY

Queen Victoria Hospital
NHS Foundation Trust

Research, Innovation & Education (RI&E) Centre, Strengthen academic and commercial partners:

There has been ongoing progress against the four pillars underpinning the Research and Innovation Strategy. A Task and Finish Group has been established to develop plans and progress development of the Research, Innovation and Education Centre. Key principles agreed are that the Centre must be accessible to all staff, help staff to connect with opportunities through QVH people and resources and, provide an environment which enables inspiration and collaboration.

QVH was fortunate to attract two National Institute for Health Research (NIHR) funding grants in 2025/26 and have been successful in part funding of two further smaller grants for 2026/7. Further opportunities will continue to be explored as funding cycles are launched. In 2026/27 the Trust has also committed to a commercial research lead role part funded by an NIHR grant, alongside modest investment in directorates aimed at developing principal investigators and pharmacy support for investigational medicinal product research studies.

A microsurgery research study in partnership with the University of Sussex is underway and several other collaborative potential studies are in discovery with a range of external partners.

The QVH Way underpins all improvement and transformation programmes

The QVH Way continuous improvement (CI) initiation programme has moved into its third and final year. In this year, the commercial partners will play a reduced role as QVH steps into the sustain phase of the programme. A refresh on use of improvement huddle boards over M12 2025/26 and M1 2026/27 has been targeted at ensuring staff feel enabled to recognise and address issues on the ground. A further cohort of staff will be taking part in Experience Based Co-Design workshops in the coming month to help them understand how best to utilise an understanding of patient experience to inform improvements. Over 80 staff from a wide range of clinical and non-clinical roles have now been trained to use improvement methods and they will support CI work in 2026/27. As improvement projects progress, impact from the CI approach now being applied to operational challenges will be reported via IQPR and directorate governance meetings.

Medical Education and Library

The next induction programme for doctors and dentists will be in August with 15 new starters currently. A new item relating to feedback and learning from incidents has been introduced into the programme. Ongoing governance of the education programme continues to be supported by feedback on issues raised at local meetings with outputs tracked on an issues log and fed back to those impacted.

The annual Specialty, Associate Specialist, and Specialist (SAS) doctor Continual Professional Development (CPD) day gave an opportunity for this important group of staff to take time out for study and was well received. The latest cohort of Leadership through Education for Excellent Patient Care (LEEP) leadership training is now also underway. Plans are in place for an education evening for General Practitioners (GPs) to learn about QVH pathways – the first in a proposed series of events will take place in July.

The library's new quiet study hub is now in place and can be used for one person for private study or two people for a confidential meeting.

Tamara Everington
Chief Medical Officer

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

Queen Victoria Hospital
NHS Foundation Trust

2026/27 Annual Objectives

1. Enhance inclusive collaborative culture including behaviours framework and speaking up (EDI)
2. Develop Trust and directorate leadership capability

2026/27 Annual goals

1. Maintain or improve performance against workforce metrics, including 90% completion of staff appraisal
2. >95% compliance with Resident Doctor 10-point plan
3. People Pulse Survey
4. Annual measurement of: Staff Survey, Workforce Race Equality Standard (WRES) / Workforce Disability Equality Standard (WDES) and update on Cultural diagnostic assessment

KSO3 EXECUTIVE SUMMARY

Queen Victoria Hospital
NHS Foundation Trust

General summary

Month 1 shows **staff in post** slightly above plan at 1076.18 whole time equivalent (WTE) against a submitted staff in post plan of 1070.12 WTE, with vacancy rates at 6.8%, remaining below the 8% target. This is despite vacancy pressures in Plastics, Canadian Wing and Theatres. Time to hire has improved significantly to an average of 25.7 days and sickness absence remains slightly above 4%. Bank and agency usage have both reduced, indicating improved workforce efficiency. However, turnover has increased marginally from 11% to 11.3%. MAST compliance has decreased slightly by 0.1% but remains above target.

Overall appraisal completion saw a marginal decrease in M1. Appraisals outstanding by >3months saw a decrease from 99 in M12 to 94 in M1. There is an ongoing focus for managers to complete their staff appraisals. Hot spot areas are being followed up by senior managers for completion.

Inclusive Collaborative Culture (incl. behaviours framework, speaking up)

The Organisational Development & Learning (OD&L) team have contacted managers across the organisation to offer a 1-2-1 meetings and support with the NHS 2025 survey. To date, out of 34 areas that received a response, OD&L have been contacted by 15 areas. Executive directors will be meeting with Triumvirate and Departmental leadership teams to understand areas of priority, action plans and support needed.

Behaviour framework workshops continue to be delivered to support the embedding and supporting managers to lead their teams.

Leadership Capability (Trust, Directorate)

Change workshops, coaching skills for managers, appraisal training and Managers Essentials Programme continue to be delivered.

Oliver McGowan face to face Tier 2 training is progressing with 12% of staff who require the training having completed it to date

16.18% of annual leave has been booked and taken up to 31 May 2026 (M1 and M2). Across the four directorates: CCCS 17.45%, Peri-operative 15.15%, OMFS and Eyes 16.71% and Plastics and Burns 14.88%. The booking / taking of annual leave will be reviewed each month at the directorate IQPR meetings and at the temporary staffing reduction oversight meeting.

Helen Edmunds
Chief People Officer

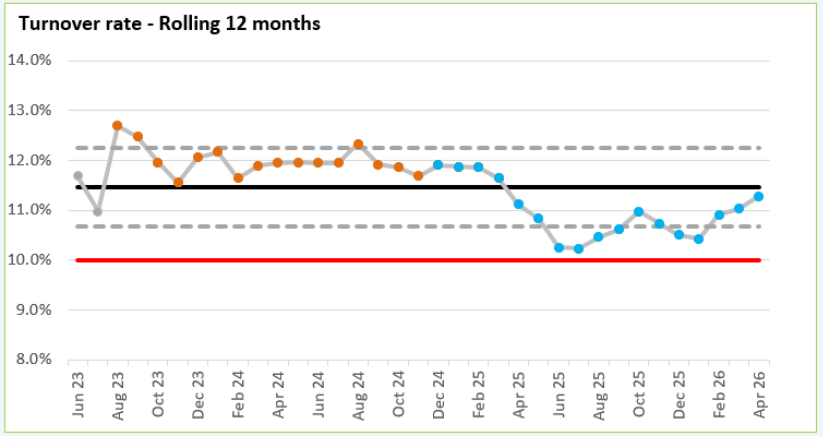
KSO3 BALANCED SCORECARD

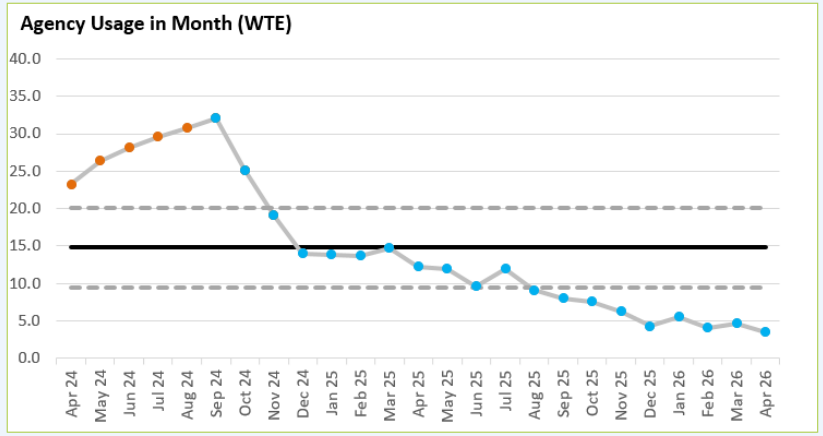
Queen Victoria Hospital
NHS Foundation Trust

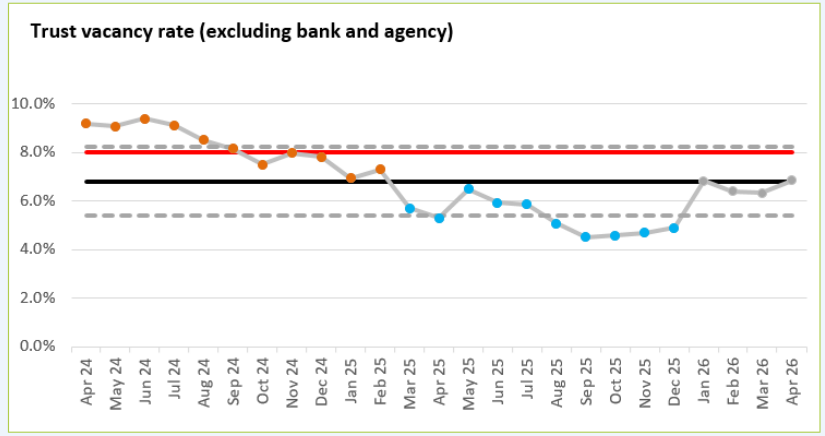
Metric	Latest Month	Target	Variation	Assurance	Actual	Actual Previous Month	Mean	LCL	UCL	Summary
Trust vacancy rate (excluding bank and agency)	Apr-26	8%			6.8%	6.3%	6.8%	5.4%	8.2%	Common cause - no signficant change
Vacancies - Incl Bank & Agency	Apr-26	8%			3.8%	1.7%	2.0%	-0.2%	4.1%	Common cause - no signficant change
Average Time to Hire - Days	Apr-26	53			25.7	50.9	55.38	21.96	88.81	Special Cause - improving variation
Turnover rate - Rolling 12 months	Apr-26	10%			11.3%	11.0%	11.5%	10.7%	12.3%	Special Cause - improving variation
Sickness absence rate - Rolling 12 months	Apr-26	3%			4.3%	4.2%	3.9%	3.8%	4.0%	Special Cause - concerning variation
Appraisal Rate	Apr-26	90%			82.3%	83.5%	83.6%	80.8%	86.5%	Special Cause - concerning variation
Statutory & Mandatory Training Compliance	Apr-26	90%			90.5%	90.6%	91.9%	90.7%	93.0%	Special Cause - concerning variation
Agency Usage in Month (WTE)	Apr-26	-			3.6	4.7	14.80	9.53	20.08	Special Cause - improving variation
Bank Usage in Month (WTE)	Apr-26	-			63.2	80.9	75.49	56.69	94.28	Common cause - no signficant change
Annual Leave Taken	Apr-26	-				96.4%	52.7%	32.8%	72.5%	Special Cause - improving variation

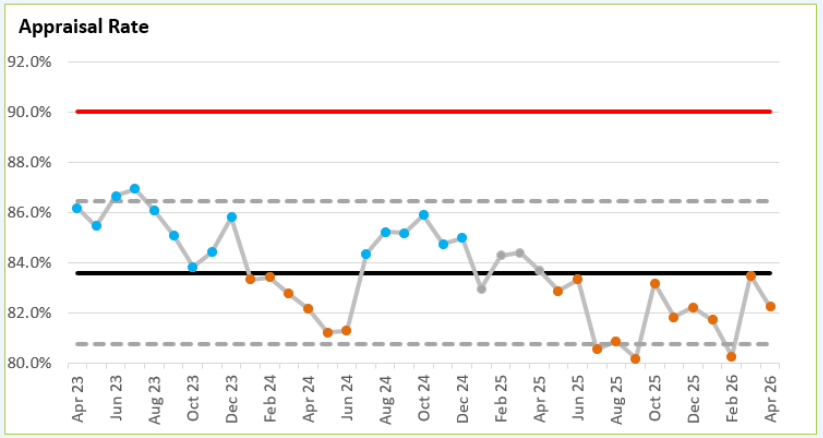
EXCELLENT EMPLOYER KEY METRICS

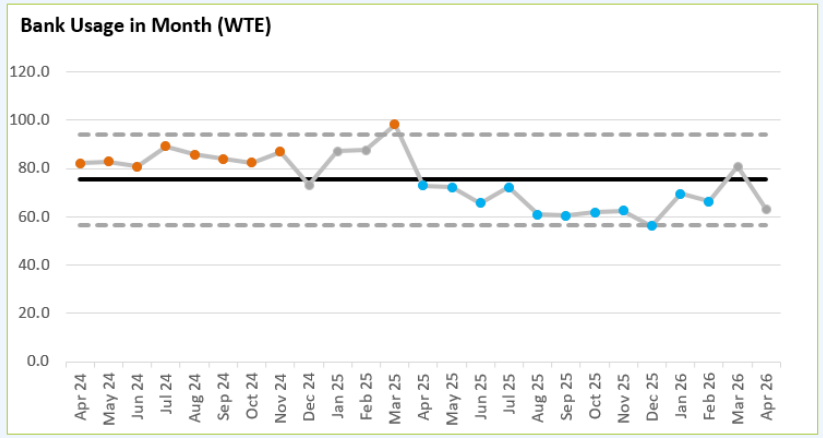
Queen Victoria Hospital
NHS Foundation Trust

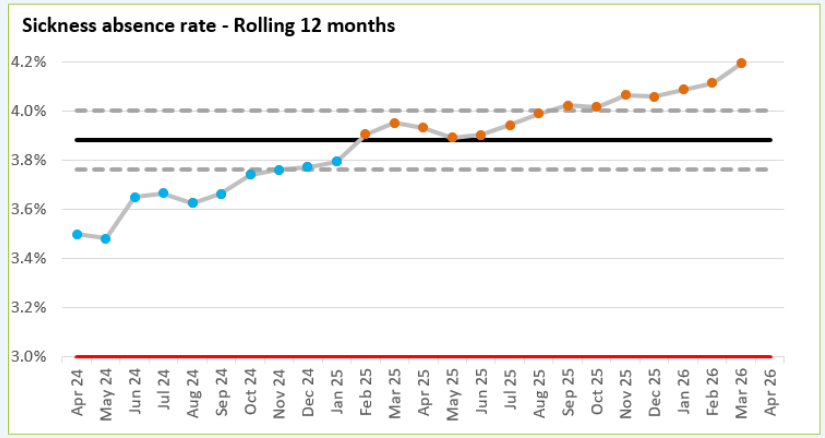












KSO3 AREAS OF FOCUS

Queen Victoria Hospital
NHS Foundation Trust

Area	Summary, impact and actions
Trust vacancy rate (excluding bank and agency)	M1 shows staff in post WTE (substantive staff) at 1076.18 (against a submitted plan of 1070.12 WTE) . Vacancies excluding bank and agency usage have increased slightly from 6.3% to 6.8% (79.68 WTE). This is below our target of 8%. The Trusts highest areas of vacancies in M1 are within Plastics (10.63 WTE) Canadian Wing (9.83 WTE) and Theatres (9.72 WTE)
Average Time to Hire - Days	Decrease to 25.7 in M1, from 50.9 in M12. This ranged from average of 7 days to 52 days. The quickest clearance taking 7 days was an employee moving from fixed term into a permanent post. Delays in Building and Engineering (52 days due to visa application process required) and Main Outpatients (46 days due to pending references).
Sickness Absence Rate - Rolling 12 Months	This measure continues to show 'concerning variation'. Performance has been above the mean for a period of time, at a current level of marginally above 4%. The highest areas of sickness are in theatres, therapies, domestics and Canadian Wing. The highest staff groups for sickness are admin and clerical and nursing. The most common reason for sickness absence is cough, cold and flu, followed by gastro. The Employee Relations team undertake a monthly deep dive into sickness areas to provide focussed support for managers. The monthly tempoarary staffing reduction oversight meetings review sickness levels in each area and return to work support. Rolling 12-month long term sickness is 2.35% and short-term sickness is 1.96%.
Agency Usage In Month (WTE)	Agency usage has decreased in M1 from 4.7 WTE to 3.6 WTE. Usage consisted of 1.97 WTE Perioperative Care, 1.22 WTE Estates & Facilities (Catering), and 0.37 WTE in Core Clinical & Community Services (CCCS). Perioperative services was in Critical Care (N&M), Recovery (AHP) and 1.7 WTE in Theatres (AHP & N&M). CCCS 0.1 WTE Healthcare Scientist in Sleep and 0.28 WTE Additional Professional & Technical in Pharmacy.
Bank Usage In Month (WTE)	Bank usage has decreased significantly from 80.9 WTE in M12 to 63.2 WTE in M1 across all directorates, keeping on trend with previous years and returning to an expected level. Perioperative services have the highest usage at 24.86 WTE followed by CCCS with 11.53 WTE. Admin and Clerical , Nursing & Midwifery and Additional Clinical Services staff groups had the highest usage (20.62 WTE, 16.42 WTE, 10.86 WTE). Within Perioperative Services , Theatres have the greatest share of bank usage (42.8%).
Grievances raised	0 grievances raised in M1
% Job plans complete	Three job plans signed off in April 2026 with 6% sitting in consultant sign off, 1% in sign off by manager, 8% 2nd sign off and 2% in 3rd sign off. The Trust currently has 81% of job plans sign off . M1 has seen a slight reduction owing to the new financial year and fresh job plans currently in process for 2026-27
Turnover rate	Turnover has increased from 11% in M12 to 11.3% in M1. The Trust' highest turnover rates for M1 are within Corporate (23.8%) CCCS (12.12%) and OMFS & Eyes (12.07%)
Statutory and mandatory training	M1 has seen a small decrease in mandatory and statutory training (MAST) compliance from 90.6% in M12 to 90.5%. Emergency Planning (annual), Information Governance and Conflict Resolution need focus. This metric will continue to be monitored to ensure performance continues to meet the trust 90% target. OD&L continue to chase where compliance is low. This month Information Governance (IG) and Fire Evacuation have been the areas of focus.
Appraisal rate	There is ongoing work to reach 90% appraisal completion rate, with continued focus with managers and highlighting outstanding areas. M1 had a decrease from 83.5% in M12 to 82.3%. The number of appraisals outstanding >3 months has continued decreased from 99 to 94 in M1, with focused work underway with senior managers to follow up in areas where rates of completion are low. Commerce & Finance directorate has the lowest compliance at 70.6%, with focussed work in progress with the leadership teams to prioritise appraisal completion.

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

Queen Victoria Hospital
NHS Foundation Trust

2026/27 Annual Objectives

1. Maintain financial sustainability, reduction of corporate costs and delivery of £7.5m Better Value Programme
2. Delivery of key estates infrastructure projects and improving estates resilience and backlog maintenance (Major Project)
3. Digital transformation to support Trust and system priority objectives, including Patient Administration System (PAS) (Major Project)
4. Transform diagnostic pathways using Community Diagnostic Centre (CDC) for neighbourhood care (Major Project)

2026/27 Annual goals

1. Successful installation of Altera PAS by November 2026
2. Delivery of the 2026/27 breakeven position
3. Delivery of key Infrastructure projects (CDC – September 2026, MRI – March 2027, RI&E – March 2027)
4. Successful delivery of Sussex Pathology Network Programme (SPN)

KSO4 EXECUTIVE SUMMARY

Queen Victoria Hospital
NHS Foundation Trust

Summary Financial Position

For the Month of April the Trust reported an Income and Expenditure deficit of £0.248m, which was slightly ahead of planned deficit of £0.252m and a cash position of £14.1m. For M1, income and expenditure actuals reflect the pay awards due in M1 with an estimate included for the Medical pay award to be paid in June. Plans will be adjusted for the revised income and expenditure uplifts above the planning assumption pay award level of 2% in M2.

Key drivers of position include:

- **Income** - Activity income is currently an estimate as fixed and variable contract baselines are not yet agreed to determine accurate commissioner payments with significant outpatient procedure volumes remaining uncoded. Estimated £0.1m adverse to plan due to Community Diagnostic Centre (CDC) underperformance of c£50k with other underperformance in plastics, max-fax and ophthalmology day cases and plastics inpatients, partly offset by over-performance in sleep outpatient procedures. Income is broadly on plan overall due to the tariff uplift reflected in actuals but not yet within plans (+£0.09m).
- **Pay:** overspent by (£0.17m) including £0.1m impact of pay award and under delivery of better value schemes. There was a c£20k impact from Industrial Action for M1.
- **Non-pay including Non-operational Expenditure:** £0.16m favourable due to lower spend in Digital, Estates and Theatres areas

Better Value Programme (BVP)

The Trust is reporting full delivery of the M1 efficiency requirement, with 55% having been delivered by BVP schemes, supported by other mitigating items. Whilst this mean the Trust is broadly living within its means; the Trust needs to accelerate the rest of the schemes in order to bring greater confidence of delivery of the annual plan.

Key Estates Infrastructure Projects (incl. resilience, backlog maintenance and Green)

The boiler replacement scheme is progressing and has reached the commission phase. The estates asbestos roof replacement scheme has been completed. Falkner's contractors have begun work on the theatre roof repairs and the MRI facility designs are in progress. A revised programme for theatre fire dampers, fire door replacements and additional access door controls is being developed.

Key Transformation Projects (digital, Sussex Pathology Network, CDC)

The East Grinstead CDC continue to track in line with the revised handover date of mid-September and an early October opening. Digital Transformation programme continues to progress, however, remains under active management with key risks with Patient Administration System (PAS) readiness, Radiology Information System (RIS) procurement, Sussex Pathology Network delivery and programme workforce/funding continuity.

Ross Dunworth
Interim Chief Finance Officer

KSO4 EXECUTIVE SUMMARY

Queen Victoria Hospital
NHS Foundation Trust

Metric	Latest Month	Target	Variation	Assurance	Actual	Actual Previous Month	Mean	LCL	UCL	Summary
Breakeven YTD	Apr-26	-£0.25m			-£0.25m					
Cash at Bank YTD	Apr-26	£14.10m			£14.10m					
Capital Spend YTD	Apr-26	£0.10m			£0.80m					
Efficiencies YTD	Apr-26	£0.50m			£0.50m					
BPPC (NHS & Non NHS) - volume	Apr-26	95%			72.1%					
BPPC (NHS & Non NHS) - value	Apr-26	95%			89.7%					
Agency spend 30% reduction on 25/26	Apr-26	£0.04m			£0.05m					
Agency staff spend as % of total staff spend	Apr-26	2%			0.73%					
Bank spend 10% reduction on 25/26	Apr-26	£0.25m			£0.25m					
Total Pay cost per Worked WTE	Apr-26				£5,795.37	£5,699.24	5680.08	5456.29	5903.88	Common cause - no signficant change
Subject Access Requests - Total Received	Apr-26				96	103	87.94	61.69	114.18	Common cause - no signficant change
Subject Access Requests - % Closed within 30 calendar days	Mar-26	100%			100.0%	100.0%	95.3%	81.1%	109.5%	Special Cause - improving variation
Freedom of Information requests – Total Received	Apr-26				42	66	50.92	16.41	85.43	Common cause - no signficant change
Freedom of Information requests – % Closed within 20 working days	Mar-26	80%			78.79%	78.85%	66.4%	42.3%	90.5%	Special Cause - improving variation

KSO4 EXECUTIVE SUMMARY

Queen Victoria Hospital
NHS Foundation Trust

Capital

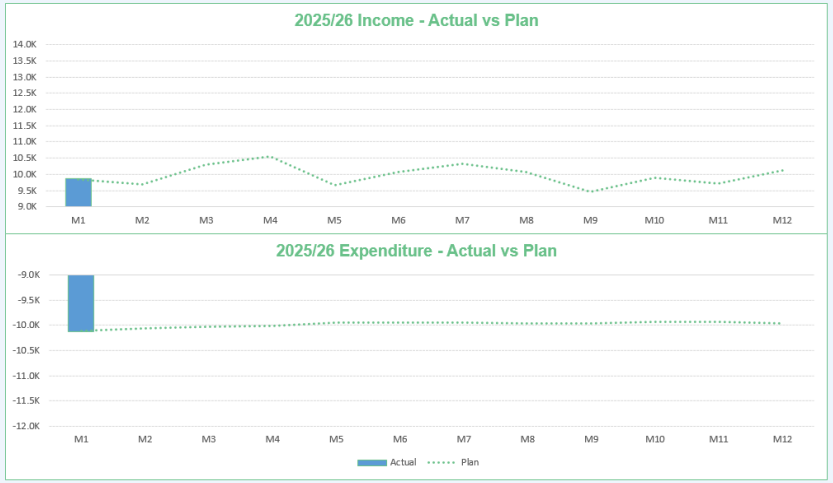
	In Month £'000			Year to Date £'000		
	Plan	Actual	Variance	Plan	Actual	Variance
IT	0	0	0	0	0	0
Medical Equipment	0	0	0	0	0	0
Estates Maintainance	63	41	(22)	63	41	(22)
Estates Other	52	0	(52)	52	0	(52)
EPR	0	155	155	0	155	155
CDC	0	585	585	0	585	585
Other Capital	0	34	34	0	34	34
Total	115	815	700	115	815	700

Income and Expenditure

	In Month £'000			Year to Date £'000		
	Plan	Actual	Variance	Plan	Actual	Variance
Income						
Patient Activity Income	9,430	9,457	27	9,430	9,457	27
Other Operating Income	425	413	(12)	425	413	(12)
Total Income	9,855	9,870	15	9,855	9,870	15
Pay						
Substantive	(6,096)	(6,286)	(190)	(6,096)	(6,286)	(190)
Bank	(271)	(246)	25	(271)	(246)	25
Agency	(44)	(48)	(4)	(44)	(48)	(4)
Total Pay	(6,411)	(6,580)	(169)	(6,411)	(6,580)	(169)
Total Non-Pay	(2,911)	(2,779)	132	(2,911)	(2,779)	132
Total Non Operational Expenditure	(795)	(769)	26	(795)	(769)	26
Total Expenditure	(10,117)	(10,128)	(11)	(10,117)	(10,128)	(11)
Surplus/(Deficit)	(262)	(258)	4	(262)	(258)	4
Technical Adjustments	10	10	0	10	10	0
Adjusted Surplus / (Deficit)	(252)	(248)	4	(252)	(248)	4

Efficiency

	In Month £'000			Year to Date £'000		
	Plan	Actual	Variance	Plan	Actual	Variance
Pay - Establishment Reviews	168	123	(45)	168	123	(45)
Pay - Corporate Service and Digital Transformation	82	53	(29)	82	53	(29)
Pay - Clincal Service Redesign	-	-	-	-	-	-
Pay - Bank	10	8	(2)	10	8	(2)
Pay - Agency	1	-	(1)	1	-	(1)
Pay - Other	30	-	(30)	30	-	(30)
Non-Pay - Procurement	101	51	(50)	101	51	(50)
Non-Pay - Other	39	243	204	39	243	204
Non-Pay Corporate Service and Digital Transformation	49	2	(47)	49	2	(47)
Non-Pay Clinical Service Redesign	-	-	-	-	-	-
Income - Non-patient care	18	19	1	18	19	1
Income - Other	1	-	(1)	1	-	(1)
Total	499	499	0	499	499	-



	Annual Target	Forecast Outturn
Income & Expenditure	£0.0m	£0.0m
Cash at bank	£14.1m	£14.1m
Capital Spend	£7.8m	£7.8m
Efficiencies	£7.49m	£7.49m
BPPC (NHS & Non-NHS)		
Volume	95.0%	91.9%
Value	95.0%	93.6%

Trust Better Value Programme

Queen Victoria Hospital
NHS Foundation Trust

Better Value Programme:

	Annual Plan			Year-To-Date		
	NHSE Plan	Latest Estimate	Risk Adjstd Value	NHSE Plan	Actual	Variance
Clinical Productivity & Efficiency	£3,479	£3,656	£2,832	£212	£164	(£48)
Corporate and Partnership	£1,250	£1,154	£788	£86	£53	(£33)
Grip and Control	£680	£621	£340	£51	£3	(£48)
Digital Transformation	£380	£455	£204	£28	£0	(£28)
Commercial and other income	£269	£398	£388	£23	£50	£27
Admin Review	£500	£250	£125	£34	£0	(£34)
Temporary Staffing	£175	£122	£103	£11	£8	(£3)
Planned Non-Recurrent items	£759	£759	£759	£54	£0	(£54)
Unidentified		£77				£0
Other Mitigating Items					£222	£222
Grand Total	**£7,492**	**£7,492**	**£5,539**	**£499**	**£499**	**£0**

Better Value Programme (BVP):
The Trust is reporting full delivery of the M1 efficiency requirement, with 55% having been delivered by BVP schemes, supported by other mitigating items. Whilst this mean the Trust is broadly living within its means; the Trust needs to accelerate the rest of the schemes in order to bring greater confidence of delivery of the annual plan.

Productivity indicators:
An increase in the value of the cost weighted activity and a reduction in the real terms cost growth have combined to improve both the Productivity Growth metric and the Workforce Productivity Growth metric. The improvement reverses two months of worsening productivity, reflecting that in January the Trust's productivity improved in relation to the previous year and produced more value with a lower input cost.

The proportion of Outpatient attendances that generate either a first attendance or an outpatient procedure tariff has continued to tail off over the last quarter but is still above the previous year's trend and above the target. The average ratio in 2024/25 was 42.9% and has improved to 45.3% in 2025/26, indicating that the Trust has improved its utilisation of outpatient (OP) capacity to deliver higher value activity for our patients.

Key Productivity Indicators:

Source	Metric	Latest Month	Latest Month	Target	Distance from Target	5 mth Trendline
Model Hospital	Productivity Growth (YTD vs Prior Year)	Dec-25	2.00%	3.00%	-1.00%	
Model Hospital	Workforce Productivity Growth (YTD vs Prior Year)	Dec-25	4.00%	3.00%	1.00%	
Income Data	Proportion of OPA that are First or OPROC	Mar-26	45.38%	44.50%	0.88%	

The headline productivity metrics are taken from the Model Hospital and are reported several months in arrears. Although there are some limitations with the underlying measurement, these metrics give a broad indicator of the productivity trajectory, by comparing the year-on-year change in the value of outputs (clinical activity) with the resources consumed (cost).

Outpatient Attendance (OPA)
Outpatient Procedures (OPROC)

KSO4 AREAS OF FOCUS

Queen Victoria Hospital
NHS Foundation Trust

Area	Summary, impact and actions
Breakeven YTD	The Trust reported a deficit position of £0.248m for M1, slightly ahead of the £0.252m deficit plan. Estimated **Activity income** was £0.1m adverse due to Clinical Diagnostics Centre (CDC) c(£50k) and other surgical day case/inpatient underperformance partly offset by over-performance in sleep outpatient procedures. The CDC under delivery is mainly offset by expenditure underspends. **Pay** is overspent by £0.17m but £0.08m after adjusting for pay awards, mainly due to under delivery of better value schemes. **Non-pay including Non-operational Expenditure** was £0.158m favourable due to lower spend in Digital, Estates and Theatres areas. The main risks to breakeven will be delivery of the £7.5m Better value programme and delivery of the income and activity target.
Cash at Bank YTD	The Trust's cash balance at M1 was £14.1m, which continues to be supported by capital cash earmarked for completion of the CDC.
Capital Spend YTD	Capital expenditure at Month 1 totals £0.8m, which is significantly above the planned £0.1m for the period. This variance reflects the phasing of the plan, with an initial assumption that some expenditure would fall later in the year. The total annual capital allocation is £8m. Of this, £5.5m is expected to be spent on the CDC and £1.2m on (Electronic Patient Record (EPR), with the remaining balance allocated across Estates, IT, and Sussex Pathology Network (SPN). The capital programme is awaiting the outcome of national bids, the Trust plan is reliant on some of these being awarded.
Efficiencies (Cost Improvement Plans) YTD	The Trust is reporting full delivery of the M1 efficiency requirement, with 55% having been delivered by BVP schemes, supported by other mitigating items. Whilst this mean we are broadly living within our means; the Trust needs to accelerate the rest of the schemes in order to bring greater confidence of delivery of the 2026/27 annual plan.
Better Payment Practice Code (BPPC) (NHS & Non-NHS) Volumes	72.1%
BPPC (NHS & Non-NHS) Values	89.7%
Agency spend 30% less than 25/26	Slightly behind plan (£4k) on a monthly target of £44k. Key usage areas are within CDC which is expected to reduce in coming months
Agency Spend Less than 2% of Total Pay Bill	Ahead of plan
Bank spend reduction of 10% of Total Pay Bill	On plan
Pay Spend	£0.17m adverse to plan overall including £0.09m impact of pay award uplift. Remainder is mainly due to non-delivery of Better value schemes and Industrial Action (IA) spend (£20k).
Non-Pay Spend	£0.16m favourable to plan due to lower than planned spend in Digital, Estates and Theatre areas. It is expected that spend will revert closer to plan over coming months

KSO4 PROJECT REPORT

Queen Victoria Hospital NHS Foundation Trust

Estates Infrastructure (incl. resilience/backlog maintenance, MRI relocation, Research, Education and Innovation Hub)

Exec Lead: CPO/CMO
Lead: Director of Estates/PMO

Reporting Month: April 26

Overall Status: Amber

Fire Doors:
- Installation of new fire doors in Canadian (C) Wing starts on the 8 June 2026.
- Critical areas (Burns, Critical Care Unit (CCU), Head & Neck, Margaret Duncombe) have been surveyed by fire door specialists and tender specification in progress for 15 June 2026 start.

Kitchen Boiler:
- In final stage of project with commissioning and handover and scheduled for 30 June.

Estates Workshop:
Project is ongoing with an expected completion date of 29 June.

Theatre Dampers:
- Specialist consultants appointed, surveys and technical report reviews underway with expected completion end of June. Tender preparation planned for completion end of July.

MRI:
- Location requirements have been identified with first design draft in progress. Surveys to begin shortly to support tender specification development. MRI shortlisted to two equipment manufacturers and site visits planned. Task and Finish group to be established in early June 2026.

Research Education and Innovation Hub:
- Terms of Reference (TORs) complete and fortnightly Task and Finish Group meetings in place.

Milestone		Start Date	Expected Completion Date	Commentary
Fire Doors C Wing		8th June 20026	8th August 2026	Installation of new fire doors in C Wing starts on the 8th June
MRI equipment purchased		15th May 2026	31st July 2026	Two equipment manufacturers shortlisted

Date Raised	Risk Description	Mitigating Actions
April 2026	Capital funding uncertainty 2026/27	Regular follow up with NHSE Finance for updates on estates safety fund monies

KSO4 PROJECT REPORT

Queen Victoria Hospital
NHS Foundation Trust

Digital Transformation Programme	Exec Lead: CMO Lead: PMO/Head of EPR	Reporting Month: April 26	Overall Status: Amber

The Digital Transformation Programme remains at Amber status and is under active management. All 15 workstreams are currently rated either red or amber. Executive focus remains on PAS replacement, RIS procurement and Sussex Pathology Network delivery, while Order Communications has now been deferred due to complex external dependencies with Sussex Pathology Network (SPN) and RIS procurement. The overall programme position reflects a broad and active portfolio, with progress being made across EPR optimisation, ePMA, Electronic Discharge Notification (EDN), Patient Know Best (PKB), Artificial Intelligence (AI), hardware/ access and patient-facing digital initiatives.

There has been tangible movement across several amber workstreams, including optimisation sprints, ePMA build and validation activity, EDN delivery planning, PKB/patient communication activity, AI governance development and hardware deployment. However, delivery remains dependent on specialist capacity, PAS system readiness, operational engagement, pharmacy validation, Business Intelligence (BI)/reporting availability and timely progression of planned milestones. Several workstreams also share common dependencies, meaning delays in one area may affect wider programme delivery.

Key risks continue to relate to PAS system readiness, data migration and reporting capacity, operational data cleansing, pharmacy validation, procurement delays, SPN delivery planning and inter-programme dependencies. Workforce continuity is also a material concern, with some programme staff leaving in June 2026 and funding for key roles ending in December 2026. Continued executive oversight will therefore be required to maintain delivery grip, support prioritisation of constrained specialist resources and manage the cumulative impact of these risks across the digital transformation portfolio.

Applications for funding have now been submitted to both Frontline Productivity and Wayfinding programmes with initial responses expected in June and July 2026 respectively.

Milestone	Start Date	Expected Completion Date	Commentary
PAS go live	4th January 2026	30/11/2026	Status remains at Red. System unavailability has impacted key workstreams including build, data migration, integration and BI/Reporting.

Date Raised	Risk Description	Mitigating Actions
April 26	Funding constraints for programme delivery. Three of the programme team are funded until end June with no funding currently available beyond December 26.	Programme team exploring funding opportunities via national and regional funding including Frontline Productivity and Wayfinding programme. Submissions provided for both with indicative responses expected in June/July '26.
April 26	PAS system unavailability has impacted key workstreams including build, data migration, integration and BI/Reporting.	Executive escalation has taken place with Altera. Altera have committed to supporting a number of the 'at risk' workstreams to ensure that the plan remains on track for a November 2026 go live.

KSO4 PROJECT REPORT

Queen Victoria Hospital
NHS Foundation Trust

Community Diagnostics Centre (CDC)	**Exec Lead: COO** **Lead: PMO**	**Reporting Month: April 20206**	**Overall Status: Green**

Programme for the delivery of CDC within the East Grinstead QVH site.

Progress has been made within the following areas:
1. Works continue on site in East Grinstead including making installation of the steel framework.
2. The roof, concrete flooring and the steel structure have now completed.
3. Activity to Plan for CDC activity in April 2026 was 87%. YTD actual income compared to planned income is 85%. Quarter 1 is likely to be under plan, however it is expected that recovery is planned for Quarter 2.

Key areas for focus are continuing the construction of the new CDC building and optimising current CDC activity in East Grinstead.

Milestone	Start Date	Expected Completion Date	Commentary
Operational opening of the centre	15/90/26	01/10/26	Transition plan drawn up for move of services.
Construction completion on East Grinstead site.	01/09/25	14/09/26	Steel installation. laying of concrete and roof completed. Centre now watertight. Opening of centre expected in October 2026.

Date Raised	Risk Description	Mitigating Actions
04/04/25	Actual CDC activity vs plan.	Continued remedial actions being taken to bring back to plan.
01/05/26	Project may go over budget because contingency has been used.	Close scrutiny of spend.

KSO4 PROJECT REPORT

Queen Victoria Hospital NHS Foundation Trust

Sussex Pathology Network (SPN)

Exec Lead: CMO
Lead: PMO

Reporting Month: Month 1 - April

Overall Status: R / A / G
Amber

Summary: There has been a full re-evaluation of the programme across Sussex, reflecting the complexity and scale of the programme. Timescales have been revised across the system with QVH LIMS/ICE due to go live in early-mid 2027.

LIMS/Order Comms (ICE) – LIMS/OCS project remains in exception status due to the outstanding re-baseline exercise with Clinisys with a decision expected in mid-June. Testing phases per discipline will start when all test entry criteria is met. OCS pages, panels and rules build is ongoing. Cerebro installation (sample tracking system) is continuing with a test workstation configured to facilitate user acceptance testing (UAT) with new LIMS environment.
Digital Histopathology (DHP) - Prior to deployment of WinPath Enterprise which enables full integration with DHP, the project at QVH has necessitated a number of workarounds to mimic the interoperability between current end of life systems. This has proved to be problematic and has delayed the go-live. Despite these hurdles, progress has been made with an anticipated go-live target of the end of Q1/early Q2.
Digital Infrastructure - PoCT UHSx local server setup is ongoing to allow connectivity from QVH to Cobas Infinity. A new PoCT contract is in place and the team is investigating the position in terms of upgrading devices. QVH is working with UHSx who is leading on the SECTRA contract for PACS-based reporting (PBR)
Managed Service Contract (MSC) – Pre-submission documentation has been issued and is due to be returned by 3rd June 2026. Evaluation and moderation will be completed during June 2026. Dialogue period is the next area of significant focus. Discussions taking place with NHSE regarding requirements of the FBC and associated governance timeline with an aim to reduce both (contract award predicted - Sept 2027)
Network Formation and Laboratory Operating Model (LOM) - The April 2026 SPN Board agreed to bring the Network Formation work forward as a separate agreement to got to the Sussex Provider Collaborative in July 2026. LOM OBC progressing with a site-agnostic preferred way forward until LIMS/MSC implemented. A future state LOM expected to take effect from approx. 2030/31

Milestone	Start Date		Expected Completion Date	Commentary
MSC – Evaluation and moderation of pre-submission tender documents	June 2026		June 2026	Bidder returns expected 3rd June 2026, evaluator training to be completed during May 2026
LIMS/OCS - Completion of review of all outstanding CCNs by Clinisys	April 2026		June 2026	Once completed, a re-baselined plan between Clinisys and SPN will be drafted and signed off
DHP – QVH go-live for digital slide scanning and reporting	April 2026		June 2026	Dependent on final configuration of Sectra/Trust patient ID data flow
LOM – Continuation of OBC development	June 2026		June 2026	NHSE TU to model options based on current state baseline

Date Raised	Risk Description	Mitigating Actions
April 2026	Lack of confirmed external NHSE funding to support programme costs for FY26/27	Trusts have agreed to proceed at risk. Funding applications have been submitted. Senior Reporting Officer (SRO) for SPN is meeting with NHSE to discuss programme/funding
April 2026	LIMS/OCS remains in exception without an agreed plan to meet proposed go-live windows (issue)	SPN & Clinisys actively negotiating re-baseline CCN and reviewing project timelines to identify opportunities to streamline programme activities

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

2026/27 Annual Objectives

1. Strategic Partnership Transition and Implementation (Major Project)
2. Delivery of external and internal engagement plan
3. Support system transformation through Provider Collaborative

2026/27 Annual goals

1. Delivery of key partnership transition milestones
2. Implementation of the Trust engagement plan
3. To support the delivery of Sussex and Surrey Provider Collaborative priority plans including single point of access (SPOA)

KSO5 EXECUTIVE SUMMARY

Queen Victoria Hospital
NHS Foundation Trust

Strategic Partnership (transition and Implementation)

A period of shared planning, analysis and assurance is now underway with Royal Surrey NHS Foundation Trust and Ashford and St Peters Hospitals NHS Foundation Trusts (RSFT/ ASPH) Group, to ensure the partnership will provide a credible route to sustainability, resilience, and strategic integration, while preserving and improving each organisations' identity and specialisms. In line with good governance, specific processes need to be followed to ensure each Board has the necessary assurance in place in order to finalise next steps.

Engagement (Internal / External)

The Trust has developed an Engagement Plan which sets out the Trusts approach to engagement and communications across key audiences, in particular strengthening the patient voice, aiming to improve patient experiences. This plan also provides a framework for strategic partnership engagement and communications, whilst building upon strengthening a consistent trust-wide approach that remains robust, open and consistent with patients, staff, volunteers, partners and our local communities. This approach that supports staff engagement, leadership and visibility whilst encouraging two-way dialogue and learning from feedback. An action plan is under development following the approval of the Trust Engagement Plan to drive delivery forward over the coming year and beyond.

Provider Collaboratives (Acute and neighbourhood, including SPOA)
In 2026, the Provider Collaborative momentum is shifting towards greater scale and system alignment, with the newly created Surrey & Sussex ICB, proposed closer commissioner involvement, signalling a move toward broader, more integrated provider models is in progress. Overall, the direction of travel is toward larger-scale collaboratives with clearer accountability for end-to-end pathways, including further development of Single Point of Access (SPOA) patient pathways, stronger financial and performance expectations, and tighter alignment with place and neighbourhood models.

Kathy Brasier
Deputy Chief Strategy Officer

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 Reported Outcome Measure
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:	09/07/2026	**Agenda reference:**	**34-26**
Report title:	Quality & safety committee assurance report		
Sponsor:	Jo Emmanuel, Non-executive director and committee Chair		
Author:	Shaun O'Leary, Non-executive director and meeting chair Katie Ally, Governance officer		
Appendices:	Appendix one – Learning from Deaths annual report 2025-2026 Appendix two – Safeguarding (Adult and Children) annual report 2025-2026 Appendix three – Infection and Control annual report 2025-2026 Appendix four – Patient Experience (formerly Complaints) annual report 2025-2026 Appendix five – Appraisal & Revalidation annual report 2025-2026		
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 enters 2026/27 below trajectory for key elective, cancer and diagnostic standards, with short-term deterioration risk driven by residual Month 12 underperformance, demand growth, pathway flow constraints and limited outpatient and diagnostic capacity (particularly Plastics, Oral and Maxillofacial Surgery, Head & Neck and sleep diagnostics). – Mitigating actions are in place, including additional capacity, pathway validation, strengthened system working and short-term funded initiatives. Recovery is not expected to be immediate and pressures are likely to continue in the early part of the year. Emerging system risks relating to external referral patterns and service dependencies (including teledermatology workforce constraints) require coordinated system-level action. – Patient safety and experience remain stable, with no increase in harm indicators, sustained safer staffing compliance and positive feedback. However, delivery risks against constitutional standards remain significant and require continued oversight. – Major transformation programmes continue to progress, although delivery risks remain linked to system dependencies, readiness and capacity—particularly across PAS, Radiology and the Sussex Pathology Network—as well as workforce and funding constraints. – Escalated risks include overdue organisational risk updates, challenged RTT and cancer performance, diagnostic constraints, fire safety compliance issues and a high incident backlog. Non-compliance with the Mental Capacity Act remains a concern. The committee is assured that recovery actions and strengthened oversight are in place. – The committee reviews key annual reports and provides assurance to the Board across patient safety, learning from deaths, safeguarding, infection prevention and control, and patient experience. – The committee reviews the Professional Standards (FAQI) Annual Report 2025–2026 and is satisfied that the Trust remains compliant, recommending Board ratification. – 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: ○ Learning from Deaths ○ Safeguarding ○ Infection Prevention & Control ○ Patient Experience (formerly Complaints)		

	○ Appraisal & Revalidation annual report 2025-2026				
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 2025-2026 confirm the Trust is compliant with the regulations.				
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:	None				
Legal:	None				
Resources:	None				
Assurance route					
Previously considered by:					
	Date:		Decision:		
Next steps:					

Report to: Board of Directors
Agenda item: 34-26
Date of meeting: 9 July 2026
Report from: Jo Emmanuel, Non-executive director and committee Chair
Report author: Shaun O'Leary, Non-executive director and meeting Chair
Katie Ally, Governance officer
Date of report: 1 July 2026
Appendices: Appendix one – Learning from Deaths annual report 2025-2026
Appendix two – Safeguarding (Adult and Children) annual report 2025-2026
Appendix three – Infection and Control annual report 2025-2026
Appendix four – Patient Experience (formerly Complaints) annual report 2025-2026
Appendix five – Appraisal & Revalidation annual report 2025-2026

Sub-committee assurance report
Quality & Safety committee – 8 June 2026 and 30 June 2026

Key agenda items

- **Quality Account 2025-2026**
- **Learning from Death annual report 2025-2026**
- **Infection Prevention & Control annual report 2025-2026**
- **Appraisal & Revalidation annual report 2025-2026**
- **Safeguarding (Adult and Children) annual report 2025-2026**
- **Patient Experience annual report 2025-2026**
- **Health & Safety annual report 2025-2026**

- **Patient Safety annual report 2025-2026**
- **Antimicrobial annual report 2025-2026**
- **Safeguarding (Adult and children) annual report 2025 2026**
- **Executive Committee for Quality & Risk – matters to raise with the committee**
- **Integrated Quality & Performance Report – month1**
- **Bi Annual Safe Staffing and Nursing Workforce Review**
- **Open incident backlog update**
- **Annual review of patient stories**

Alert

- The committee notes that the Trust enters 2026/27 below trajectory across elective, cancer and diagnostic standards, with continued short-term deterioration risk driven by demand growth, pathway constraints and limited capacity.
- Recovery actions are underway; however, improvement is not expected to be immediate and system-level risks (including referral patterns and workforce constraints) require continued escalation and coordination.
- Patient safety and experience remain stable, although delivery risks standards require continued scrutiny.
- Transformation programmes continue to progress, but delivery risk remains due to dependencies, capacity and funding constraints.
- Escalated risks from Executive Committee for Quality and Risk include overdue risk register updates, performance challenges, diagnostic capacity issues, fire safety compliance concerns, a high incident backlog and ongoing Mental Capacity Act (MCA) compliance issues. Assurance is provided that actions are in place.

Assure

- The committee was assured that robust patient safety systems and processes are embedded across the organisation, supported by a positive reporting culture, effective implementation of the Patient Safety Incident Response Framework, and demonstrable learning that is driving improvements in practice. Whilst challenges remain in the timely closure of incidents, actions are in place to address these. The committee noted continued progress and provides assurance regarding the organisation's commitment to patient safety, learning and continuous improvement.
- The committee was assured that safe nursing staffing levels are in place and aligned with national guidance, with no adverse impact on patient safety following recent service reconfiguration. Rostering improvements and reduced reliance on temporary staffing support efficiency, underpinned by robust governance.
- The committee was assured that progress is being made in addressing the historical incident backlog, with improved pace of closures and strengthened oversight arrangements in place. Actions to enhance engagement, clarify incident classification and embed more timely reporting processes are underway, supporting a more sustainable approach to incident management going forward.
- Research, innovation and continuous improvement programmes continue to progress, supported by National Institute for Health and Care Research funding, strengthened partnerships and development of the Research, Innovation and Education Centre.
- The QVH Way programme is embedded in its sustain phase, with increasing staff capability and application of improvement methodologies.
- The committee was assured that medicines management remains safe and effective, with high reporting and low harm levels. Prescribing trends following Electronic Prescribing and Medicines Administration implementation are actively

monitored, supported by strengthened governance and learning systems. Key specialist roles have been successfully recruited during the year, enhancing resilience and leadership capacity. Further development is focused on improved analytics, audit capability and follow-up of actions, with ongoing assurance sought on progress.

- The Clinical audit annual report 2025–2026 provides robust assurance, with comprehensive coverage, clear governance and effective follow-up of actions
- The Antimicrobial stewardship annual report 2025-2026 has provided assurance progress has been made in strengthening antimicrobial stewardship, with sustained high compliance supported by strong clinical leadership and multidisciplinary collaboration. Key roles have been stabilised following recruitment, and digital developments through Archie EPR are expected to further enhance prescribing practices, audit capability and oversight. Ongoing focus on education, workforce resilience and optimisation of data will support continued improvement.
- The Health & Safety annual report 2025-2026 demonstrates governance continues to strengthen with improved reporting, policy compliance, incident culture and estates collaboration. While key risks remain particularly around risk assessment timeliness, fire safety actions, workforce wellbeing pressures and statutory health surveillance gaps these are clearly identified and subject to active management. The committee recognised a solid foundation for continued improvement, with targeted actions in place to strengthen compliance, capability and assurance.

Advise

- The committee has reviewed and provided feedback on the Trust's Quality Account 2025-2026 which highlights the significant achievement of the Trust, acknowledging the areas for improvement. The committee agreed to recommend the Quality Account 2025-2026 for Board approval at its meeting in June 2025.

Risks discussed and new risks identified

The committee was assured that the Board Assurance Framework and Organisational Risk Register provide a comprehensive overview of strategic and operational risks, with key risks clearly identified and monitored. While a number of risks remain outside appetite and some updates and actions are overdue, these gaps are recognised, with plans in place to refresh risk content, strengthen ownership and improve timeliness of updates. Overall, the committee acknowledged that further refinements are underway to enhance the effectiveness and accuracy of risk management arrangements.

Quality annual reports 2025-2026

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:

- **Learning from Deaths**
  The report provides assurance that the Trust has met its statutory duties under the Learning from Deaths framework for 2025/26. There are effective processes are in place and no quality or safety issues identified. All relevant deaths were appropriately identified and reviewed, with mortality levels stable and no trends or concerns relating to quality of care identified. Two inpatient deaths occurred during the year, with no deaths following transfer out. One Structured Judgement Review and three inquests were completed, none of which raised concerns about care. Demographic findings were in line with

expected patterns, with no evidence of disproportionate impact across patient groups.

- **Safeguarding**
  The committee was assured that robust safeguarding systems and governance arrangements are in place, supported by strong partnership working, effective training and continued service improvements. Progress is evident in areas such as MCA compliance, clinical pathway development and organisational learning, with actions in place to address remaining challenges. Overall, the committee recognised sustained commitment to safeguarding and ongoing strengthening of assurance and practice across the Trust.

- **Infection Prevention & Control**
  The report provides assurance that appropriate systems are in place to prevent and control healthcare associated infections, with continued compliance against CQC standards. The committee was assured that infection rates remain low, with no cases of MRSA or MSSA bacteraemia and only a small number of other infections reported. It was noted that all cases were subject to Root Cause Analysis, with learning identified and actions implemented where appropriate. The committee acknowledged the ongoing programme of infection control audits, demonstrating a clear cycle of review, action, and feedback to clinical teams. Strengthening collaboration with Estates team in relation to ventilation safety and refurbishment works, and requested continued assurance that any estates-related infection risks are effectively managed and clearly articulated to the committee.

- **Patient Experience (formerly Complaints)**
  The Patient Experience annual report 2025-2026 provides assurance that high levels of patient satisfaction are consistently maintained, with strong performance against national benchmarks and effective governance of complaints and feedback. Patient insights are systematically triangulated to inform learning and service improvement, with clear evidence of a transparent, patient-focused culture. While complaint volumes have increased, processes remain robust, and continued focus on communication, responsiveness and frontline engagement will support ongoing improvement including variation between outpatient and inpatient experience.

- **Professional standards: framework for quality assurance and improvement (FAQI) annual report 2025-2026 (Appraisal and Revalidation)**
  The report provides assurance that the Trust is meeting the Responsible Officer's (RO) statutory requirements and continues to strengthen arrangements for appraisal and revalidation of the medical workforce. Robust arrangements are in place with the clear focus on continuous improvement and maintaining compliance with regulatory requirements. Achievements includes; well-established and embedded processes are in place to support appraisal and revalidation, internal audit (RSM) provided assurance, with no concerns identified regarding the effectiveness of these processes and continued organisational commitment to maintaining high professional standards. Areas for development include further enhancements planned to support continuous improvement, including the introduction of peer audit of appraisal, establishment of a Responsible Officer Advisory Group to strengthen oversight, governance, and shared learning.

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 2025-2026 confirm the Trust is compliant with the regulations.

Report cover-page					
References					
Meeting title:	Board of Directors				
Meeting date:	09/07/2026	**Agenda reference:**	**34-26**		
Report title:	Annual Learning from Deaths Report 2025/26				
Sponsor:	Tamara Everington, Chief Medical Officer				
Author:	Michelle Wickens, Head of Quality and Compliance				
Appendices:	None				
Executive summary					
Purpose of report:	This annual report provides assurance to the Trust Board on how Queen Victoria Hospital NHS Foundation Trust (QVH) has met its statutory duties under the Learning from Deaths framework (LfD) during the 2025/26 financial year.				
Summary of key issues	Throughout the year, all reported deaths of patients occurring within 30 days of an inpatient admission or outpatient procedure were subject to robust scrutiny. Mortality notifications remained stable across all quarters, with no identified trends, themes, or concerns relating to quality of care. Two inpatient deaths and no deaths following transfer out from the Trust during the year. One of the two Structured Judgement Reviews (SJR's) completed in this year was associated with a Coroner's inquest. Three inquests concluded during the year; none identified concerns regarding the care provided by QVH. Demographic analysis showed deaths predominantly occurred in older age groups (70-99 years), largely reflecting the national mortality pattern. Ethnicity data demonstrated good capture with no evidence of disproportionate impact. Overall, the Learning from Deaths process at QVH operated as intended, providing assurance that deaths were identified, reviewed proportionately, and learning was shared where relevant.				
Recommendation:	The Board is asked 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:	CQC, NHS England, Learning from Deaths framework (LfD)				
Legal:	None				
Resources:	None				
Assurance route					
Previously considered by:	Quality and Safety Committee				
	Date:	08/06/2026	Decision:	Submit to Board	
Next steps:					

Queen Victoria Hospital
NHS Foundation Trust

Holtye Rd,
East Grinstead
RH19 3DZ

Quality & Safety

Annual Report

Report covering the period from
April 2025 to March 2026

Document Control:

Executive sponsor: Tamara Everington, Chief Medical Officer

Authors: Michelle Wickens, Head of Quality and Compliance

Date: 29th of April 2026

Type: Annual Report
Version: Final
Pages: 6
Status: Public. Written and prepared for the Trust Board
Circulation: Quality & safety committee

Contents List

1.	Executive Summary
	This annual report provides assurance to the Trust Board on how Queen Victoria Hospital NHS Foundation Trust (QVH) has met its statutory duties under the Learning from Deaths framework (LfD) during the 2025/26 financial year. Throughout the year, all reported deaths of patients occurring within 30 days of an inpatient admission or outpatient procedure were subject to robust scrutiny. Mortality notifications remained stable across all quarters, with no identified trends, themes, or concerns relating to quality of care. There were: • Two inpatient deaths and no deaths following transfer out from the Trust during the year. • One Structured Judgement Review (SJR) completed in the first half of the year, associated with a Coroner's inquest. • Three inquests concluded during the year; none identified concerns regarding the care provided by QVH. Demographic analysis showed deaths predominantly occurred in older age groups (70-99 years), largely reflecting the national mortality pattern. Ethnicity data demonstrated good capture with no evidence of disproportionate impact. Overall, the Learning from Deaths process at QVH operated as intended, providing assurance that deaths were identified, reviewed proportionately, and learning was shared where relevant.

2.	Introduction
	This report sets out QVH's approach, activity and learning arising from the review of patient deaths during the period 1st of April 2025 to the 31st of March 2026. The purpose of Learning from Deaths is to: • Ensure every death is reviewed appropriately • Identify any potential problems in care • Learn and improve patient safety This work supports compliance with: • NHS England Learning from Deaths requirements • The NHS Patient Safety Incident Response Framework (PSIRF) • Statutory duties of transparency and assurance. The report focuses on deaths occurring within 30 days of an inpatient stay or outpatient procedure at QVH.

3.	**Service aim, objectives and expected outcomes**

Service Aim
To provide a systematic, transparent and proportionate approach to identifying, reviewing and learning from patient deaths to improve care quality and maintain public confidence.

Objectives for 2025/2026:

- Ensure all relevant deaths were identified and recorded
- Apply Structured Judgement Reviews where indicated
- Maintain effective governance and Coroner liaison
- Analyse demographic data to identify any inequalities
- Finalise and ratify the updated Responding and Learning from Deaths Policy

Expected Outcomes

- Timely and proportionate reviews
- No avoidable harm identified
- Evidence of learning and improvement
- Assurance to Trust Board and regulators

4.	**Activity analysis/ achievement**

Death Notification Activity

Quarter	Death Notification (within 30 days)
Quarter 1	17
Quarter 2	10
Quarter 3	12
Quarter 4	13

Numbers remained stable across the year
No upward trend or clustering identified
No deaths occurred following transfer out
Two deaths occurred in the Trust (one in quarter 1 and one in quarter 2)

- Quarter 1 death was an expected death
- Quarter 2 death under multi agency review due to safeguarding concern, no QVH care concerns

Services are alerted to deaths within 30 days of outpatient treatment in the Trust once a cause of death has been ascertained by the Medical Examiner or Coroner. Services are asked to assess for any connection between treatment and death with discussion in morbidity and mortality meetings where relevant. Service decisions are reviewed by the Clinical Lead for Quality and Chief Medical Officer.

This consistency provides assurance that activity reflects expected population-based mortality rather than avoidable system issues.

Structured Judgement Reviews (SJRs) were completed for both deaths in hospital and scrutinised through Directorates and the Executive Sub Committee for Quality.

- One of the SJR's was completed in quarter 1
- This was linked to an inquest concluded in September 2025
- The coroner determined that death resulted from complications of a necessary medical procedure
- No concerns or actions identified for the Trust

	• The second SJR was completed in quarter 2, no concerns with quality of care identified This demonstrates appropriate use of SJRs in line with national guidance. Inquests • September 2025: Read-only (narrative) conclusion – complications of necessary medical procedure • Quarter 3: Inquest of a burns patient who had died in the previous year; narrative conclusion issued with no implications for QVH. This case has also been reviewed by the Local Southeast and National Burns Networks • Quarter 4: no inquests • One case where QVH was granted Interested Person status for care delivered elsewhere; inquest pending beyond this reporting period (Interested Person status defines an individual or organisation that has a legal right to actively participate in the investigation and hearings regarding a patient's death). It is recognised that considerable preparation is required for inquests and the experience of acting as a witness can feel stressful. All inquests were managed appropriately. Staff were supported in preparation and debriefs. System-Wide Learning • No system-wide learning actions from other Trusts • Learning from Deaths Quality Improvement Network was established but paused due to ICB restructure.

5.	**Involvement & Engagement**
	Involvement • Patient Safety Team • Clinical teams contributing to reviews • Coroner's Office liaison • Executive oversight and assurance via the Sub committee for Quality Engagement • Reporting through Quality and Safety Committee • Learning shared via Datix, within Mortality review meetings in services, Executive Subcommittee for Quality and Clinical Learning forum • Outcomes included within Patient Safety Overview reports

6.	**Learning and continuous improvement**
	Key learning from 2025/26 included: • Validation that current mortality scrutiny processes are fit for purpose • Confirmation that proportionality is being applied correctly • Improved consistency in ethnicity data capture • Completion and ratification of the Responding and Learning from Deaths Policy, strengthening governance clarity Reflections indicate that the service is stable and embedded within wider patient safety processes.

7.	**Recommendations**
	• Ongoing development of demographic benchmarking • Continued proportionate approach to mortality review

8.	Future plans and targets
	• Benchmark age-related mortality against QVH activity data. • Align ethnicity and deprivation analysis with Health Inequalities work • Re-engage with system Learning from Deaths network once ICB arrangements stabilise and meeting recommence • Maintain compliance with PSIRF and National Learning from Deaths Requirements These objectives will be monitored through the Executive Subcommittee for Quality.

9.	Conclusions and assurance
	This annual report provides assurance that QVH continues to meet its statutory and regulatory responsibilities under the Learning from Deaths framework. Evidence demonstrated: • Stable mortality rates • No identified quality of care concerns • Appropriate use of reviews and inquests • Effective governance and transparent reporting The Trust can be assured that deaths are reviewed appropriately and that opportunities for learning and improvement are identified and acted upon when necessary.

10.	Appendices
	None

11.	Report approval and governance
	This report will be presented to: • Executive Committee for Quality and Risk • Quality and Safety Committee For review, assurance and ratification prior to publication.

Report cover-page					
References					
Meeting title:	Board of Directors				
Meeting date:	09/07/2026	**Agenda reference:**	**34-26**		
Report title:	Safeguarding (Adult and Child) Annual Report 2025-2026				
Sponsor:	Liz Blackburn, Acting Chief Nursing Officer				
Author:	Katy Fowler, Safeguarding Children and Looked After Children Named Nurse and Sarah Beedy, Adult Safeguarding Named Nurse and Mental Capacity Act Lead				
Appendices:	None				
Executive summary					
Purpose of report:	To provides assurance to the Board that QVH is effectively meeting its safeguarding responsibilities.				
Summary of key issues	This report outlines the robust safeguarding systems and processes in place at Queen Victoria Hospital NHS Foundation Trust (QVH), demonstrating the Trust's ongoing commitment to meeting its statutory responsibilities and ensuring the safety and wellbeing of all service users. Key Areas of Focus • Statutory safeguarding responsibilities and governance • Partnership working and external assurance • Staff training, policies and safe recruitment • Safeguarding performance, challenges, and risks • Quality improvement and learning from reviews Highlights • Strong governance arrangements through the Strategic Safeguarding Group • Active contribution to Safeguarding Adult Reviews and Domestic Abuse Reviews • Enhanced safeguarding training and role-specific education • Implementation of new clinical pathways to support vulnerable patients • Continued focus on improving Mental Capacity Act compliance				
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:	KS01, KS02 & KS05				
Organisational risk register:	None				
Regulation:	CQC				
Legal:	The Care Act 2014. Section 11 of the Children Act 2004. Working Together to Safeguard Children 2023. Mental Capacity Act 2005. Safeguarding Accountability & Assurance Framework 2026				
Resources:	None				
Assurance route					

Previously considered by:	Executive committee for quality & risk			
	Date	15 June 2026	Decision	Noted. Submit to QSC
	Quality & safety committee			
	Date	30 June 2026	Decision	Approved.
Next steps:	Submission to Trust Board 9 July 2026			

Queen Victoria Hospital
NHS Foundation Trust

Holtye Rd,
East Grinstead
RH19 3DZ

Quality & Safety

Safeguarding Annual Report

Report covering the period from
April 2025 to March 2026

Document Control:
Executive sponsor: Liz Blackburn, Acting Chief Nursing Officer

Authors:
Katy Fowler, Named Nurse for Safeguarding and Looked After Children
Sarah Beedy, Named Nurse for Safeguarding Adults and MCA lead

Date: April 2026

Type: Annual Report
Version: Final
Pages: 21
Status: Public. Written and prepared for the Trust Board
Circulation: Quality & Safety committee

Contents List

1.	Executive Summary

The Queen Victoria NHS Foundation Trust (QVH) Annual Safeguarding Report outlines the robust systems and processes in place to protect children, young people, and adults who access its services. It reflects the Trust's ongoing commitment to fulfilling its statutory safeguarding responsibilities and provides an overview of activity and performance across the reporting period from 1 April 2025 to 31 March 2026.

Statutory Responsibilities and Assurance

- Named nurses in adult and child safeguarding are in place, meeting the statutory requirements.
- The Chief Nursing Officer is the Board Executive Lead for safeguarding.
- Safeguarding governance is overseen by the Strategic Safeguarding Group (SSG) with an onwards governance structure to enable reporting and assurance.
- There is involvement with the Local Safeguarding Children Partnership and Safeguarding Adult Board in West Sussex.
- QVH has contributed to two learning reviews; One Safeguarding Adults Reviews (SAR) and one Domestic Abuse Related Death Reviews (DARDR).
- There is a safeguarding training programme in place to ensure QVH staff have received the appropriate level of safeguarding training, role dependent.
- Policies, protocols, and processes are in place to support the assessment of need and vulnerability of children, young people and adults accessing QVH services.
- QVH has a safeguarding supervision policy.
- Robust recruitment processes are in place, with pre-employment clearance for all new staff. QVH complies with guidance in relation to modern day slavery and human trafficking and undertakes enhanced Disclosure and Barring (DBS) checks for staff working with children and adults.

Current challenges:

- Compliance with the Mental Capacity Act (MCA) and consent remains a significant challenge within the hospital. The most recent audits have not shown improvement on last year's position. However, there are some examples of good practice.
- While the Trust does not provide acute mental health services, this risk is clearly recognised and managed through the organisational risk register. The safeguarding team works proactively with staff to provide support and guidance where there are identified safeguarding concerns.
- Clinical systems were updated throughout the year, with significant safeguarding team input; remaining issues will be addressed during optimisation.
- The QVH safeguarding audit programme requires review. Audits completed this year include MCA, children's dog bites, and Was Not Brought (WNB). Additional audits are needed to provide further assurance across safeguarding work streams.

	• The safeguarding team continues to work with staff to ensure consistent understanding of safeguarding responsibilities and the role of the safeguarding team. **Current Achievements:** • QVH have been involved in several learning reviews Safeguarding Adult Reviews (SAR), Domestic Abuse Related Death Review (DARDR) and Local Safeguarding Children Practice Reviews (LSCPR). Any identified local actions and learning have been disseminated at learning forums, governance meetings and training. • Bruise and physical injury pathway designed to support staff in recognising and responding to children who attend with concerning presentations. • A task and finish group was established to address key barriers to MCA compliance. Children not brought to appointments pathway embedded in practice and compliance monitored through audit. Increased staff awareness of Was Not Brought (WNB) and possible links to neglect. • Delivery of bespoke role specific training, including domestic abuse, MCA, bruise pathway, mental health and CP-IS. • Appointment of named nurse and specialist nurse roles.

2.	**Introduction**
	This annual report provides assurance to the Board that the Trust is fulfilling its safeguarding responsibilities in line with the NHS standard contract. 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 suffering or at risk of harm from abuse or neglect. Additional arrangements include: • Safe recruitment • Effective training for staff • Effective supervision arrangements • Working in partnership with other agencies. The Trust requires all employees and volunteers to share responsibility for ensuring that safeguarding principles and duties are consistently applied to promote the wellbeing of children and adults. This commitment is clearly outlined within the supporting information aligned with each job description and is provided as part of the application process.

3.	Service aim, objectives and expected outcomes

The core service objectives for the safeguarding team are monitored by the ICB using the Safeguarding Sussex Standards Assurance Tool, which is completed and submitted to the Safeguarding Team in the ICB biennially, this was completed during the year 2025-26. The standards are as follows:

- **Strategic Leadership**
- **Lead Effectively to Reduce the Potential of Abuse**
- **Responding Effectively to Allegations of Abuse**
- **Safeguarding Practice and Procedures**
- **Staff Competence**
- **Safer Recruitment**
- **Learning from incidents**
- **Commissioning**

QVH was Red Amber Green (RAG) rated green overall with only three areas rated Amber:

1. Each organisation is required to have a safeguarding and looked after children audit plan that includes information on the audit process, involvement of managers and staff and how the findings from audit will be disseminated.
2. There are clear safeguarding procedures that are followed in practice, monitored and reviewed, which are consistent with the local multi-agency safeguarding policy and procedures for children and adults, which set out the responsibilities of all workers to operate within it. This includes clear up-to-date local information on who/how to contact for advice and support.
3. All organisations are required to understand their legal responsibilities under the Mental Capacity Act including LPAs, Court of Protection, best interest decision making and capacity assessments.

These areas were rated amber due to constraints within the audit programme (items 1 and 2) and issues relating to MCA compliance (item 3). They have remained key priorities throughout the year and will continue to be prioritised in the coming year.

Review of key priorities for the year 2025-26:

- **EPR: To support and monitor the effectiveness of the safeguarding and MCA sections of the EPR**.

The safeguarding team worked collaboratively with EPR design and implementation colleagues to develop risk assessment tools and documentation within the Archie system. The children's risk assessment tool has been effective overall, supporting the well-established practice of universal safeguarding screening at admission, although some variability in data entry has been observed.

Adult safeguarding screening assessment represents a newer component of the admission process and has not yet been consistently applied across all patients. Consideration is being given to strengthen this process to support improved compliance.

Currently, the Archie system does not include functionality to clearly flag patients with safeguarding concerns, which may affect the visibility of risk. In addition, key

	documentation, such as safeguarding referrals, Lasting Power of Attorney, and parental responsibility are recorded within the Evolve system. While this system is accessible via Archie, opportunities remain to further streamline access and improve integration for staff. The safeguarding team continues to work in partnership with the EPR team to progress these developments. • **To monitor how effectively the children's WNB guidance is being embedded by audit.** A baseline audit has been completed, with a further audit planned for the new financial year. An increase in awareness and enquiries to the team has been noted throughout the year. • **To continue with the safeguarding audit programme**. To support effective monitoring of safeguarding activities undertaken during the year, the safeguarding team recognises that a robust audit programme will be a central priority for the year ahead. • . **Improve compliance with the MCA** The following actions were implemented during the year to support MCA compliance. These include: • Task and finish group • Department specific training and general face to face MCA training • Evaluation of face-to-face training • Audit • **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.** Think family has been embedded in training across the Trust, with a particular focus on domestic abuse. There have been 12 adult patients during this year where children in their care have been identified as possibly being at risk.

4.	Activity analysis/ achievement
	Roles and Responsibilities The Chief Executive Officer holds overall responsibility for safeguarding children and adults. The Chief Nursing Officer (CNO) is designated as the executive lead for safeguarding. Providing strategic leadership on all aspects of the Trust's contributions to safeguarding. QVH have named professionals in place for adults, children and MCA meeting the statutory requirements as identified in: • Section 11 of the Children Act 2004

- Working Together to Safeguard Children (2023)
- The Care Act (2014)
- NHS England Accountability and Assurance Framework (2024)
- Mental Capacity Act (2005).

Governance and Accountability

Safeguarding governance and assurance is monitored by the Strategic Safeguarding Group (SSG), which meets quarterly and is chaired by the CNO. The outcomes of this meeting are overseen by the Quality and Safety Committee via the alert, advise and assure framework. On a monthly basis the safeguarding team provide the suite of metrics and overview of current work streams.

The 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 and ensures that effective systems and processes are in place to support the ongoing review, monitoring of risks, and updating of safeguarding arrangements.

Safeguarding representatives from NHS Sussex Integrated Care Board (ICB), attend the SSG which allows them to have oversight of the trusts safeguarding processes and developments.

A network of safeguarding champions operates across clinical areas within the Trust, supporting and promoting safeguarding at QVH.

Any relevant policies and procedures will also be taken through other governance groups, for example Paediatric Governance Meetings, Additional Needs Forum and the Collaborative clinical Forum.

During this year, the safeguarding team have reviewed the safeguarding policy in line with the Fuller recommendations and NICE guidance CG89. This is awaiting approval from the SSG.

Reporting
The safeguarding team provide monthly reports to the Executive Sub-Committee for Quality this include:

- Training data
- Safeguarding activity
- Updates on multi-agency reports
- Policy and protocol development
- Clinical system updates

Quarterly reports are provided and shared with the SSG:

- ICB assurance / exception reports NHSE Safeguarding Commissioned Assurance Tool (SCAT)
- NHSE Prevent
- NHSE FGM

The safeguarding team completes biennial reports for safeguarding adults and children (section 11) in alternate years, as well as the Sussex Safeguarding Standards report that was submitted earlier this year.

Safeguarding Risks

There were two safeguarding risks recorded on the risk register:

MCA - There is a risk that mental capacity assessments may not always be undertaken when required. This could result in procedures being carried out without valid consent, or conversely, procedures being declined where the individual lacks the capacity to make such decisions. Consequently, this may lead to treatment or procedures being completed without full compliance with the Mental Capacity Act (MCA). Further detail is provided within the MCA section.

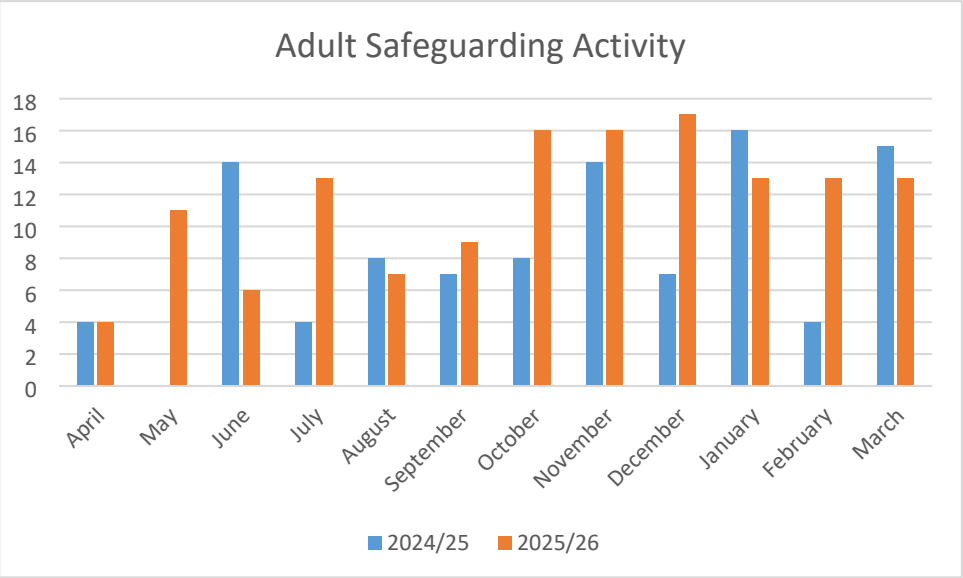
Minor Injuries Unit – There is a risk that staff are not able to access historical information about previous attendances at QVH. This may result in known safeguarding information not being available to staff to inform risk assessment. This risk was closed during the year as the EPR system has been implemented.

Safeguarding Adults

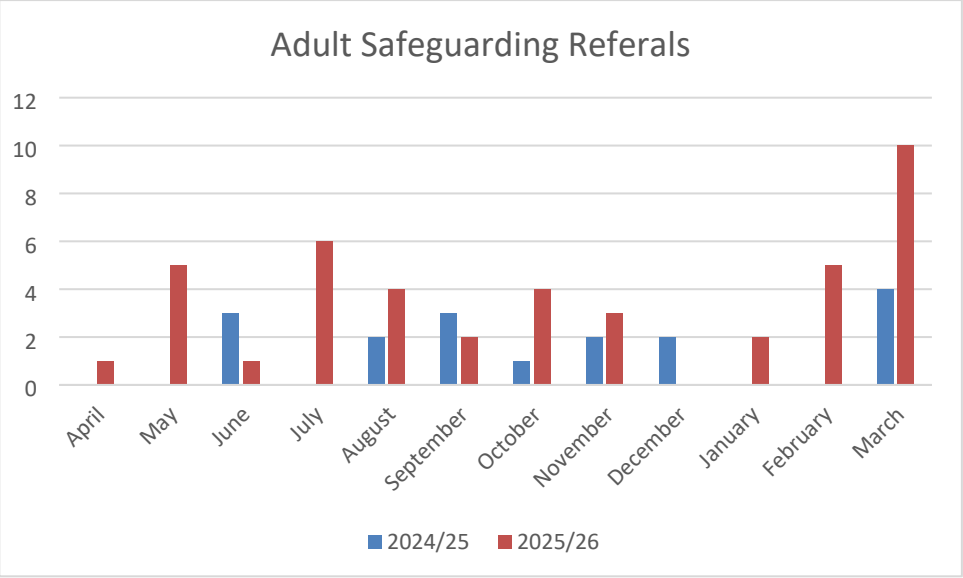
The Care Act provides the legislative basis for Adult Safeguarding. The local authority, who are the lead agency, will use safeguarding procedures in the following circumstances:

- The patient has care and support needs and
- They are less able to protect themselves due to their care and support needs and
- 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.



The chart above demonstrates adult safeguarding activity, when compared to last year the data shows an increase of 27 cases, this represents an almost 25% increase in safeguarding adult concerns shared with the safeguarding team. There appears to be an increase in concerns around self-neglect leading staff to seek advice. This may be as a result of increased awareness and visibility of the team.



The above chart shows the number of referrals to the local authority for safeguarding purposes. There is incomplete data for the year 2024/25.The numbers are low, however due to the specialist nature of the work at QVH, safeguarding measures will have often been taken by the referring hospital in trauma cases. The increase in referrals in March 2026 appear to have been linked to concerns around neglect and self-neglect, which has informed the coming year's priorities. The Safeguarding team will monitor referral numbers.

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 and supported by the Domestic Abuse Policy. It is important to recognise that staff may be the victim / survivor or perpetrator of domestic abuse. QVH has been involved in one DARDR during this year.

Safeguarding Children

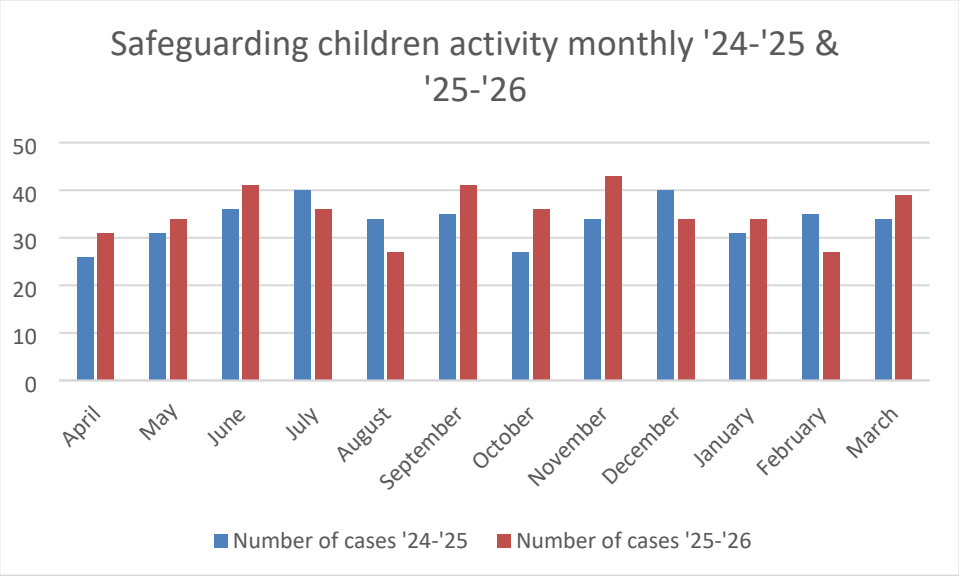
All QVH staff have a statutory duty to safeguard and promote the welfare of children who come into contact with our service, this is defined as:

- 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.

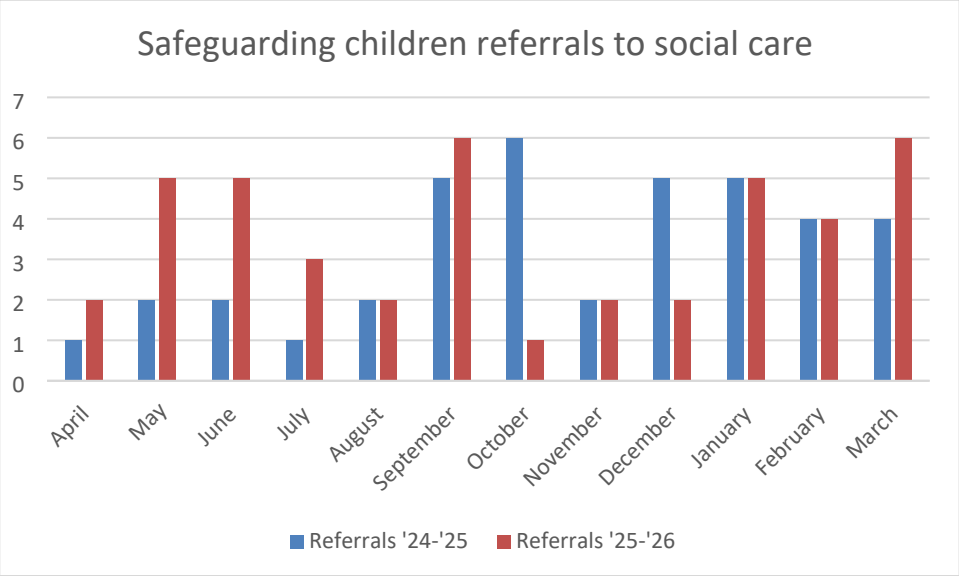
(Working Together to Safeguard Children 2023)

Safeguarding children activity is reported to the Executive sub-committee for Quality on a monthly basis, as well as the SSG and champions meeting.

The chart below shows safeguarding children activity this year and compares it to last year's data. There were an additional 20 cases of concern managed this year.



Due to the specialist tertiary nature of the Trust, many children attending the Trust have been triaged and reviewed prior to admission. As a result, those children identified with safeguarding concerns have been referred to the local authority prior to admission. The table below shows the referrals made to children's social care during the year 2024-25 (39) and 2025-26 (43) by QVH, showing a small increase in the amount of referrals made. No specific themes have been identified.



The Introduction of Archie EPR has fully digitised the MIU records which has allowed for greater visibility and oversight of care.

Child Death
Child deaths are an extremely rare occurrence at the Trust. In the event that a child were to die unexpectedly or be brought to the hospital already deceased, there is clear guidance within the Bereavement Policy as to next steps. There have been zero cases in 2025/26.

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 the Trust 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 need to identify who has parental responsibility for the purposes for care, treatment and consent. Staff are encouraged to use a trauma informed approach to support all children but particularly those who are care experienced.

The Named Nurse has support from the Designated Nurse team within the ICB and has utilised these links to ensure that the safeguarding and looked after children policy is updated to include additional information about looked after children as well as care leavers.

The Peanut pre-assessment team has close links with the safeguarding team and works to identify children in care to ensure valid consent is gained from the person who holds parental responsibility.

Mental Health and Safeguarding

The safeguarding team continues to receive concerns regarding patients with coexisting mental and physical health needs and provides support where safeguarding risks are identified. The Safeguarding Policy has been updated to reflect the Pan Sussex Safeguarding Procedures. Targeted, bespoke training has been delivered in collaboration with psychological therapy service, following a Local Safeguarding Children Practice Review. New leaflets to support signposting and safety planning are under development. Work to strengthen mental health provision across the Trust is being led by the CMO and CNO.

Mental capacity Act and DoLS

The Mental Capacity Act (MCA) 2005 provides safeguards for those patients who are unable to consent to care and treatment. Complying with the MCA is a legal requirement and is important to ensure patients who may be unable to make informed decisions regarding their care and treatment. This legislation provides a framework for ensuring that all patients receive appropriate and ethical care.

There is currently an organisational risk with a rating of 12:
'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'.

Through the year, work has been ongoing to improve compliance with the MCA.

The safeguarding team aim to review addition to waiting list forms where capacity concerns are identified and provide advice on appropriate processes. Where correct processes have not been followed, incidents are reported via Datix to support a positive reporting culture and improve compliance. This approach supports the Pre-Assessment team in identifying patients with capacity issues prior to procedures and is monitored through audit to assess improvement over time.

In November 2025, Archie EPR was introduced. Included in the first phase was electronic MCA form. The MCA tab is visible to staff which acts to remind staff to consider mental capacity. However, the initial plan to make this field mandatory has not been possible from a software perspective. The safeguarding team continue to work with the Archie team to make improvements.

Deprivation of Liberty Safeguards (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 6 (DoLS) applications made by QVH in the year 2025-26. This included patients with dementia and delirium. This represents a decrease in applications from 2024/25. Ongoing work will focus on improving staff understanding of when a DoLS application is required.

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)

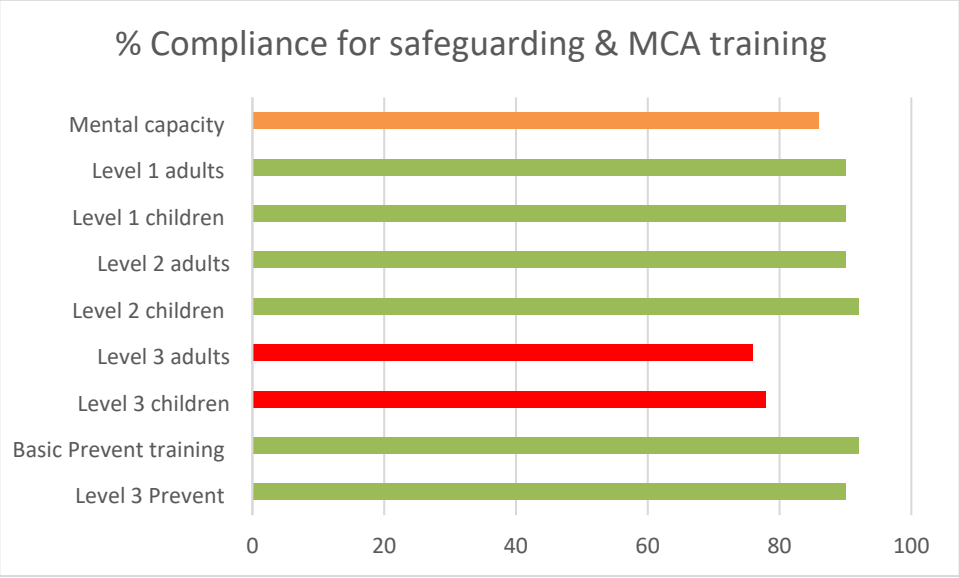
Compliance at QVH for Prevent training at level 3 is 85% which equals the national target.

- QVH has a Prevent delivery plan.
- QVH contributed to the Counter Terrorism Local Profile (CTLP).
- Training figures are submitted to NHSE via quarterly reports.
- Prevent national referral form is available on QNet.
- The Safeguarding leads attended the South East Region Prevent leads meeting.

No Prevent referrals were made during the year 2025-26.

The Prevent Training and Competency Framework (2025) introduces annual updates and a three-yearly refresher cycle, replacing the previous one-off WRAP/e-learning model. The Safeguarding Team, through engagement with the regional Prevent forum and ICB Prevent lead, has confirmed that themed screen savers can be used as an alternative to annual face-to-face updates. This approach will be implemented over the coming year.

Training, Development and Staff Competence



As at March 2026, compliance with safeguarding and Mental Capacity Act (MCA) training is largely meeting the Trust target of 90%; however, Level 3 safeguarding and MCA training remain below target. Work is ongoing with Learning and Development and Medical Education to identify staff requiring Level 3 competency and address non-compliance. Data accuracy is impacted by a small number of individuals no longer employed by the Trust who remain recorded as requiring training.

During this year the children's intercollegiate document was published which provides guidance on staff competency, and this is being used to guide further changes to safeguarding training. Once approved, a review of the safeguarding Learning and Development Strategy and a Training Needs Analysis will be completed alongside the education teams.

Incidents & Complaints
There have been no Patient Safety Incident Investigations (PSII) related to safeguarding during the year and one complaint relating to safeguarding children. On investigation, it was found that staff had followed correct process. An updated patient information sheet has been put forward to the patient information group for approval as a result.

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 Managing Staff Complaints guidance. Allegations against staff can be varied and not all relate to safeguarding. The CNO and workforce services share allegations against staff related to safeguarding with the team. Advice can be sought from the Local Authority Designated Officer (LADO) or the Person in Position of Trust (PIPOT). Information is kept securely, relevant issues are reported to the ICB in the quarterly exception reports.

EPR and Clinical Systems
The safeguarding children and MCA pages have amalgamated previous documentation while the safeguarding adult's page is completely new for staff to utilise.
Further work is required in the following areas:

- Safeguarding flag on EPR
- Flow of information between medical and nursing notes

Challenges with information flowing between medical and nursing documentation. In conjunction with the EPR team, there will be amendments made to ensure that documents can be updated.

Electronic Discharge Notification (EDN)
The safeguarding team are part of a working group, responsible for design and implementation of EDNs with information populating directly from Archie into the GP copy. Staff can then decide what information is appropriate for the patient copy, giving particular consideration to domestic abuse cases.

Patient Knows Best (PKB)
The PKB team have requested input around the addition of clinic letters to PKB and guidance on occasions where this may be a risk to patients. This work is in the early stages and updates will be reported into the SSG.

Child Protection Information Sharing (CP-IS)

Phase 2 rollout of CP-IS is underway. The safeguarding team has worked with orthodontics and information governance to enable checks and agree a service SOP.

The Named Doctor has liaised with NHSE, confirming that by end of 2026 all children accessing QVH services should have a CP-IS check.

Work is ongoing to ensure Altera PAS can support and streamline this prior to trust-wide rollout. NHSE is currently testing functionality with another provider, and Altera has confirmed CP-IS is on its roadmap.

Was Not Brought (WNB) for children

During the year, the safeguarding team has worked across the Trust to embed the concept of 'Was Not Brought' (WNB) in place of the term 'Did Not Attend' (DNA) for children. This represents an important cultural shift, acknowledging that children rely on their parents or carers to attend appointments and that non-attendance may be a safeguarding concern.
Collaborative work has also been undertaken with clinical systems teams to ensure that instances where children are not brought to appointments can be appropriately recorded as WNB, within electronic systems.
The WNB protocol incorporates risk assessment processes and the use of standardised template letters to support consistent decision-making. A key component of the protocol is to encourage staff to clearly communicate with parents, carers and young people about the potential implications of not attending appointments.

5. Involvement & Engagement

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 external forums, subgroups and networks which enables QVH to work collaboratively. See list below.

Safeguarding children meetings	Frequency
West Sussex Safeguarding Children Partnership Group	New arrangements.
Learning and Developments 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
National Network for Safeguarding Children Named Professionals	Monthly
CP-IS Meeting	Quarterly
Safeguarding Adults meetings	**Frequency**
West Sussex Safeguarding Adults Board	Quarterly
NHS Professionals Safeguarding Adults	Quarterly
MCA Steering Group	Quarterly
Domestic and Sexual Violence, Abuse Oversight Group	Quarterly

Prevent	Frequency
South East Prevent Leads Network	Quarterly

The Named professionals will be co-opted into additional groups as required.

A site visit from the ICB has been postponed from November 2025. Due to the changes within the ICB, we are awaiting updated information on this.

Supervision
Safeguarding named professionals receive supervision from designates within the ICB. This allows for case discussion and strategic oversight. Assurance has been given that the changes within the ICB will not affect the provision of this. QVH has a safeguarding supervision policy that provides a framework for supervision across the trust to support staff with challenging safeguarding cases.

Safeguarding Champions
The safeguarding team actively engage with staff representing all clinical areas via a network of Link Champions, who are invited to attend a bi-monthly Safeguarding Champions meeting. There is a focus on learning within the group, particularly in relation to case reviews (local and national) and incidents. The champions also support the function of scrutinising policies, protocols and guidance. 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.

The safeguarding team attend a variety of internal meetings to support the safeguarding agenda across. For example:

- Collaborative Clinical Forum
- Additional Needs Forum
- Health Inequalities Group
- Paediatric Governance
- Other Governance groups as required

6.	Learning and continuous improvement

Clinical learning forum
The safeguarding team now contributes a regular slot at the monthly Clinical Learning Forum, enabling dissemination of learning from incidents, national and local reviews, as well as providing updates and discussion of case vignettes. Over the past year, this forum has supported shared learning following the DARDR and has been used to highlight key topics, including Archie safeguarding and CP-IS. The forum allows for access to a wide variety of staff helping to raise the profile of safeguarding, increase staff knowledge and improve visibility of the team.

Audit
Audits in safeguarding are important to ensure practice is safe, effective, accountable, and continuously improving.
The safeguarding team participate in internal and external audits and safeguarding practice reviews.

The audits undertaken this year are:

- Children's dog bites audit found that in total 94% of children with dog bite injuries had been reported to Police. However of the 4 cases of children seen through MIU only 50% of cases were reported. Guidance from Archie should remind staff to complete this following roll-out.
- WNB children's baseline audit demonstrated the need for robust protocols for children not brought to appointments. The audit found that practice varied significantly. Following the launch of the protocol, further audits are planned to assess compliance.
- MCA – An audit was undertaken prior to launch of Archie as a baseline audit. This demonstrated that the Trust is not compliant with the MCA and therefore not consistently following a legal pathway to providing care and treatment. In some cases this means that patients may not have a full understanding of the decision of surgery, and this will have implications on their post-operative care and wellbeing.
- A Rolling monthly MCA audit was commenced in March 2026. The sample of patients used have been coded with a diagnosis of Dementia and treated at QVH.

Any reports and action plans are reviewed and monitored in the QVH strategic safeguarding group and the QVH safeguarding champions group.
Outstanding audits include:

- Domestic abuse
- Adult dog bites
- EDN audit, safeguarding section audit.

The safeguarding team audit programme is under review.

The safeguarding team inputs to the West Sussex Safeguarding Children Partnership (WSSCP) and West Sussex Safeguarding Adults Board (WSSAB) multi-agency audits as required e.g.: Section 11 self-assessment (child) and Providers self-assessment (adults). During this year the adult provider's self-assessment was submitted.

MCA Task and finish group
A task and finish group was established in March 2025 following a 2023 audit that highlighted low compliance with the Mental Capacity Act. The group has identified key improvement areas and is strengthening processes across the patient pathway to improve outcomes for individuals who may lack capacity, using a continuous improvement approach. . The three key areas are;

Patient Pathway

- Capacity concerns are highlighted at referral through GP engagement and website guidance.
- Double appointments can be arranged where capacity concerns are identified to allow time for assessment.
- Appointment letters request patients bring their Health and Welfare Lasting Power of Attorney where applicable.
- Updates to Evolve have simplified identification of capacity concerns and improved access to MCA documentation.
- MCA assessment forms are available on Archie.

- The Named Nurse/MCA Lead has observed outpatient clinics to better understand pathway challenges and inform improvements.

Audit – See audit section above

Training – Despite training compliance reaching 86%, a gap remains between staff knowledge and the consistent, practical application of Mental Capacity Act (MCA) principles. In response, the safeguarding team has revised the training programme to strengthen its focus on application, this includes practice at completing an MCA assessment as a group activity. Face-to-face, QVH specific training is not currently mandatory, so many staff complete online training which does not support practical application. A recommendation from the Task and Finish Group is that all surgeons at QVH receive an hour of mandatory face-to-face training.

MCA training has been discussed in various forums including the MCA task and finish group. The face-to-face training has been updated and reduced in length to meet the needs of the service.

SARS & DARDRs
The adult safeguarding team has been involved in one Safeguarding Adult Review (SAR) published in April 2026. The learning from this related to safe discharge.
The discharge team have been involved in the development of a complex discharge checklist to support complex discharge processes to reduce the risk of a similar situation occurring again.
One onward referral from the Trust for a SAR has met the criteria and is currently in process. The safeguarding team will represent QVH in this process and invite specialist teams to the panel if required.
QVH has been involved in one DARDR, during this year. The focus of the review has been to identify good clinical practice, missed safeguarding opportunities and service improvement measures. All internal actions and service improvements were identified early in the process and have been implemented, including bespoke targeted training. The report is yet to be published; the SSG will continue to be updated.

Bespoke training
The safeguarding team offer bespoke training to specific areas in in response to local and national cases, this has included:

- Domestic abuse
- Mental health in children
- Bruise and physical injury pathway
- Department specific MCA training
- WNB (children)
- Clinical learning forum topics including professional curiosity and safeguarding in Archie.

The majority of these bespoke sessions can be used as evidence towards L3 safeguarding training.

Bruising and physical injury Guidance
Following some identified good practice, the safeguarding team built on this success to design and embed a pathway to support staff in identifying and managing cases

	where the presenting injury is not consistent with the proposed mechanism or the child presents with other concerning injuries such as bruises. This pathway has been socialised across the trust and is available on Qnet. Bespoke training has been delivered to the majority of relevant teams with the support of the named doctor.

7.	**Recommendations / Future plans and targets**
	Key Objectives for the coming year: **Domestic abuse**: In England and Wales, an estimated 3.8 million people aged 16 and over experienced domestic abuse in the year ending March 2025 (ONS). Recognition and appropriate support for survivors remains a key priority for the safeguarding team. Following the DARDR the safeguarding team implemented bespoke training to support staff and raise awareness. An increase in reporting domestic abuse has been noted as compared to the previous year (Q2 25/26 – 12 cases, Q2 24/25 – 8 cases) However, overall, there has been a decline in the reporting of domestic abuse this year, with 26 cases being reported during this year and 32 cases last year. It is not clear why the number of cases have decreased. The safeguarding team are planning a staff knowledge audit to be administered via the safeguarding champion's network and surgical governance meetings. With a proposed date for completion by the end of 2026. Domestic abuse bespoke training has been incorporated into training at all levels, using case examples, with a 'Think Family' approach. Informal feedback from staff has been positive. **Was Not Brought**: Children: Following implementation of the WNB protocol and baseline audit, the Safeguarding Team will continue to monitor staff compliance and report to safeguarding and governance committees. Early indications show increased enquiries since launch, with the expectation of reduced 'was not brought' cases and a more consistent management approach. Adults: A protocol for adults at risk has been recognised as being required. The safeguarding team aim to have a protocol agreed / approved by the end of 2026-27 financial year and launched the following year with associated audit of staff compliance set during the following year. **CP-IS**: The national roll out for CP-IS is due by the end of 2026. Orthodontics has been identified as a priority area in phase 2. Roll out across the trust is dependent on the availability of the new PAS system and it's functionality for CP-IS. **MCA Task and Finish Group recommendations**: Following the completion of the Task and finish group the following actions have been agreed: • All surgeons to undertake 1 hour of mandatory, face-to-face MCA training • MCA monthly risk oversight • Patient pathways – double appointments for all patients identified as requiring an MCA

	• Monthly audit – continuation of monthly audit **Liberty Protection Safeguards (LPS)**: Liberty Protection Safeguards (LPS), introduced under the Mental Capacity (Amendment) Act 2019 to replace Deprivation of Liberty Safeguards (DoLS), have not yet been implemented and DoLS remains the current legal framework. Implementation has been repeatedly delayed, with the government announcing a further consultation in 2026 to inform revised guidance and future rollout. At present, no confirmed implementation date has been set, though national direction indicates continued movement towards a more streamlined and wide-ranging system. **Optimisation of clinical systems**: The safeguarding team will continue their involvement with clinical systems to ensure that safeguarding considerations are addressed at the earliest opportunities. **Training:** As described on page 16 the intercollegiate documents have been reviewed and a proposal formulated to be agreed by the SSG for safeguarding training across the trust. The proposal is to include • QVH specific induction training, allowing staff to passport their level 3 training across from a previous trust. • Level 3 training for all clinical staff, including resident doctors. • Closer alignment between adult and children training to include transitional safeguarding. This is a significant change to the current provision and will need support from various teams to support implementation. The safeguarding team envisage the implementation to take around 1 year. Compliance will be monitored and reported by the current governance mechanisms.

8.	**Conclusions and assurance**
	This report demonstrates the significance of safeguarding as a core organisational priority at QVH throughout 2025–26. It highlights the continued strengthening of safeguarding governance, the commitment to meeting statutory responsibilities, and the work undertaken to support staff in identifying and responding to safeguarding concerns across children, young people and adults. Key themes within the report include increased safeguarding activity, improvements in staff awareness and reporting, and strong engagement in multi-agency working and learning reviews. The implementation of the Archie EPR system has enhanced oversight of safeguarding activity, although challenges remain in optimisation and functionality. Learning from audits, incidents, and reviews has been actively disseminated and embedded through training, forums and revised pathways, including the development of the bruising pathway and the embedding of the Was Not Brought (WNB) process. The report also highlights central challenges, most notably ongoing compliance with the Mental Capacity Act, pressures on audit capacity, and the need to further strengthen systems supporting patients with mental health needs. These issues have been clearly identified and prioritised, with structured actions already underway through the MCA task and finish group, training improvements, and planned work streams.

	Overall, safeguarding arrangements at QVH remain well-established and responsive, with a clear patient focus and on continuous learning and improvement.

9.	**Report approval and governance**
	This annual report is submitted to ECQR for review.

Report cover-page					
References					
Meeting title:	Board of Directors				
Meeting date:	09/07/2026	**Agenda reference:**	**34-26**		
Report title:	Infection Prevention and Control annual report 2025-2026				
Sponsor:	Liz Blackburn, Acting Chief Nursing Officer				
Author:	Sarah Prevett, Lead Infection Control Nurse				
Appendices:	Appendix A – IPC structure chart Appendix B – The requirements of the Health and Social Care Act 2008 Appendix C – IPC Annual Programme objectives 26/27 Appendix D – Ratified IPC policies				
Executive summary					
Purpose of report:	This report provides assurance to the Board regarding systems in place to prevent and control healthcare-associated infections				
Summary of key issues	• 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 ○ 0 cases of Methicillin Sensitive Staphylococcus aureus (MSSA) bacteraemia ○ 1 case of E. coli bacteraemia ○ 1 case of Pseudomonas aeruginosa bacteraemia ○ 1 case of Clostridium difficile infection, CDI 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 fed back through the relevant teams and departments. • Ongoing work continues to enhance collaboration with the Estates team, ensuring assurance on ventilation safety and full inclusion of key stakeholders in refurbishment programmes.				
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:	KSO1				
Organisational risk register:	Risk 0107 – High consequence infectious disease PPE				
Regulation:	CQC				
Legal:	Health and Social Care Act 2008				
Resources:	None				
Assurance route					
Previously considered by:	Executive committee for quality & risk				
	Date:	18 May 2026	Decision:	Submission to Q&S	
	Quality & safety committee				
	Date:	08 June 2026	Decision:	Approved	

Queen Victoria Hospital
NHS Foundation Trust

Holtye Rd,
East Grinstead
RH19 3DZ

Infection Prevention and Control

Queen Victoria Hospital NHS Foundation Trust
Service Annual Report

Report covering the period from
April 2025 to March 2026

Document Control: Executive Committee for Quality and Risk
Executive sponsor: Acting Chief Nursing Officer and DIPC

Authors: Lead Infection Control Specialist Nurse

Date: 2 June 2026

Type: Annual Report
Version: 6
Pages: 20
Status: Public. Written and prepared for the Trust Board
Circulation: QVH Trust Board

Contents List

1. Executive Summary

The purpose of this report is to provide assurance to the Trust, 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.

This report covers the period from 1 April 2025 to 31 March 2026 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
  - 0 cases of Methicillin Sensitive Staphylococcus aureus (MSSA) bacteraemia
  - 1 case of E. coli bacteraemia
  - 1 case of Pseudomonas aeruginosa bacteraemia
  - 1 case of Clostridium difficile infection, CDI
    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 fed back through the relevant teams and departments.
- Ongoing work continues to enhance collaboration with the Estates team, ensuring assurance on ventilation safety and full inclusion of key stakeholders in refurbishment programmes.

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 2025 to 31 March 2026 and highlights key achievements and future priorities in infection prevention and control.

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 (1 WTE)
- Infection Control Nurse (0.6 WTE)

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 Officer (CEO) 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.

3. Service aim, objectives and expected outcomes

As laid out in the Health and Social Care Act (2008) all NHS organisations must ensure that they have effective systems in place to control healthcare associated infections (Appendix B). The prevention and control of infection is part of the Trusts overall risk management strategy.

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.

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

Collaborative Working

The Infection Prevention and Control Team (IPACT) works collaboratively with both clinical and non-clinical teams to embed IPC principles into all aspects of healthcare. Adherence to the HBN 00-009 Infection Control in the Built Environment is key and work is ongoing to embed this with the Estates and Facilities team.

Infection Prevention and Control microbiology activity

All the trust microbiology specimens are processed in laboratories owned and managed by UHS pathology/microbiology providers. National accreditation previously held by UHS was removed in December 2024. The laboratory continued to function throughout the financial year whilst improvements were made following UKAS recommendations.

Infection rates, identification of multi-drug resistant (MDR) and infection clusters are all monitored by the IPC team with significant, reportable or unexpected results being directly communicated by the on call microbiologist. Virtual ward rounds are now embedded within the Trust and 24 hour telephone advice cover continues. There were gaps in quarterly contract meetings between the Trust and UHSx in 25/26 due to staff changeover. No harm resulted from this and there is a planned schedule of meetings for 26/27.

Infection prevention and control link persons (ICLP)

There is an IPC link nurse in each clinical area with the ICLP group meeting quarterly to share learning. The link nurses complete monthly audits, attend educational opportunities and promote compliance with IPC standards.

Key updates in 2025/26 included:

- Guidance/updates on Measles, MPox, hydrogen peroxide machines, Bacillus Cereus and Scrubs
- Review of infection control audits including Aseptic Technique, Surgical Site Infection and Isolation Room
- RCA discussions for reportable infections
- Review of 7 updated IPC policies and introduction of one new policy
- Training on Sharps, Candida Auris and CPE

External Meetings

The IPC team continue to attend regional and national IPC networks through webinars and virtual meetings. Ensuring alignment with best practice and to contribute to policy development at regional level. This meeting offers valuable opportunities to share learning, provide peer support and infection numbers within the local area.

Mandatory Surveillance

Mandatory surveillance data is required to be submitted to UK health security agency (UKHSA) for a set number of named organisms as detailed below.
Target thresholds are set by the UKHSA for each Trust every financial year for mandatory reportable infections.

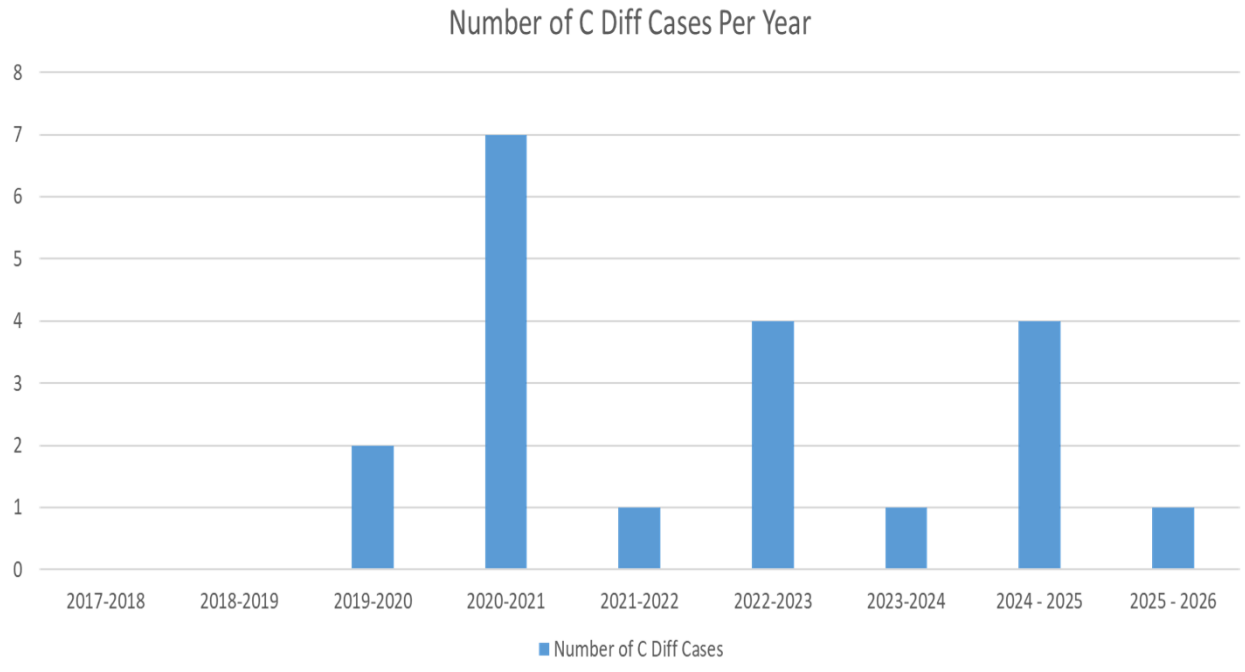
- MRSA Bacteraemia

QVH have a target of zero cases of avoidable MRSA bacteraemia every year – the trust achieved this during the 2025/2026. There has been no update or revision to this target for 2026/27.

- *Clostridium difficile* infection (CDI)

QVH had one reportable CDI case against a target of zero (Figure 1).

Figure 1

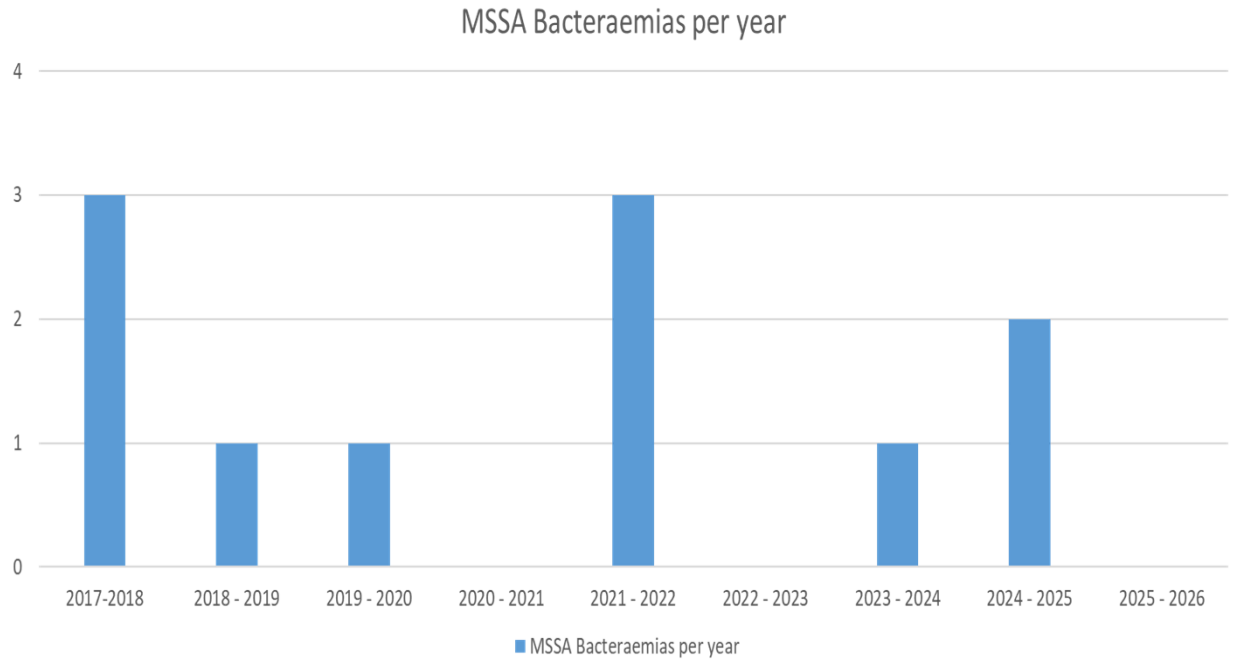


MSSA bacteraemia

No formal target is set for MSSA bacteraemia, although they are reportable. In 2025/26, QVH reported zero MSSA bacteraemia cases:

Figure 2 illustrates MSSA bacteraemia trends over time

Figure 2

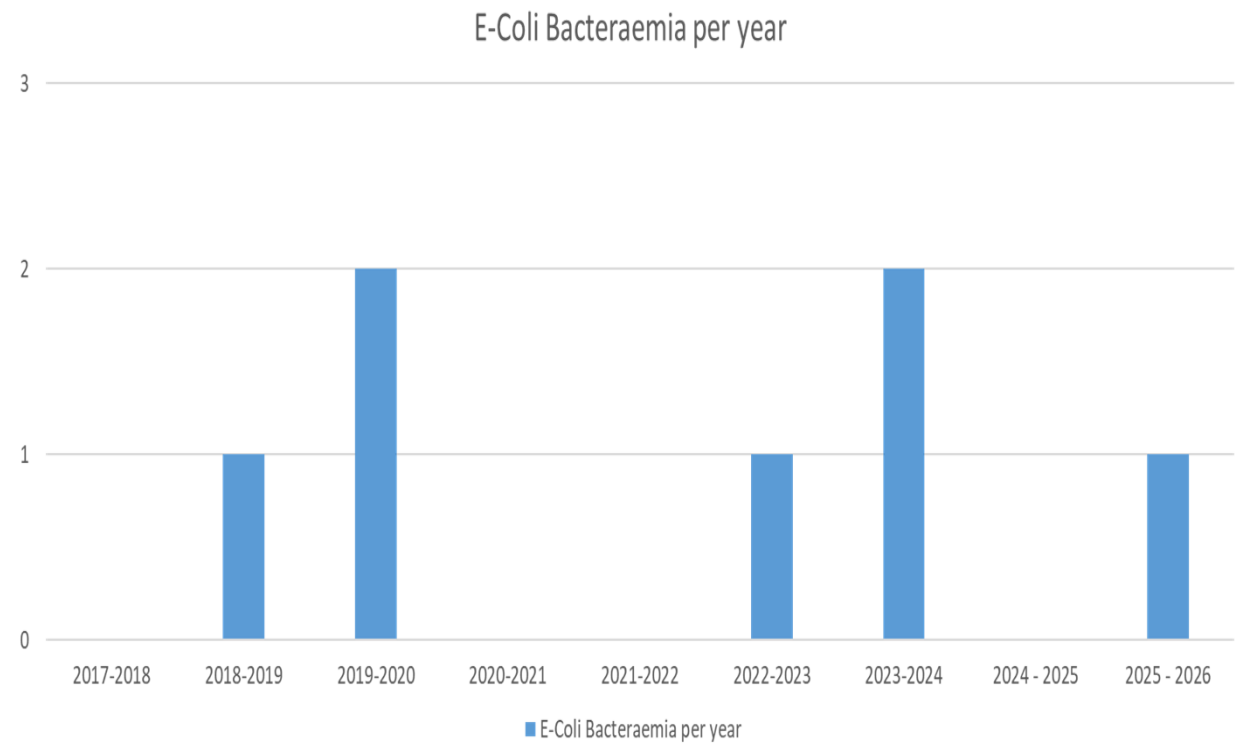


- ***E. Coli bacteraemia***

The target threshold for *E.coli* bacteraemia in 2025/26 was set at zero cases. The Trust did not meet this threshold with one case 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.

MRSA positive patients April 2025 to March 2026 (Infected and colonised)

A total of 241 MRSA positive cases (colonisation or infection) were recorded, up from 219 the previous year. This is mirrored across the network and reflects a national rise in MDR infections. Breakdown of MRSA cases:

- 121 detected on or before admission
- 80 were previous positives
- 2 classified as healthcare-associated
- 38 of unknown origin

All cases were identified via surface or wound swabs. Despite the rise in MRSA cases there have been no outbreaks or onward transmission within the Trust.

4.	**Activity analysis/ achievement**

Complaints

No formal IPC-related complaints or claims were received this year. One informal complaint was raised by a patient in June 2025 regarding their experience in Burns outpatients (EBAC). Concern was managed and resolved by the ICN and feedback was shared with the clinical team.

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
- Antimicrobial resistance
- Safe clinical practices

Training compliance fluctuated across the quarters, with Q2 and Q4 not achieving the target of 90% compliance. A variety of mediums are used to the deliver the training, including face to face, e-learning and bespoke service training to encourage greater compliance.

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	1450	1318	91%
Quarter 2	1433	1272	89%
Quarter 3	1436	1305	91%
Quarter 4	1416	1225	86%

The ICNS also delivers infection prevention and control training to student pharmacists at the University of Brighton.

Whilst in general the need to actually wear appropriate respiratory protection (FFP masks) is low at QVH in normal times, all clinical staff are required to undertake annual FIT testing. . Compliance with this training remains low although has increased by 10% overall as compared to 24/25 (Table 2). IPACT worked with the department leads to ensure reminders were sent to all clinical staff on the need to undertake their annual FIT testing, this included reminders in Connect and the IPACT conducting 2 drop in days through the year.

FIT testing is 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. Through mutual aid, a Portacount machine has been acquired which aims to simplify testing and this will be rolled out in the next financial year.

Table 2

Fit Testing as of 1/4/26		
Assignment Count	**Achieved**	**Compliance %**
652	464	**71.17%**
133	51	**38.35%**
785	515	**65.61%**

Fit Testing as of 1/4/25		
Assignment Count	**Achieved**	**Compliance %**
636	384	**60.38%**
156	39	**25.00%**

792	423	**53.41%**

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 2025 to March 2026.

- **Breast Surgical Site Infection Audit (SSI)**

- March 2025

All patients undergoing major breast surgery were included and the National SSI template and guidance was followed. An important caveat to collection of wound infection data by survey in this manner is the reliance on patient reported outcomes following surgery based on review in community settings as well as at the QVH. The data collection for this audit was conducted in the 2024/2025 year but results were not available until quarter 1 of 2025/2026 and therefore they have been included in this report.

Results show that readmission to QVH following breast surgery with confirmed infection is 0%. In the previous audit 1 patient was re admitted with confirmed SSI.
Reported post-operative SSI rate in outpatients was 7% from the returned questionnaires which was lower than the previous two breast SSI audits (33% in November 2023 and 23% in March 2024) and is below the national average for breast surgery SSI of 9.2% (GIRFT 2019).

- July 2025

The Breast SSI was repeated in July to verify the change and see if SSI rates vary depending on the season. Results of this audit showed that no patients were readmitted to QVH with confirmed infection following breast surgery, however one patient was admitted to another hospital with infection.

Reported post-operative SSI rate in outpatients was 21% from the returned questionnaires which was higher than the previous breast SSI audit of 7%. Research does show that there is a link between warm weather and an increase in infections however the overall variance does not allow for any meaningful conclusions on this.

This audit has shown a sustained improvement in treatment of post-operative problems that were not infections and, a reduction in the antibiotics being prescribed when patients were reviewed at the QVH. This improvement is not reflected for patients post-operatively reviewed elsewhere, particularly those being seen at their GP practice. Ongoing work continues in primary care through the antimicrobial 5 year UK action plan which aims to reduce use of unnecessary antimicrobials.

- **LAU Surgical Site Infection Audit (SSI)**

A follow up audit to review SSI rates after the opening of the LAU was completed in this audit period. A total of 240 patients were treated through LAU with a response rate of 65% (155). 19% of patients who responded reported issues with wound healing, with 4.5% of these meeting the criteria of a SSI, both an increase on last year's audit results which showed an SSI rate of 3% however the overall variance does not allow for any meaningful conclusions on this. .

All of the patients meeting the SSI criteria received one or more courses of antimicrobial therapy. It is notable that, of the seven patients with confirmed SSI, only one was reviewed here at the QVH. Although the SSI rate during this audit is slightly higher than that of the LAU audit last year which was 3%, this rate is still lower than other surgical specialities (Breast SSI audit shows rate of 21% this year and 7% in the previous year).

There is no national requirement to audit the LAU surgical group and therefore no benchmarking data is available to inform a comparison. The IPACT will continue to monitor infection rates and re-audit in the year 2026/2027 as an additional area has opened within the LAU. Patient information leaflets have been reviewed ensuring that the appropriate advice and guidance is given along with contact details for patients to use if they are concerned or have questions and to help patients understand what represents normal wound recovery and what might represent signs of infection.

- **Sharps box audit** (annual audit)

All sharps boxes were included in this audit and was undertaken by our sharps box provider, throughout the year an increase in incident reporting is noted related to the closure of sharps box lids. Results revealed that common areas of non-compliance were containers not assembled properly, inappropriate contents and temporary closure not in place. Results were fed back to department managers and targeted training delivered by Sharps representative.

- **Aseptic Technique Audit** (annual audit)

Results show a 71% compliance with all steps of the audit a decrease from 73% in 2024 and 74% in 2023. The infection control team in collaboration with the audit team are introducing an electronic audit form which will mandate answering of all questions, aiming to improve data quality and analysis. Themes and learning has been shared with departments.

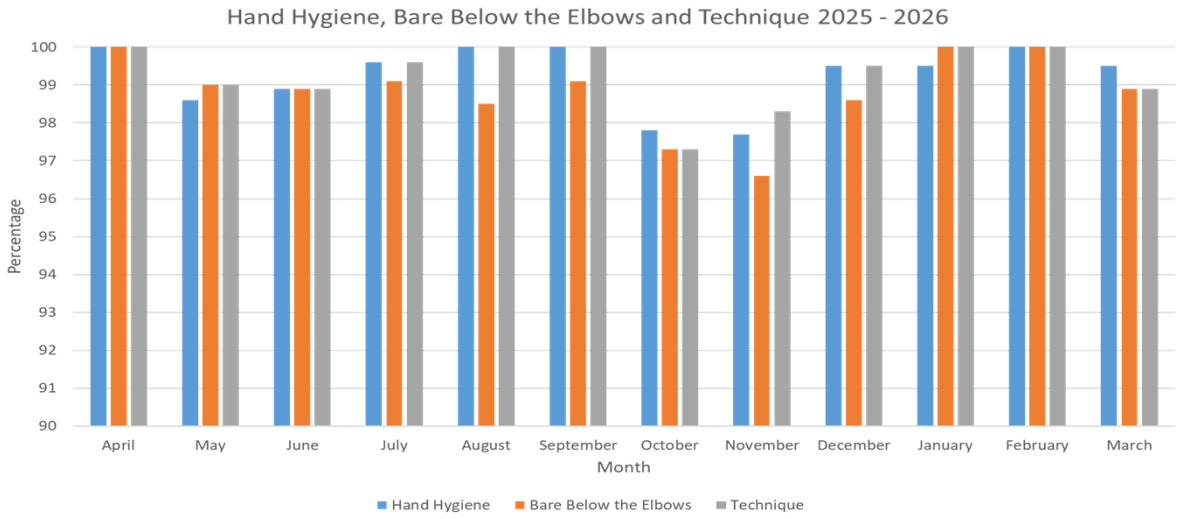
- **Isolation Room Audit** (annual audit)

IPACT reviewed all side room occupants to ascertain correct allocation of patients and utilisation of isolation facilities. During the year many wards were relocated due to urgent Estates work creating some additional challenges in terms of patient placement. Audit found that isolation rooms were being used appropriately. Where rooms were not being used due to risk of suspected/confirmed infection, they were in use for other reasons such as privacy/dignity.

Hand Hygiene Audits (monthly)

Monthly audits have maintained >95% compliance across all areas (Figure 4). Ongoing training, leadership support and visible reminders help reinforce standards. Whilst this audit data is reflective of actions witnessed at the time of the audit, it is noted that further spot checks and challenges to practice continue to ensure ongoing compliance.

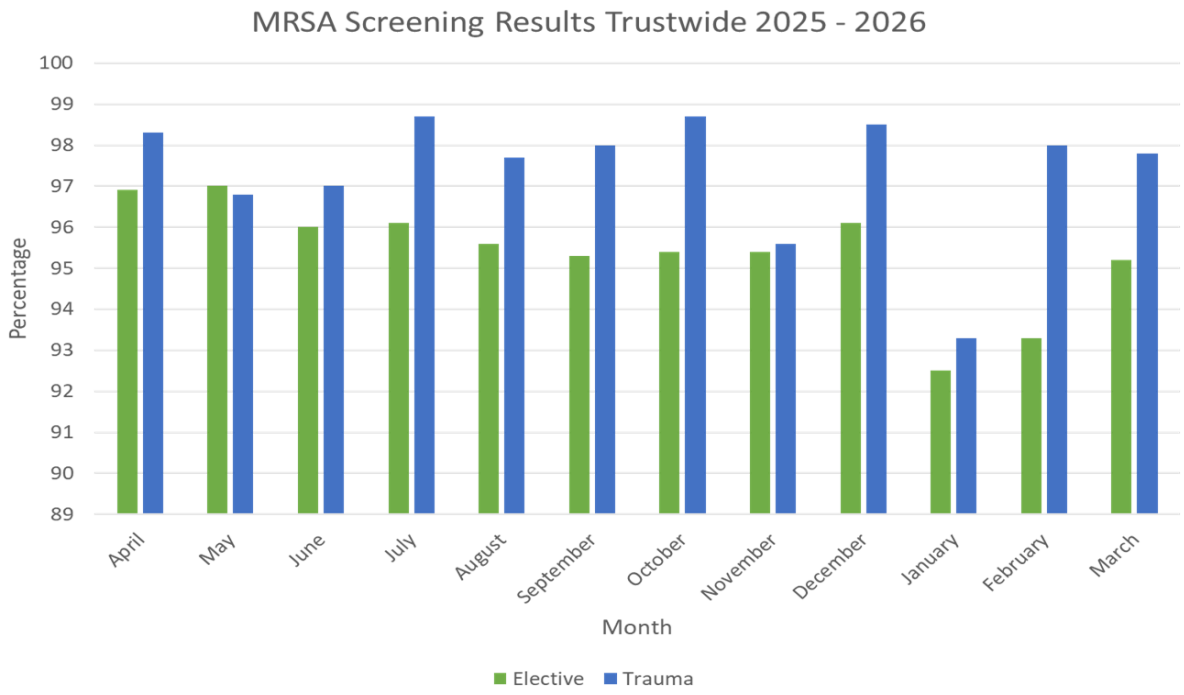
Figure 4



MRSA screening (monthly)

A noted reduction in elective screening compliance has prompted targeted staff training (Figure 5). Results and actions have been shared with areas concerned. Whilst there has been no change to the MRSA screening guidance or policy there appears to be multiple factors affecting compliance in screening, including staff not identifying patients who have had hospital admissions in the last 12 months and a breakdown in communication between the wards and theatre staff when wounds require swabbing.. IPACT is working with the department leads to reinforce policy, improve the process and provide education.

Figure 5



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 D).

Influenza arrangements

Flu vaccination update is reported through the emergency planning reporting system.

Notable events, including Outbreaks

April–June 2025

- Reconfiguration of the wards was required due to emergency estates work within the Paediatric Unit and surrounding departments. IPACT assisted with co-ordinating the ward moves and deep cleans. IPACT worked closely with the wards to ensure all patients with infections were managed as safely as possible within the constraints of available beds and side rooms. The IPACT monitored infections with no concerns noted.
- Healthcare associated C.Diff patient - root cause analysis (RCA) showed that all appropriate IPC precautions were implemented and likely cause due to use of antibiotics. Incident were deemed unavoidable as all antibiotics were prescribed in line with Trust policy.

July–September 2025

- Positive E.coli in blood cultures - RCA showed patient had multiple risk factors with the cause of bacteraemia unknown due to co-morbidities and risk factors.
- FIT test drop in day held by the IPACT for all staff to attend to undertake their annual FIT testing - 14 members of staff attended.

October–December 2025

- An increase in flu cases was noted amongst staff which aligned with both the local and national figures. The implementation of mandatory mask wearing for all clinical facing staff was introduced to aid further spread of infection.
- Influenza A positive patient – RCA showed community acquired, all IPC precautions were implemented and no secondary cases noted.
- FIT test drop in day held by the IPACT for all staff to attend to undertake their annual FIT testing - 6 members of staff attended.

January–March 2026

- Healthcare associated MRSA positive patient – RCA resulted in no cause identified with no secondary cases.
- CPE positive patient – Due to screening criteria the patient was not required to be tested on admission, however at request of transferring hospital screening completed. RCA resulted in no cause identified and likely that patient was carrying CPE on admission. Accepting hospital informed of result and not secondary cases noted.

5. Involvement and Engagement

Antimicrobial report

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. Antimicrobial stewardship is outlined in the Antimicrobial annual report.

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. Work is underway to identify a replacement 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). During the year, the Trust experienced challenges related to a shortage of scrubs. The Infection Prevention and Control (IPC) team collaborated closely with Hotel Services and the Theatre lead to source additional supplies. Where this was not feasible, guidance on scrub use was reviewed and adapted to ensure available stock met operational needs. Infection rates were closely monitored throughout this period, with no concerns identified. A new laundry supplier is scheduled to commence in early 2026/27.

Estates report

It is necessary for there to be close collaboration between the Infection Prevention and Control group and the Estates team to ensure appropriate mitigation where needed. To provide appropriate assurance, regular reports are expected covering ventilation systems, water safety, and general estates activities. Where written reports are not submitted, a verbal update should be provided to ensure oversight and continued governance. The yearly ventilation audit was undertaken in January 2026 with results to be reported in the next financial year. Ventilation units within the Theatre complex have been maintained and serviced throughout the year.

Stakeholder engagement for new builds and refurbishment requires a final sign off form to confirm broad consideration of potential impacts. This is currently under development.

Water Safety

Monthly monitoring for legionella Pneumophilia and biannual Pseudomonas sampling continue and are clear of any waterborne pathogens. A full water risk assessment is planned for the next financial year. During the water outage there was clear evidence of shared working; activity was maintained and no patients came to harm from the outage.

Infection Control Risks and incidents.

There were 110 infection control related incidents during this period, all harm levels are noted as no harm, low harm or near miss. Over half the incidents related to sterile services and are being managed accordingly. 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 is limited to one centre. 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. Training plans for 2026/27 underway.

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 the consistent application of robust infection prevention and control (IPC) practices remains fundamental to the delivery of safe, effective, and high-quality patient care. Whilst the overall incidence of healthcare-associated infections (HCAIs) has remained low during the reporting period, continuous learning has been derived from routine surveillance, incident investigations, audit activity, and frontline practice. Key areas of learning over the past year have highlighted the need to strengthen compliance in several domains, including MRSA screening, completion and submission of audit programmes, and the consistent uptake of mandatory IPC training. These findings have informed targeted actions to improve reliability, accountability, and staff engagement across clinical services. The Infection Prevention and Control Team has further enhanced its visibility and accessibility across the organisation, providing proactive, real-time advice, education, and support within clinical areas. The expansion of departmental IPC inspections has enabled more structured oversight, facilitated early identification of risks, and ensured that clinical teams receive timely, constructive feedback to support continuous improvement and adherence to required standards. Audit processes continue to present challenges in achieving optimal coverage, consistency, and data quality. The implementation of an electronic auditing solution was explored as a means of improving audit reliability and standardisation, however this is not currently prioritised The IPC Team will continue to refine and strengthen existing audit methodologies, with a focus on improving data validity, increasing completion rates, and ensuring that audit outputs are meaningful, actionable, and demonstrably linked to service improvement. Overall, the Trust remains committed to fostering a culture of continuous learning and improvement, ensuring that lessons identified through audit, surveillance, and incident review are translated into measurable actions that enhance IPC practice and patient safety.

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: This area remains a high priority, with targeted interventions planned to reinforce practice and provide support to clinical teams. • Continue to review 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. • Continue to work collaboratively with Estates and Facilities to achieve effective management of 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 C). Key goals

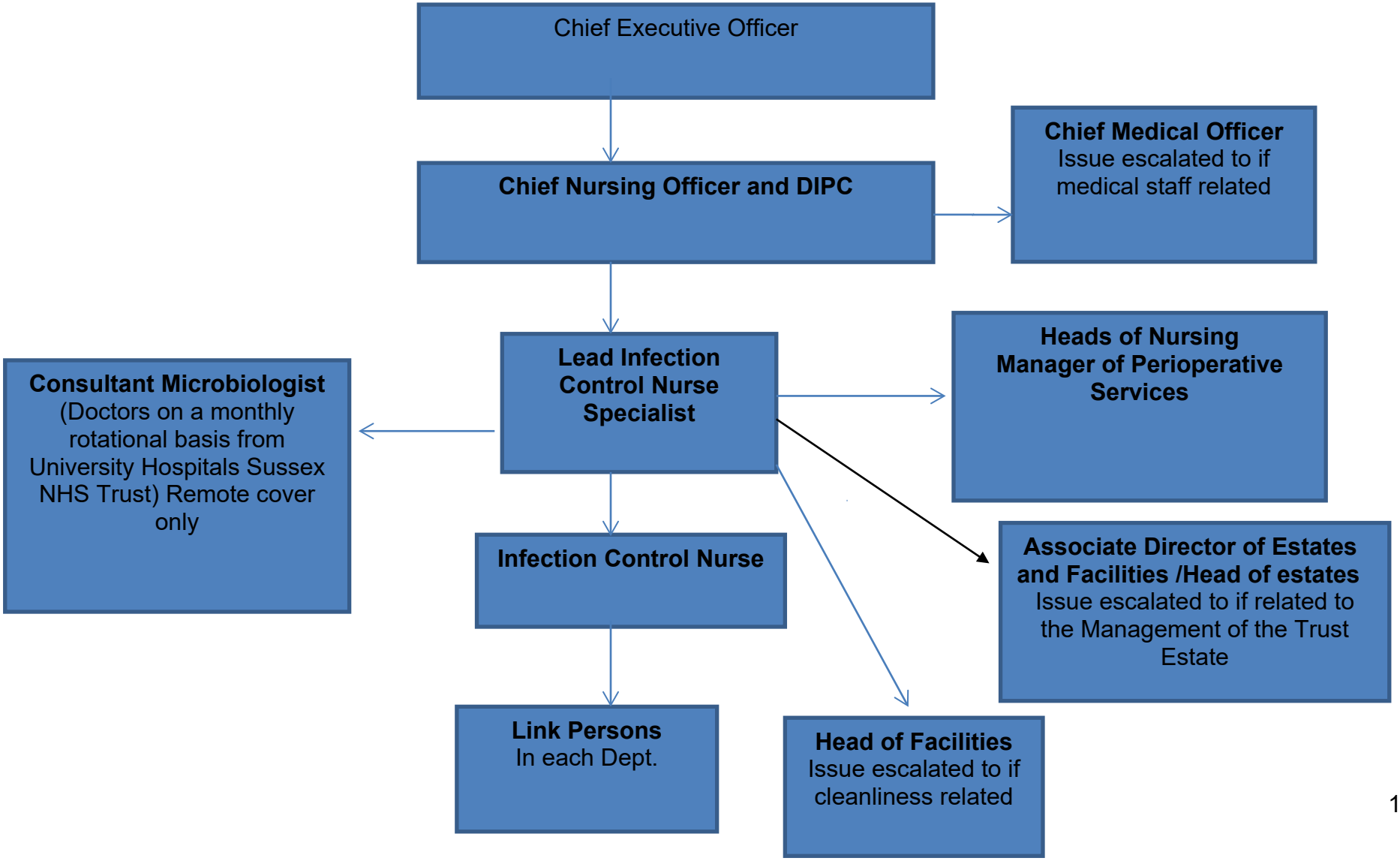
	for the upcoming year include: • Embedding robust and targeted auditing to identify areas for improvement and monitor adherence to infection control standards across all departments. • Expanding access to meaningful training through tailored education sessions that are adaptable to staff roles, availability, 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 maintains effective governance, leadership, and operational systems to meet the requirements of the Health and Social Care Act (2008): Code of Practice on the prevention and control of infections. Through a comprehensive programme of audit, education, alert organism surveillance, and proactive incident management, the Infection Prevention and Control Team has supported the consistent delivery of safe, high-quality care and the continued prevention of healthcare-associated infections. The Trust benefits from a robust internal assurance framework, strengthened by external oversight and collaborative working with the Integrated Care Board, peer review networks, and professional leadership from the Chief Nursing Officer/Director of Infection Prevention and Control. This ensures the IPC programme remains responsive, resilient, and aligned with system-wide expectations. IPC policies and procedures are subject to regular review and are updated in line with current national guidance, ensuring staff have access to evidence-based best practice. The Infection Prevention and Control Team remains visible, accessible, and proactive in supporting clinical and non-clinical teams to embed and sustain safe practice across all services. Overall, the Trust continues to demonstrate a strong commitment to infection prevention and control, with systems in place to support ongoing improvement, assurance, and compliance.

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 2026/2027**



Appendix B

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.

Appendix C
Infection Control Annual Programme Objectives for 2026/27

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	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. New Decontamination Lead to be identified within the theatre team.	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 where possible the 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	Predominantly now covered by E-learning except monthly induction
IC	Education	Link person training and education	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 D

Ratified IPC Policies April 2025 – March 2026

- Introduction to Infection Control Policy
- Policy for the Control of Varicella Zoster Virus Infection (Chickenpox and Shingles)
- Policy for the Prevention of Healthcare Associated Infection in Peripheral Venous and Arterial Cannulae (updated by ICN and approved at IPCH however ownership transferred to CCU clinical teams)
- Policy for the Insertion and Care of Central Venous Catheters(updated by ICN and approved at IPCH however ownership transferred to CCU clinical teams)
- Policy for the Mandatory reporting of infections
- Policy for the management of patients with CJD
- Policy for the management of suspected or confirmed respiratory infections
- Policy for the management of Blood borne Viruses (BBV)
- Taking blood cultures policy
- Animals in hospital policy
- Christmas Decoration guidance (SOP)

Report cover-page					
References					
Meeting title:	Board of Directors				
Meeting date:	09/07/2026	**Agenda reference:**	**34-26**		
Report title:	Patient Experience Annual Report 2025-2026				
Sponsor:	Liz Blackburn – Acting Chief Nursing Officer				
Author:	Chris Parrish, Patient Experience Manager				
Appendices:	None				
Executive summary					
Purpose of report:	This report provides assurance to the Board on patient experience feedback at Queen Victoria Hospital NHS Foundation Trust (QVH) for the period April 2025 to March 2026.				
Summary of key issues	This report provides an overview of patient experience at Queen Victoria Hospital (QVH) from April 2025 to March 2026, highlighting performance, themes and organisational learning. Key points: • High levels of patient satisfaction maintained across all services, with several areas meeting or exceeding national benchmarks • Minor Injuries Unit (MIU) consistently performing above national FFT recommendation scores throughout the year • Increase in formal complaints in line with local and national trends, with key themes relating to communication, delays, appointments and administration • Learning-driven approach with patient feedback systematically triangulated across FFT, surveys, complaints, PALS and direct engagement • Strong governance and compliance, with statutory complaint handling targets met and leadership oversight continuing to mature • Ongoing commitment to improvement, ensuring patient and carer feedback is embedded in service development and quality improvement				
Recommendation:	The Board is asked 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:	CQC, LASS and NHS Complaints (England) Regulations 2009				
Legal:	None				
Resources:	None				
Assurance route					
Previously considered by:	Executive committee for quality & risk				
	Date:	15/06/2026	Decision:	Approved to go to Q&S	
	Quality & safety committee				
	Date:	30/06/2026	Decision:	Approved to go to Board.	

Queen Victoria Hospital
NHS Foundation Trust

Holtye Rd,
East Grinstead
RH19 3DZ

Queen Victoria Hospital NHS Foundation Trust
Complaints Annual Report

Report covering the period from
April 2025 to March 2026

Document Control: Quality and Safety Committee
Executive sponsor: Liz Blackburn, Acting Chief Nursing Officer

Authors: Chris Parrish, Patient Experience Manager

Date: 4 June 2026

Type: Annual Report – Patient Experience
Version: 2
Pages: 21
Status: Public. Written and prepared for the Trust Board
Circulation: Quality and Safety Committee

Contents List

1.	Executive Summary
	This report provides a comprehensive overview of patient experience feedback at Queen Victoria Hospital (QVH) for the period April 2025 to March 2026. 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. FFT recommendation scores across inpatient, outpatient, Minor Injuries Unit (MIU) and day surgery services remained strong throughout the reporting period, with a number of clinical services performing at or above national benchmarks. The MIU, in particular, consistently exceeded published national FFT recommendation scores every month of the year. At the same time, the volume of formal complaints has increased compared with the previous year. Between April 2025 and March 2026, the Trust received 88 formal complaints, reflecting a year on year increase back to 1 April 2021 when 56 formal complaints were received that year. This aligns with local and national trends of rising complaint volumes. Recurring themes identified within complaints include treatment, communication, trust administration, appointments, delays and staff behaviour. 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, while concerns and complaints guide learning and service development. Feedback is systematically reviewed and triangulated across multiple sources, including complaints, PALS queries, FFT responses and patient experience incidents, allowing for a broader and more reliable understanding of themes and trends. During 2025/26, strong performance was maintained against statutory complaint handling requirements, including acknowledgement and response times. Governance and oversight arrangements continued to mature, with Directorate Leadership Triumvirates playing a central role in investigating complaints and implementing learning. Preparatory work was also completed to support the launch of a Trust-wide Patient Experience Meeting in April 2026. This report evidences how QVH actively listens to and acts on the voice of patients and those important to them and provides assurance that learning from patient feedback is embedded across the organisation.

2.	Introduction
	The year 2025/26 continued to build on the organisational transformation undertaken in recent years, including the embedding of triumvirate led directorates and strengthened governance structures. These changes have supported a more consistent and integrated approach to understanding patient experience and responding to feedback.

	The focus of our patient experience work remains aligned to the Trust's strategic objective of delivering outstanding patient experience and ensuring that patient voice is central to improvement activity. The scope of this report includes feedback received through the Friends and Family Test, Patient Advice and Liaison Service (PALS), formal complaints, national patient surveys and other feedback channels, such as patient stories and digital platforms. Analysis of this feedback, including thematic review and triangulation, enables the Trust to identify learning and improvement opportunities across services.

3.	**Service aim, objectives and expected outcomes**
	The Patient Experience function is committed to supporting the Trust's patient experience agenda by ensuring a reporting culture that is fully embedded and integral to everyday practice and by ensuring that improvements in patient experience are identified, prioritised and delivered. A fundamental responsibility across the organisation is fostering a culture where staff feel confident to raise concerns and respond to patient feedback in a non-judgemental and constructive way. Directorate Leadership Triumvirates have continued to play a key role in supporting staff and driving improvement in response to patient feedback. Key performance expectations during the year included achieving timely acknowledgement and resolution of complaints, maintaining high FFT recommendation rates, improving FFT response rates and strengthening learning through triangulation of complaints, PALS, claims, patient experience incidents and survey data. Key targets include: • 90% of all complaints will be acknowledged within three working days • 90% of all complaints will be closed within thirty (30) 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 • 25% 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**
	The Trust remains committed to improving patient experience through meaningful collaboration with patients, carers, friends and families, ensuring that feedback directly informs service development and improvement activity. A key mechanism for understanding patient experience continues to be the Trust's survey programme, which includes the Friends and Family Test (FFT),

local patient surveys and national survey programmes. These sources provide valuable insight into patient experience and help identify both areas of good practice and opportunities for improvement.

However, the Trust recognises that survey data alone does not always capture the full breadth of patient experience. During the reporting period, there has therefore been a continued focus on developing more responsive and accessible ways for patients and carers to share feedback in real time.

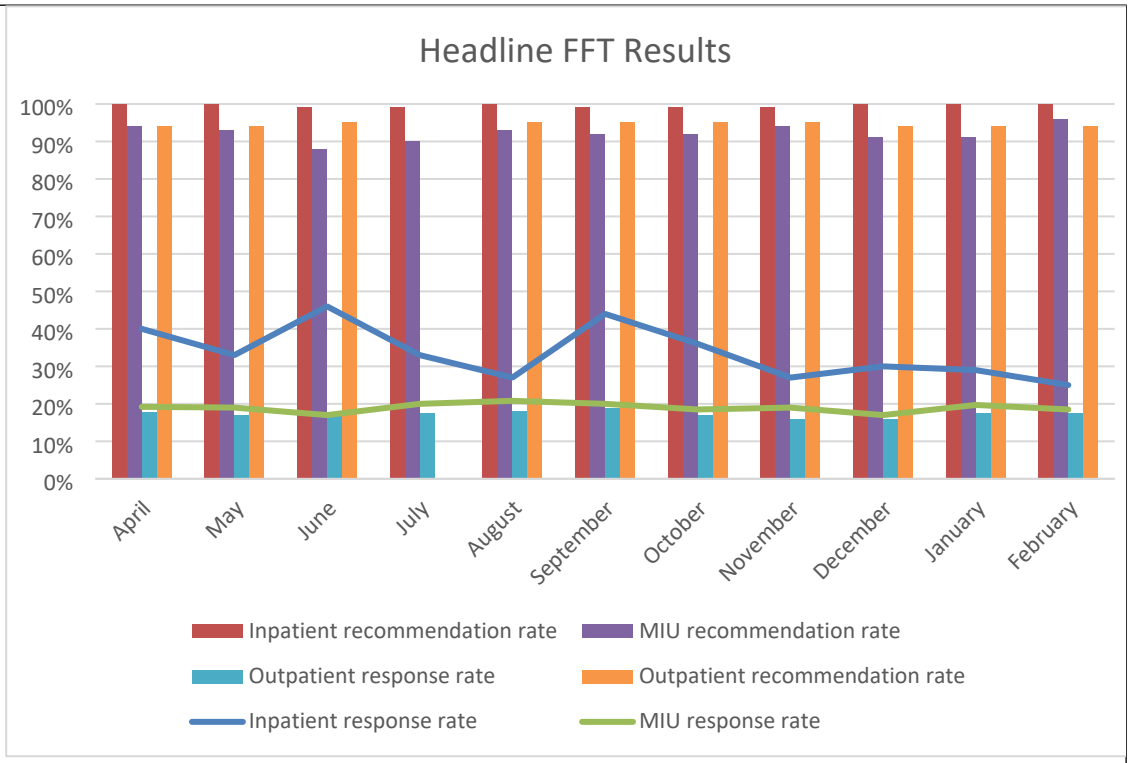
One such initiative has been to encourage direct engagement with the Patient Experience Manager when concerns, compliments or suggestions are raised during a patient's care journey, rather than relying solely on formal survey mechanisms. This approach aims to support earlier resolution of issues, strengthen patient involvement and enable more immediate learning and service improvement.

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.

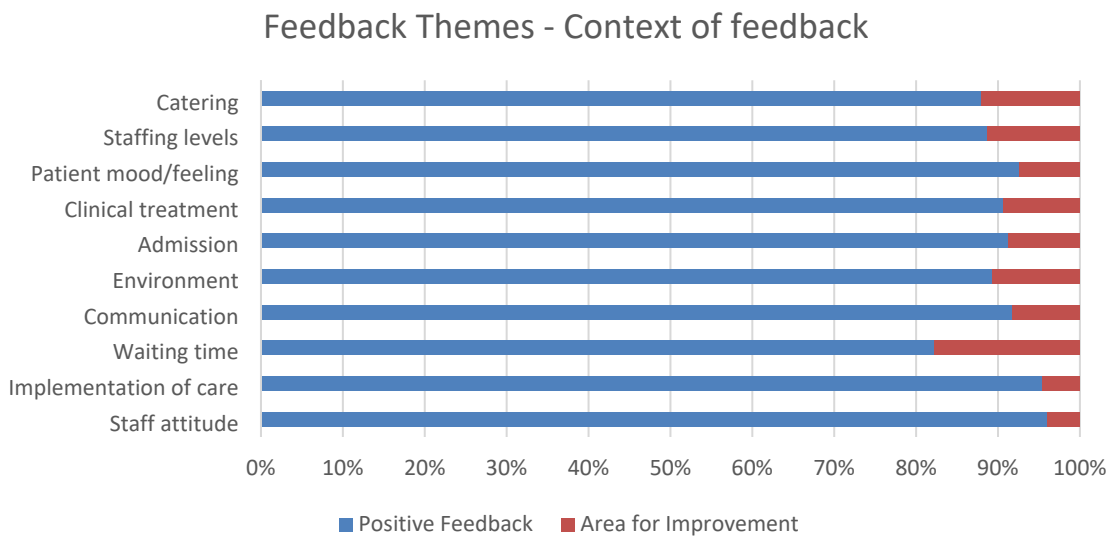
Between April 2025 and March 2026 we received **38,082** responses to the FFT, with over **14,000** comments given showing high patient engagement from the **20.5**% of patients responding to us.

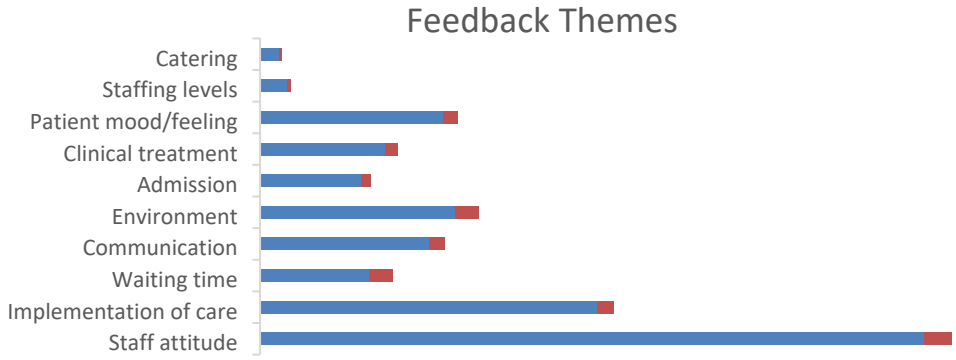
We have not achieved our inpatient response rate target of 40% and achieved **33.8%.** We have not achieved our outpatient response rate target of 20% and have achieved **17.4%.** Work is ongoing at a service level to understand why response rates have not achieved targets and what driver, or drivers, are behind this (such as the medium for feedback, the timing of feedback and the ease of providing feedback).

We achieved our recommendation rate with **99.6%** of all responding inpatients and **94.5%** 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	233	137	200	129	197	82	108	124	29	22
Positive Feedback	5625	2853	924	1435	1655	857	1055	1550	227	161

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 Minor Injuries Unit (MIU) revisited the trust website to share expected wait times, describe how they triage 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 (CQC) National Patient Survey Programme, which provides an important opportunity to understand and benchmark patient experience across NHS organisations.

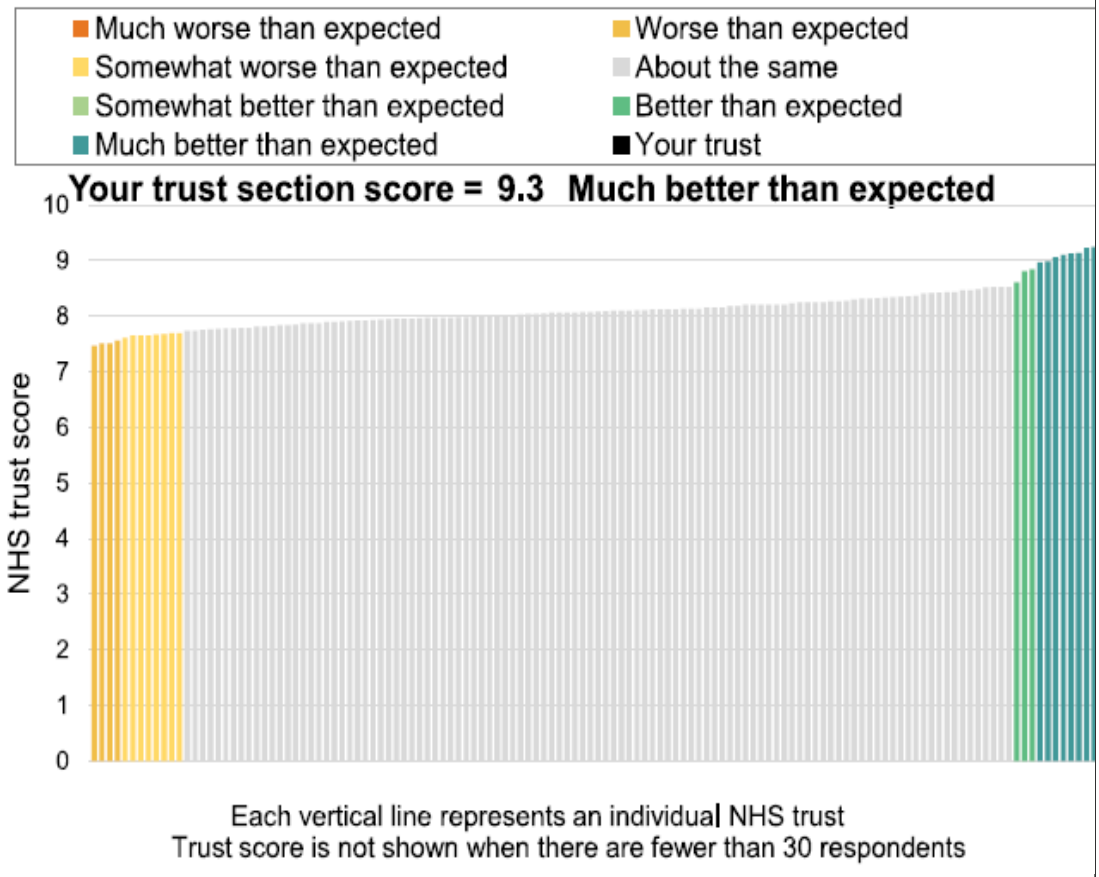
The National Patient Survey results for this year have not been released at the time of writing so not included in this report: ; therefore, last yearsresults are summarised below for completeness.

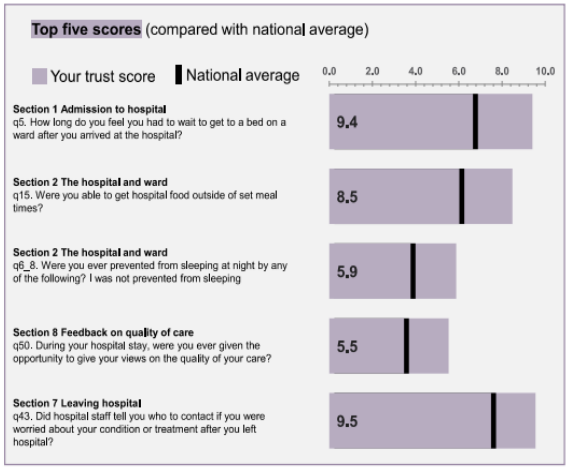
For the Adult Inpatient Survey 2023, patients rated their overall hospital experience as **9.3** out of 10. This represents an excellent result and the Trust was ranked the highest performing Trust nationally for overall patient experience.

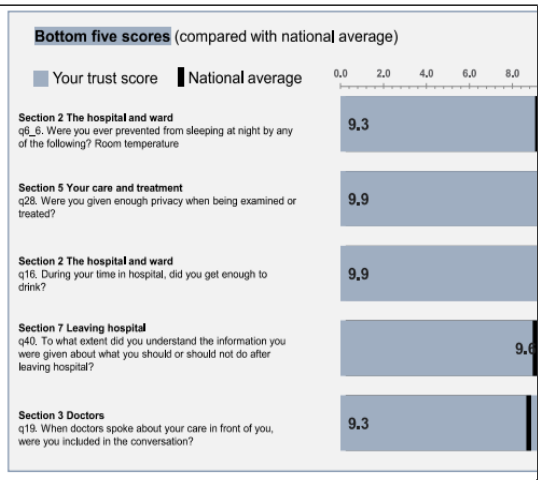
To sustain and further improve patient experience, the Trust has continued to focus on identified areas for development, including:

- promoting rest and sleep on inpatient wards
- improving discharge information
- strengthening patient involvement in care and decision making

The Trust looks forward to reviewing the impact of these improvements within the Adult Inpatient Survey 2024 results once published and repeats the graphics of the Adult Inpatient Survey 2023.



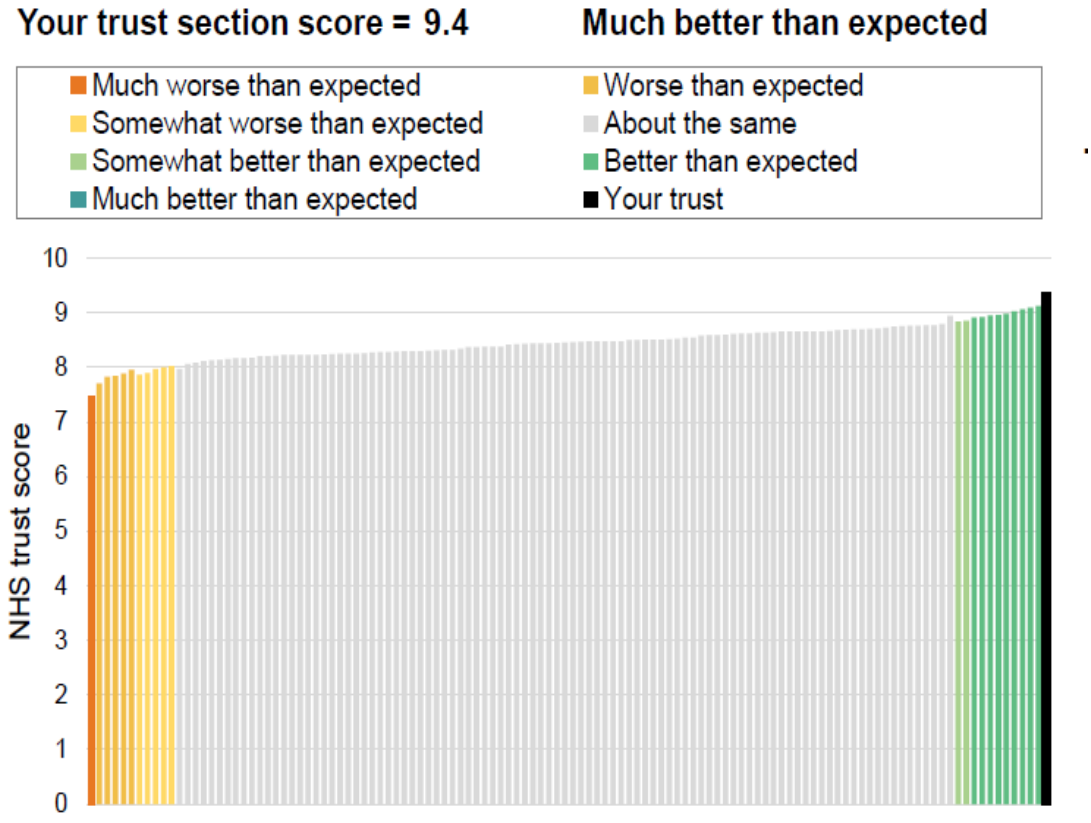


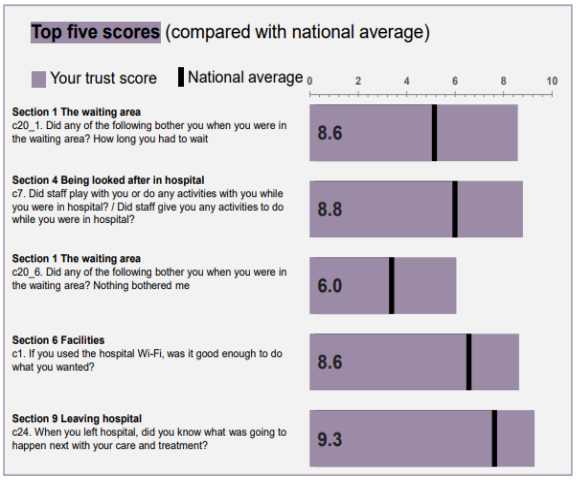


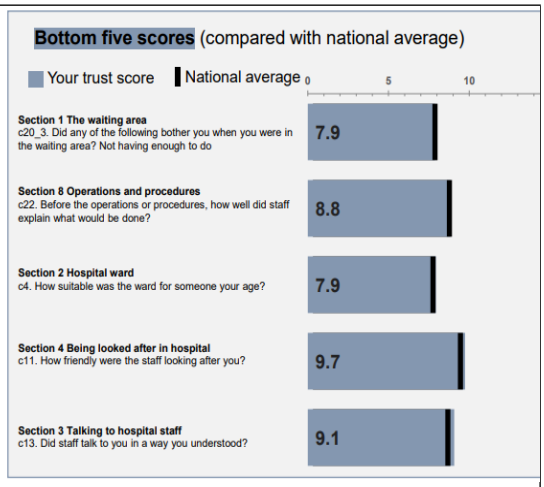
The Trust also achieved the highest national ranking in the Children and Young People Survey 2024, reflecting continued positive feedback from children, young people and their families regarding the care and support received.

Areas identified for further improvement through this survey included:

- the waiting environment
- information provided about surgery and procedures
- improving how information is shared to support involvement in care







In the Cancer Patient Experience Survey 2023, patients rated their overall experience as **9.0** out of 10. This was again an excellent result, with no survey questions scoring below the expected national range.

Website feedback

Alongside the Trust's formal survey programmes, patient and carer feedback is received through external feedback platforms, including Care Opinion and via Trust social media channels. Feedback submitted through these routes is reviewed and responded to by the Patient Experience Manager, Chief Nursing Officer or Communications Team. Responses include thanking individuals for sharing their experiences and, where appropriate, inviting further discussion to support service learning and improvement.

During the reporting period, **18** comments were received through Care Opinion, in addition to further feedback shared across the Trust's social media platforms. Themes and learning identified through this feedback contribute to ongoing service development and patient experience improvement activity.

Patient Story at Board

Patient stories continue to play an important role in helping the Trust understand the lived experience of those who use our services. They provide valuable insight into what it feels like to receive care at QVH, highlighting both opportunities for improvement and examples of excellent practice that can be shared more widely.

By hearing directly from patients, the Board gains a deeper understanding of the impact that services, behaviours and processes have on individuals and their families.

Patient stories are a standing item at Board meetings held in public and are welcomed by Board members as an important opportunity to listen and learn. In addition to a patient story a staff story may be shared. Stories are drawn from a variety of sources, including compliments, complaints, patient feedback and recommendations from clinical teams.

Between April 2025 and March 2026, the Board heard a range of patient experiences reflecting both positive feedback and opportunities for improvement. There were three stories and these were:

- A patient who described a challenging experience involving theatre care, continuity of care and complaint handling, whilst also recognising the positive impact of personalised care and communication received later in their treatment journey.
- A patient who shared their experience of multiple surgical procedures and participation in the Community Diagnostic Centre pathway, highlighting the professionalism and kindness of staff while identifying opportunities to improve communication around test results and diagnoses.
- A patient who travelled from Northern Ireland to access specialist facial palsy treatment at QVH, sharing the significant impact of the service on their quality of life and praising the expertise, compassion and commitment of the specialist team.

Patient stories were also scheduled twice more throughout the year, but circumstances prevented patients from attending on the day. Where possible, these stories were rearranged for future meetings to ensure that patients' experiences continued to inform Board discussions.

The themes and learning arising from patient stories are reviewed by the relevant services and incorporated into improvement plans where appropriate. During 2025/26, actions resulting from patient stories included:

- Reviewing communication processes relating to diagnostic pathways and test results to ensure patients receive timely and clear information.
- Strengthening communication and awareness of specialist services, including referral pathways and what patients can expect from treatment.
- Reviewing aspects of continuity of care and personalised communication to ensure patients feel listened to, informed and involved throughout their treatment journey.
- Sharing examples of excellent care and compassion demonstrated by clinical and non-clinical staff to support wider organisational learning and recognition.

Patient stories remain a powerful mechanism for ensuring that the patient voice is heard at the highest level of the organisation and continue to support the Trust's commitment to learning, improvement and outstanding patient experience.

Patient Advice and Liaison Service (PALS)

The Patient Advice and Liaison Service (PALS) continues to experience increasing demand, reflecting its important role in supporting patients, carers, families and staff. The service provides advice, information, signposting and early resolution of concerns, with the aim of addressing issues promptly and

informally wherever possible.

Between 1 April 2025 and 31 March 2026, the Trust received 338 PALS enquiries, representing a 21% increase compared to the previous reporting period.

Of these enquiries:

- **226** related to concerns requiring resolution, including **eight** cases which were subsequently escalated to formal complaints or linked to existing complaint investigations
- **112** related to requests for advice and information

The most common themes identified related to communication issues, including insufficient or unclear information regarding appointments and treatment. Additional themes included concerns relating to aspects of care and staff behaviours.

Themes and trends identified through PALS enquiries were triangulated with other patient experience information sources and reviewed through the Trust's 'Learning From' meetings with leadership triumvirates to support shared learning and service improvement activity.

Complaints

The NHS Constitution and Local Authority Social Services and NHS Complaints (England) Regulations 2009 set out the rights of patients to raise concerns or complaints about NHS services, alongside the responsibilities of organisations in responding appropriately. The Trust takes these responsibilities seriously and recognises the importance of listening to patient feedback to support both service improvement and organisational learning.

The Trust operates an integrated Complaints and PALS service, which manages complaints, concerns and patient feedback in accordance with the Trust Complaints Policy. The service is currently delivered by one full time member of staff, who is responsible for complaints management, PALS enquiries and the wider patient experience function. The role also includes providing advice, guidance and training to staff in relation to complaints handling and patient experience processes.

Between 1 April 2025 and 31 March 2026, the Trust received **88** formal complaints, representing a 20% increase compared to the previous reporting period (73 complaints). Local and national trends show rising levels of patient feedback and complaints activity across NHS services, but the percentage of such increases are inconsistent.

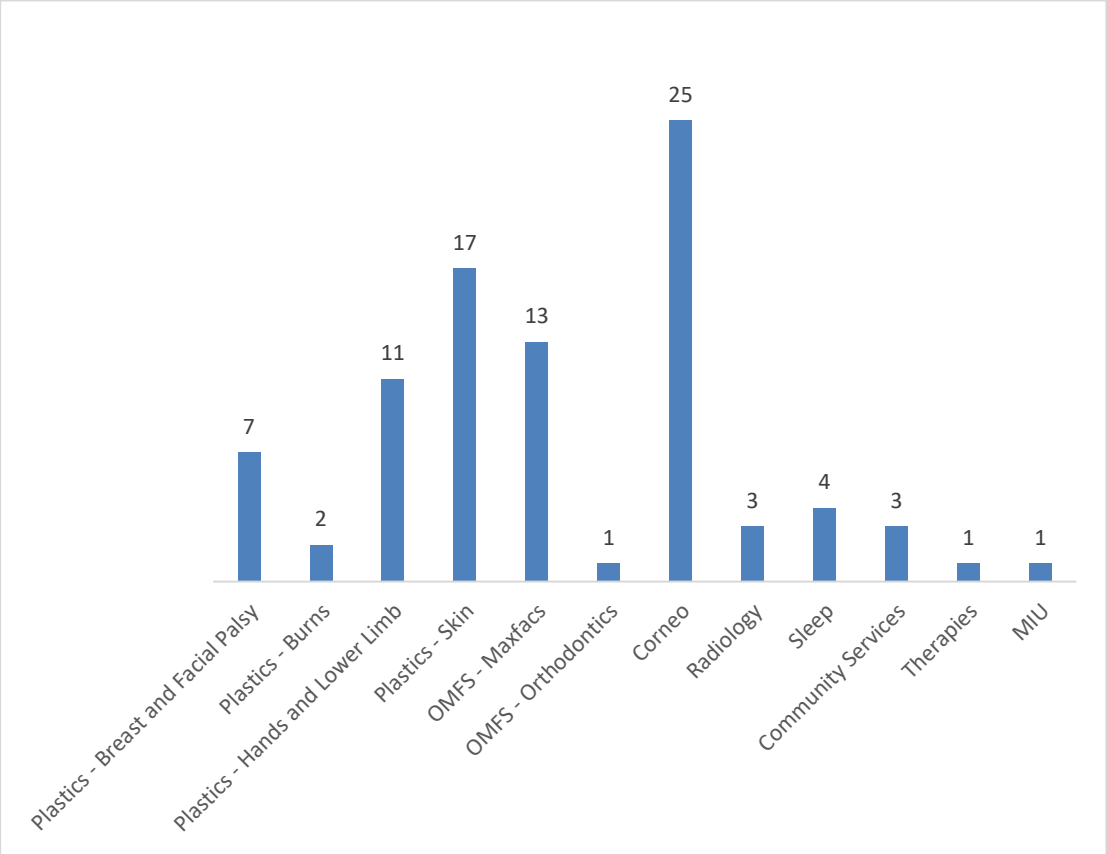
During this reporting period, the Trust embedded four Directorates, each led by a triumvirate leadership structure consisting of a Clinical Director, Head of Nursing and General Manager. Alongside increasing patient activity, a

number of services also implemented revised operational processes and pathways. It is recognised that periods of organisational transformation can contribute to increased volumes of patient feedback, concerns and complaints.

Performance against complaints handling timescales remained positive overall. The Trust acknowledged **92%** of newly received complaints within three working days and closed **86%** of complaints within 30 working days. The Trust targets 90% for each respective timescale representing a slight reduction on the previous year's performance. Where investigations could not be completed within the expected timeframe, complainants were informed and revised timescales agreed. These were broadly due to the complexity of concerns to investigate.

It should be noted that the complaints process was refined during the reporting period based on the ongoing monitoring arrangement between the Patient Experience Manager and Chief Nursing Officer to assess the effectiveness and consistency of the existing process.

Complaint activity is also monitored proportionately against overall Trust activity levels, including inpatient and outpatient contacts, to support benchmarking and comparison with other organisations. During the reporting period, the Trust recorded a complaint rate of **0.384** complaints per 1,000 patient contacts based on 88 complaints received.



There continued to be some limitations in the consistency of activity data captured across certain services, including inpatient areas. These limitations are reflected in a level of assurance associated with the underlying total activity data, rather than service specific data.

The Trust remains committed to ensuring that concerns and complaints are reviewed thoroughly, fairly and in a timely manner. All complaint responses were personally reviewed by a lead Executive prior to issue. Directorate leadership triumvirates continue to review complaints relating to their services and oversee the associated investigations and learning actions.

Parliamentary and Health Service Ombudsman (PHSO)
Where a complainant remains dissatisfied following completion of the Trust's complaints process, they have the right to refer their complaint to the Parliamentary and Health Service Ombudsman (PHSO) for independent review.

Before undertaking an investigation, the PHSO will usually seek assurance that all reasonable opportunities for local resolution have been explored. Where a case is accepted for investigation, the PHSO provides an independent assessment of the complaint and may determine that the complaint is upheld, partly upheld or not upheld.

During the reporting period, no new complaints relating to the Trust were referred to the PHSO for investigation. This provides assurance that concerns raised through the Trust's complaints process were either resolved locally or did not progress to external review.

'Learning From' and triangulation
The purpose of collecting feedback at QVH is to learn from it. Positive feedback helps us understand what matters most to patients and where services are performing well, while concerns and complaints identify opportunities to improve care, communication and patient experience.

To support this approach, the Trust has continued to embed a systems based methodology for reviewing patient feedback, aligned to the principles of the Patient Safety Incident Response Framework (PSIRF). This approach focuses on understanding the factors that contribute to patient experience rather than attributing blame, enabling learning and improvement to be identified in a structured and consistent way.

A key element of this process is the triangulation of feedback from multiple sources. The Patient Experience Manager has oversight of complaints, PALS enquiries, local resolutions, Friends and Family Test responses, claims and violence prevention and reduction investigations. Bringing these sources together provides a richer understanding of patient experience and enables themes to be explored in greater depth than would be possible from any

single dataset alone.

All feedback is categorised using a standard thematic framework, allowing trends to be reviewed consistently across complaints, concerns, claims and compliments. This supports more meaningful analysis and helps identify both areas of good practice and opportunities for improvement. For example, a theme such as treatment may include communication about treatment, delivery of treatment and consent processes, allowing related feedback and claims to be considered together.

Throughout the year, the Patient Experience Manager and Directorate Leadership Triumvirates met quarterly through dedicated “Learning From” meetings to review triangulated findings. Where wider organisational themes were identified, additional discussions were held through existing governance structures to ensure appropriate oversight and action.

Each meeting resulted in both Trust wide and directorate specific action plans. Directorate plans focused on local improvements and staff development needs, while Trust wide plans addressed broader opportunities such as service redesign, process improvement, communication initiatives and customer care training.

Feedback received during the year has informed a range of improvements, including:

- Strengthening arrangements for hybrid clinics to reduce the risk of delayed or missed telephone appointments.
- Reviewing Duty of Candour processes and training following learning identified through complaints and claims.
- Working with NHS 111, the Integrated Care Board and system partners to improve understanding of Minor Injuries Unit referral criteria.
- Improving communication with patients attending trauma clinics to ensure expectations are clearer before appointments.
- Enhancing discharge planning processes and communication to help patients better understand arrangements for leaving hospital and travelling home.
- Reviewing administrative processes and correspondence pathways where feedback highlighted delays or inconsistencies.

Learning from feedback is embedded within directorate governance arrangements. For medical staff, relevant themes and actions are discussed through annual appraisal processes, supporting individual reflection and professional development.

We are equally committed to demonstrating how feedback leads to change. Learning and improvement are shared through a variety of channels, including:

	• Direct feedback to patients and families through meetings, telephone calls and written responses. • Opportunities for patients and carers to participate in projects, discussion groups and service improvement work. • "You Said, We Did" communications within departments. • Trust wide communications, posters and information displays. • Governance reporting and annual publications. All new staff receive training on customer care, handling concerns and the Trust's values as part of their induction programme. This helps ensure that listening to patients, responding compassionately and learning from feedback remain central to the way we deliver care.

5.	Involvement & Engagement
	Patient Experience Governance Delivering an outstanding patient experience remains central to everything QVH does. The Trust's Key Strategic Objectives (KSOs) begin with KSO1: Outstanding Patient Experience, reflecting our commitment to placing patients, carers and families at the centre of everything we do. This commitment is embedded within the Trust's five year strategy, which sets out our vision, values, strategic objectives and future direction. Developed through engagement with more than 3,000 patients, volunteers, staff, health and care partners, and stakeholders from across Kent, Surrey, Sussex and beyond, the strategy reflects what matters most to the communities we serve and shapes our ambitions for the future of our services. **Patient Experience Governance Arrangements** During 2026/27, the Trust continued to strengthen the way patient experience is governed and embedded within decision making. Building on the work previously undertaken through the Patient Safety and Experience Sub-Committee (PSESC), the Trust established the Patient Experience Meeting in April 2026 to provide a dedicated forum for reviewing feedback, overseeing learning and monitoring improvement activity across services. The Patient Experience Meeting brings together clinical, operational and patient experience leaders to review feedback from multiple sources, including complaints, PALS contacts, Friends and Family Test responses, patient experience incidents, claims, national surveys and Healthwatch reports. This ensures that learning is considered in the round and that emerging themes are identified and acted upon at the earliest opportunity. The meeting supports the Trust's commitment to "listen to improve", ensuring that the experiences of patients, carers and families directly influence service development and quality improvement. Findings and assurance are escalated through the Trust's governance structure, supporting oversight by the Quality and Safety Committee and ultimately the Board.

A key area of focus during the year has been ensuring that feedback is reviewed as close as possible to the point of care. Directorate Leadership Triumvirates play an important role in reviewing themes, leading investigations and implementing improvements, creating greater ownership of patient experience across clinical services.

The Trust has also continued to develop collaborative approaches to improving care for patients with additional needs. This includes ongoing work to bring together learning from a range of patient groups and experiences to support a more consistent and inclusive approach to service delivery.

Complaints
The NHS Complaints Standards set out a clear vision for how organisations should respond when concerns are raised by patients, carers and families. They promote openness, accountability and learning, supporting organisations to improve services through meaningful engagement with feedback.

The Trust remains committed to creating a culture in which concerns and complaints are welcomed as opportunities to learn and improve. Complaints are managed through the integrated Complaints and PALS service and investigated in partnership with Directorate Leadership Triumvirates, ensuring that concerns are reviewed by those closest to the services involved. Throughout 2026/27, further developments were made to strengthen complaint handling. These included continued improvements to communication with complainants, enhanced governance oversight of complex cases and ongoing refinement of investigation processes to ensure responses are timely, person centred and focused on learning.

Support is offered to complainants throughout the process, with regular updates remaining the most frequently requested form of assistance. The Trust continues to seek feedback on the complaints process itself and is exploring a range of methods to better understand the experiences of complainants and identify opportunities for further improvement.

Learning from complaints is reviewed alongside PALS contacts, claims, patient experience incidents and survey feedback through the Trust's quarterly "Learning From" process. This triangulated approach enables themes to be understood in context and supports coordinated improvement activity across services.

By embedding complaints within wider patient experience governance arrangements, the Trust continues to strengthen its ability to learn from feedback, improve services and ensure that the patient voice remains central to decision making.

6.	Learning from Experience
	The introduction of clinical directorates and triumvirate leadership teams has continued to strengthen governance, reporting and organisational learning across the Trust. During 2025/26, reporting arrangements and information requirements were further refined to ensure that leaders received meaningful, timely and actionable intelligence to support service improvement and patient care. Within the Safety and Patient Experience Team, reporting frameworks have continued to evolve in partnership with directorate leadership teams. This collaborative approach has resulted in the development of more comprehensive and integrated reports, bringing together information from complaints, PALS contacts, patient experience feedback, incidents, claims and other governance processes. The enhanced reporting suite supports a more consistent understanding of themes and risks across services, enabling learning to be shared more effectively throughout the organisation. The governance arrangements introduced alongside the directorate model are now well established. Throughout the year, reporting and assurance processes have been embedded within the Trust's committee structure, providing clearer oversight of patient experience, safety and quality performance. This has strengthened the ability of services to identify trends, respond to emerging issues and monitor the impact of improvement actions. A significant development during the year was the introduction of the Clinical Learning Forum. This multidisciplinary forum brings together learning from a wide range of governance activities, including complaints, incidents, investigations, claims and patient feedback. The forum provides a structured opportunity to identify common themes, share learning across directorates and agree actions that support continuous improvement. By considering information from multiple sources, the Clinical Learning Forum helps ensure that learning is embedded consistently across the Trust and contributes to safer, more effective and person centred care. Together, these developments have strengthened the Trust's ability to learn from experience, promote a culture of openness and continuous improvement, and ensure that feedback and governance intelligence are translated into meaningful service improvements for patients, carers and staff. Whilst significant progress has been made in strengthening patient experience governance and learning during the year, development of the Trust's Patient Experience and Public Engagement Strategy has not progressed as far as originally anticipated. This has largely been due to organisational priorities associated with the developing collaborative partnership with Guildford, which has required considerable leadership focus and engagement resource throughout the period. The Trust has therefore prioritised ensuring that the patient voice is

	represented within the development of collaborative working arrangements and future service planning. Whilst this has delayed the formal publication of a refreshed Patient Experience and Public Engagement Strategy, valuable engagement activity has continued through existing patient groups, patient representatives, Healthwatch partners, feedback mechanisms and governance forums. The learning and insight gathered through this work will provide a strong foundation for the strategy's development during 2026/27. The Trust remains committed to producing a refreshed strategy that reflects the needs and expectations of patients, carers, staff and partners, and supports the delivery of its strategic objective of Outstanding Patient Experience.

7.	**Recommendations**
	The Patient Safety and Experience Team will continue to adapt to organisational, system and national developments, ensuring that the information and intelligence provided remain meaningful, timely and focused on supporting improvement. As governance arrangements mature and collaborative working evolves, the team will continue to refine reporting mechanisms to strengthen shared learning, identify emerging themes and support opportunities for service improvement. The Trust recognises that the NHS continues to operate within a rapidly changing environment, with ongoing transformation at service, organisational and system levels. Future priorities, plans and targets must therefore remain flexible and responsive to change. The Patient Safety and Experience Team will work closely with clinical and operational colleagues to ensure that patient experience, feedback and learning continue to inform decision making and support the delivery of safe, effective and person centred care.

8.	**Future plans and targets**
	There is much to celebrate from the past 12 months. The year has seen continued development in the way we listen to, learn from and respond to patient feedback. Alongside maintaining high levels of patient satisfaction, we have strengthened our governance arrangements, embedded directorate ownership of patient experience, introduced the Clinical Learning Forum and further developed our approach to triangulating feedback and learning across the Trust. Whilst progress has been made in many areas, we recognise that improvement is a continuous process. The development of the Patient Experience and Public Engagement Strategy has not progressed as far as originally planned due to the priority given to supporting the Trust's developing collaborative partnership arrangements. However, this work has provided valuable insight that will inform the strategy's future development. Looking ahead to 2026/27, the Trust will focus on:

	1. Developing and launching a refreshed Patient Experience and Public Engagement Strategy aligned to the Trust's strategic objectives and collaborative ambitions. 2. Embedding the new Patient Experience Meeting and Clinical Learning Forum to strengthen oversight, shared learning and organisational improvement. 3. Continuing to improve the timeliness and quality of complaint responses, ensuring concerns are resolved as quickly and effectively as possible in line with NHS Complaints Standards. 4. Further enhancing triangulation and thematic analysis across complaints, PALS, FFT, claims, incidents and patient experience feedback to provide deeper insight into patient outcomes and experiences. 5. Expanding opportunities for patient, carer and public involvement in service development and quality improvement initiatives. 6. Supporting directorates to demonstrate how patient feedback has informed local improvements and service changes. Progress against these priorities will continue to be monitored through the Trust's governance framework and reported to the Patient Experience Meeting, Executive Sub-Committee for Quality, Quality and Safety Committee and Trust Board.

9.	**Conclusions and assurance**
	Despite a year of continued change and increasing demand across services, patient feedback remains overwhelmingly positive. The Trust continues to achieve high levels of patient satisfaction through national surveys, the Friends and Family Test and the many compliments received from patients, carers and families. The Patient Safety and Experience Team has played a central role in ensuring that patient feedback is listened to, understood and translated into meaningful action. Through the triangulation of complaints, PALS contacts, patient experience feedback, claims, incidents and other sources of intelligence, the Trust has strengthened its ability to identify themes, understand patient experiences and target improvement activity where it will have the greatest impact. The introduction of enhanced governance arrangements, directorate ownership of patient experience, and the Clinical Learning Forum has further strengthened the Trust's approach to organisational learning. These developments help ensure that feedback is considered alongside other quality and safety information, enabling learning to be shared more effectively across services and improvements to be implemented consistently. By continuing to focus on openness, engagement, learning and continuous improvement, QVH remains committed to delivering outstanding patient

	experience and ensuring that patients, carers and families feel listened to, valued and involved in shaping the services they receive.

10.	**Report approval and governance**
	This report will be reviewed and approved by the following committees/sub-committees as follows: 1. Executive Sub-Committee for Quality 2. Executive Leadership Team 3. Quality and Safety Committee

Report cover-page					
References					
Meeting title:	Board of Directors				
Meeting date:	09/07/2026	**Agenda reference:**	**34-26**		
Report title:	Annual Report 25/26 for Appraisal and Revalidation				
Sponsor:	Tamara Everington, Chief Medical Officer				
Author:	Tamara Everington, Chief Medical Officer				
Appendices:	None				
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 2024/2025 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	• The report uses a template provided by NHSE and sets out the information and metrics that a designated body is expected to report for assurance purposes. • Processes to support appraisal and revalidation of the medical workforce are well established and supported. • Internal audit by RSM in year did not identify concerns with appraisal and revalidation processes at QVH. • A number of improvements are planned to support further learning including peer audit of appraisal and a Responsible Officer Advisory Group				
Recommendation:	That the Board **notes and ratifies** 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:	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:	Quality & People BAF				
Organisational 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:	Compliance with anti-fraud measures.				
Resources:	This annual report was produced using existing resources.				
Assurance route					
Previously considered by:	Executive Committee for Quality & Risk (ECQR) and Quality & Safety Committee				
	Date:	18 May 2026 and 8 June 2026	Decision:	Approved	
Next steps:					

Annex A

Illustrative Designated Body Annual Board Report and Statement of Compliance

This template sets out the information and metrics that a designated body is expected to report upwards, through their Higher Level Responsible Officer, 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 – Metrics
Section 3 - Summary and conclusion
Section 4 - Statement of compliance

Section 1 Qualitative/narrative

All statements in this section require yes/no answers, however the intent is to prompt a reflection of the state of the item in question, any actions by the organisation to improve it, and any further plans to move it forward. You are encouraged therefore to provide concise narrative responses

Reporting period 1 April 2025 – 31 March 2026

1A – General

The board/executive management team 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.

Y/N	Y
Action from last year:	RO responsibilities are included within scope of the CMO role
Comments:	Tamara Everington, GMC No 4032698 is the Chief Medical Officer and Responsible Officer for the Trust
Action for next year:	none

1A(ii) Our organisation provides sufficient funds, capacity and other resources for the responsible officer to carry out the responsibilities of the role.

Y/N	Y
Action from last year:	Explore the possibility of automating reports to be disseminated across triumvirates to ensure they support compliance with appraisals.
Comments:	ESR Manager Self Service has been introduced to ensure all managers have oversight of the appraisal status of their staff and these are discussed with directorate triumvirates as part of the integrated performance review process. The electronic appraisal system, L2P is in place which although not automated gives individuals and the CMO oversight of medical & dental appraisals. There has been a gap in the Medical Workforce Manager role but this has been covered with support from the Deputy Chief People Officer and MW Administrator in the interim. The new MWM is now in place. Any concerns over individual cases are explored with the Clinical Directors / Appraiser Group.
Action for next year:	Develop a formal Responsible Officer Advisory Group, possibly in collaboration with partner providers.

1A(iii)An accurate record of all licensed medical practitioners with a prescribed connection to our responsible officer is always maintained.

Y/N	Y
Action from last year:	Continue using GMC portal; maintain current process for updating of starters and leavers to ensure accuracy.
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 current practice.

1A(iv) All policies in place to support medical revalidation are actively monitored and regularly reviewed.

Y/N	Y
Action from last year:	Timetabled for next renewal date January 2027.
Comments:	none
Action for next year	Policy to be reviewed and updated in 26/27

1A(v) A peer review has been undertaken (where possible) of our organisation's appraisal and revalidation processes.

Y/N	Y
Action from last year:	Following internal audit, to look at findings and improve processes.
Comments:	An internal audit was undertaken by the Trust Auditors RSM in 2025/26 with recommendations and actions advised that the Trust delivered in year.
Action for next year:	Continue to monitor processes internally through a Responsible Officer Advisory Group

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.

Y/N	Y
Action from last year:	By Q4 end to have 95% compliance on in date appraisals
Comments:	A robust induction programme is in place. Resident doctors

	not in training posts are supervised in the same way as trainees and measures have been put in place to ensure SAS doctors have strong support in development including progression to autonomous practice where appropriate. A process is in place to ensure every appraisal includes information on scope of practice including governance parameters such as incidents and complaints. At year end 25/26 88% of doctors had completed their annual appraisal.
Action for next year	Improve % of doctors completing annual appraisal in year to over 90%. Ensure that where delays occur these are understood, supported and appropriately resolved.

1B – Appraisal

1B(i) Doctors in our organisation have an annual appraisal that covers a doctor's whole practice for which they require a 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.

Y/N	Y
Action from last year:	Ensure appraisal supports completion of audits and declaration of interest updates on ESR including detail around scope of work.
Comments:	Adherence to appraisal timelines is an actively facilitated and managed process led by the CMO and supported by the Medical Workforce Team. Delays are explored with appraisees and escalated to Clinical Directors and General Managers for intervention if there is no satisfactory explanation for delay. Appraisal outputs are scrutinised in a regular review process to ensure coverage of scope of practice with flagging of any complaints or incidents for reflection. Audits are registered with the Quality and Compliance team and outputs are captured in the appropriate section on L2P.

Action for next year:	Continue current practice, through 26/27 Quality Priority work, ensure clinical outcome audits are available and can be evidenced in appraisal documentation.

1B(ii) Where in Question 1B(i) this does not occur, there is full understanding of the reasons why and suitable action is taken.

Y/N	Y
Action from last year:	Continue to champion achievements and putting in place early interventions where possible
Comments:	There is an ongoing process in place to encourage and support where there are practical reasons for delay in appraisal such as ill health, parental leave or sabbaticals. Reasons for delay are captured in L2P with personalised actions to help address this. The value of annual appraisal in support of personal development is regularly messaged with appraisers supporting this messaging. If there is no adequate engagement with appraisal despite best efforts, Trust policies in relation to Managing Performance and Managing High Professional Standards are followed. There is regular engagement between the CMO and the GMC Employment Liaison Advisor and, non-engagement will be raised with them where applicable.
Action for next year:	Continue personalised support approach where needed

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).

Y/N	Y

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, This was ratified by the Finance & Performance Committee and published in January 2024. Changes incorporated use of electronic systems 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.

Y/N	Y
Action from last year:	Continue to promote appraisal training
Comments:	There have been sufficient trainers in place however they have been working near capacity as some appraisers have retired. Further appraisers have been recruited in 26/27 to ensure there is always excess capacity for need. These individuals are being trained and will be supported through their first 3 appraisals as per the normal approach.
Action for next year:	Ensure new appraisers are settled in and supported in starting their roles

1B(v) Medical appraisers participate in ongoing performance review and training/ development activities, to include attendance at appraisal network/development

[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.

events, peer review and calibration of professional judgements (Quality Assurance of Medical Appraisers or equivalent).

Y/N	Y
Action from last year:	Implement and embed new clinical leadership model
Comments:	Engagement and training meetings are regularly held for appraisers to discuss practice and learning.
Action for next year:	A peer review audit of appraisal quality by the Clinical Lead for Quality will be performed in 26/27.

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.

Y/N	Y
Action from last year:	Continue to share feedback and complete PROGRESS audit sampling appraisals from each appraiser
Comments:	An audit is underway
Action for next year:	The peer review audit will be completed, reviewed and discussed with feedback in appropriate forums including appraiser meetings.

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.

Y/N	Y

Action from last year:	Ensure revalidation portfolios are completed at least 1 month before revalidation due date.
Comments:	Meetings are held throughout the year with revalidation portfolios reviewed by the RO and recommendations made on time. L2P has increased visibility of upcoming revalidations with reminders sent to doctors in line with expected timescales. Any delays are recorded on L2P. L2P has replaced a manual process with an efficient system whilst maintaining quality.
Action for next year:	Continue current practice

1C(ii) Revalidation recommendations made to the GMC 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.

Y/N	Y
Action from last year:	Continue with confirmation on same day and RO to discuss with individual if deferral is mandated.
Comments:	All doctors receive confirmation of the revalidation recommendation on the day. Confirmation of either a positive recommendation or deferral due to insufficient evidence is 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 current practice

1D – Medical governance

1D(i) Our organisation creates an environment which delivers effective clinical governance for doctors.

Y/N	Y
Action from last year:	Ensure the effective sharing of clinical governance to business units continues during organisational rewiring.
Comments:	The central quality team work closely with services to support best local practice in governance. There is good sharing of information including cascade from the quality team staff in supporting doctors' appraisal discussions and professional development
Action for next year:	Continue current practice

1D(ii) Effective systems are in place for monitoring the conduct and performance of all doctors working in our organisation.

Y/N	Y
Action from last 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.
Comments:	Effective systems are in place to support informal and formal conduct and performance review for doctors of all grades. Maintaining High Professional Standards (MHPS) investigations have been conducted in line with policy and guidance.
Action for next year:	Continue current practice

1D(iii) All relevant information is provided for doctors in a convenient format to include at their appraisal.

Y/N	Y
Action from last year:	Implement and embed annual data packs
Comments:	The Medical Workforce Administrator ensures relevant information is provided for doctors ahead of their appraisal.
Action for next year:	Continue current practice

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.

Y/N	Y
Action from last year:	Continue to follow agreed policies
Comments:	Nothing to add
Action for next year:	Continue current practice

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.

Y/N	Y
Action from last year:	Continue with current procedures and ensure analysis of protected characteristics and country of primary medical qualification are included.
Comments:	The Chief People Officer supports the CMO in responding to Concerns. Issues are discussed with the GMC Employment Liaison Officer and the regional advisor from NHS Resolution where required. Regular meetings happen with these individuals at least 2 times a year and there is review and discussion of detail of protected characteristics and country of primary medical qualification of the doctor. As relevant numbers are low, no conclusions can be drawn from this data currently. A named non-executive Board member acts as an objective independent overseer of process. Numbers and types of investigations are reported to the Board.
Action for next year:	Continue current practice

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.

Y/N	Y
Action from last year:	Continue with current procedures
Comments:	The Trust's process for transferring information and concerns meets 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 current practice

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 (Ref GMC governance handbook).

Y/N	Y
Action from last year:	Continue to follow agreed policies and procedures
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, e.g. from national reviews, reports and enquiries, and integrate these into the organisation's policies, procedures and culture. (Give example(s) where possible.)

Y/N	Y
Action from last year:	Progress insights and learning through cultural workstreams to support recognition of individual needs and inclusivity

Comments:	Freedom to speak up and active bystander training have been rolled out with support from Employee Relations. Neurodiversity awareness training has been offered And, well received. There is ongoing work to support inclusivity through the Cultural Transformation Steering Group led by the CEO and CMO.
Action for next year:	Continue to explore opportunities to improve practice through participation in RO meetings / notifications and the work of the CTSG.

1D(ix) Systems are in place to review professional standards arrangements for all healthcare professionals with actions to make these as consistent as possible (Ref Messenger review).

Action from last year:	Continue to embed processes to ensure development and promote management courses – exploring making this mandatory for new managers
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.

Y/N	Y
Action from last year:	Continue 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. IDVT was implemented in 24/25 and is proving successful and helping with timely and safe recruitment checks. The trust continues to adhere 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 at the same time as seeking time savings and reduction of hand offs to support timely and safe recruitment.

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.

Y/N	Y
Action from last year:	Continue to embed Freedom to Speak Up Service and continuous improvement methodology to drive improvement.
Comments:	Outsourced and independent FTSU service continues. Actions and reporting directly to Trust board. Sessions to all

	staff via Team Talk. Continuous improvement through the QVH Way is being embedded across Trust with both Yellow and Green belt facilitators trained
Action for next year:	Continue with current plans

1F(ii) A system is in place to ensure compassion, fairness, respect, diversity and inclusivity are proactively promoted within the organisation at all levels.

Y/N	
Action from last year:	Continue to promote courses in line with the ethos of the organisation
Comments:	Nil to add
Action for next year:	Continue current practice

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.

Y/N	
Action from last year:	Embed behavioural framework, identify training needs to support doctors make positive change.
Comments:	Patient Safety Incident Response Framework (PSIRF) supports an open learning culture. Tell Liz (Chief Nurse) 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:	Continue current practice

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).

Y/N	Y
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.

Y/N	Y
Action from last year:	The Trust does not record primary medical qualification and will investigate how this can be captured going forward for assessing level of parity.
Comments:	Reports are received from the GMC in regard to these factors and are reviewed with the RO. There is an ongoing recruitment EDI process review.
Action for next year:	Consider outputs from EDI recruitment process review to further check for 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.

Y/N	Y
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 2025 – 31 March 2026.

All data points are in reference to this period unless stated otherwise.

The number of doctors with a prescribed connection to the designated body on the last day of the year under review	133
Total number of appraisals completed	107
Total number of appraisals approved missed	13
Total number of unapproved missed	15
The total number of revalidation recommendations submitted to the GMC (including decisions to revalidate, defer and deny revalidation) made since the start of the current appraisal cycle	14
Total number of late recommendations	1
Total number of positive recommendations	9
Total number of deferrals made	4
Total number of non-engagement referrals	1
Total number of doctors who did not revalidate	4
Total number of trained case investigators	3

Total number of trained case managers	1
Total number of concerns received by the Responsible Officer[2]	4
Total number of concerns processes completed	3
Longest duration of concerns process of those open on 31 March (working days)	70
Median duration of concerns processes closed (working days)[3]	80
Total number of doctors excluded/suspended during the period	1
Total number of doctors referred to GMC	0
Total number of appeals against the designated body's professional standards processes made by doctors	0
Total number of these appeals that were upheld	0
Total number of new doctors joining the organisation	93
Total number of new employment checks completed before commencement of employment	79
Total number claims made to employment tribunals by doctors	0
Total number of these claims that were not upheld[4]	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
There has been a gap in the Medical Workforce Manager post for unavoidable reasons which has been internally covered in year. Of the 93 doctors that started new to the Trust in the reporting year, 79 had all checks completed prior to their start date (83%). The remaining 17% were Resident Health Education England doctors who

[2] Designated bodies' own policies should define a concern. It may be helpful to observe https://www.england.nhs.uk/publication/a-practical-guide-for-responding-to-concerns-about-medical-practice/, which states: *Where the behaviour of a doctor causes, or has the potential to cause, harm to a patient or other member of the public, staff or the organisation; or where the doctor develops a pattern of repeating mistakes, or appears to behave persistently in a manner inconsistent with the standards described in Good Medical Practice.*

[3] Arrange data points from lowest to highest. If the number of data points is odd, the median is the middle number. If the number of data points is even, take an average of the two middle points.

[4] Please note that this is a change from last year's FQAI question, from number of claims upheld to number of claims not upheld".

started in post in line with their rotation prior to submitting all required paperwork to the Trust. Where doctors start without pre-employment checks being completed a risk assessment is performed and escalated to the Chief Medical and Chief People Officers for approval and sign off taking into account recent DBS and Occupational Health checks done in other organisations. With a new Head of Medical Workforce in post since mid-April 2026 it is anticipated that this gap in pre-employment checks will reduce moving forward.

New appraisers are being on-boarded to increase capacity and the new Clinical Lead for Quality will be evaluating the quality of appraisals. A Responsible Officer Advisory Group will be set up. If agreed and feasible this may be done together with partner providers.

'Concern processes' listed above have been defined by the Designated Body as those that were not remediated with individual or local resolution processes including cultural reviews within services and, needed to progress to MHPS investigation. It should be noted for organisational purposes that QVH employs dentists registered with the GDC as well as doctors registered with the GMC. Not included in the numbers above is 1 investigation into the conduct of a member of staff registered with the GDC which concluded in year with a similar approach and timescale.

Actions still outstanding
As above
Current issues
One ongoing MHPS investigation
Actions for next year (replicate list of 'Actions for next year' identified in Section 1):
Develop a formal Responsible Officer Advisory Group to provide peer review and audit oversight. Connect with partner providers if feasible in year. Ensure policies remain up to date.

Improve % of doctors completing annual appraisal in year to over 90% and, linking to Quality Priority outcomes work, map evidence to appraisals.

Support new appraisers in developing their skills and practice, continue to share learning through the appraiser forum.

Clinical Lead for Quality to complete a peer review audit of appraisal quality with findings to be discussed and shared for learning.

Continue to explore opportunities to improve practice through participation in RO meetings / notifications and the work of the CTSG.

Consider outputs from EDI recruitment process review to further check for parity.

Ensure that where delays occur these are understood, supported and appropriately resolved.

Overall concluding comments (consider setting these out in the context of the organisation's achievements, challenges and aspirations for the coming year):

A formal audit by our internal auditors was performed in year by our internal auditors, RSM. This audit explored job planning, appraisal and revalidation. The audit evidenced considerable improvement in practice since 24/25 but partial compliance overall due to improvements required in job planning, declarations of interest and annual documentation of consent to breach European Working Time Directive hours where individuals chose to do this. No concerns were identified in this audit around appraisals and revalidation. Processes have been put in place to achieve full compliance with other matters identified in the audit and full assurance on this was given to the auditors by year end 25/26.

Overall there is evidence of appropriate targeted resolution of concerns raised within a just culture framework. MHPS investigations where required have proceeded according to policy and with good support internally and externally. Timeframes to complete MHPS investigations have been longer than desirable due to case complexity and challenges to the process by individuals which has made delay unavoidable.

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:	
Role:	
Signed:	
Date:	

Name of the person completing this form:	Tamara Everington
Email address:	Tamara.everington1@nhs.net

Report cover-page					
References					
Meeting title:	Board of Directors				
Meeting date:	09/07/2026	**Agenda reference:**	**35-26**		
Report title:	Financial, workforce and operational performance assurance				
Sponsor:	Jag Dosanjh-Elton, Non-executive Director				
Author:	Jag Dosanjh-Elton, Non-executive Director Katie Ally, Governance officer				
Appendices:	None				
Executive summary					
Purpose of report:	To alert, assure and advise the Board regarding matters considered at the last committee meeting.				
Summary of key issues	– The Trust is reporting RTT performance at 61.37%, below plan, with capacity constraints impacting pathways. – 65+ week waits remain a concern (34 patients), with risk of further increases – Rising 40–51 week waits signal future 52-week breach risk. – Diagnostic waits increasing (e.g. sleep diagnostics - 20 weeks) due to demand exceeding capacity. – Cancer standards below target (Faster Diagnosis Standard, 62-day, 31-day) driven by staffing and capacity pressures. – Workforce slightly above plan; vacancy rate within target but pressures remain in key areas. – Financial position slightly favourable to plan in Month 1; pay pressures offset by non-pay underspend. – Income subject to estimation pending contract agreement; some activity shortfalls noted. – Archie Patient Administration System programme on track for November 2026 but risk rating increased (Red/Amber) due to delivery and funding risks. – Recruitment improving; reduced agency usage, though sickness and turnover present risks.				
Recommendation:	The Board is asked to **note** the contents of the report.				
Action required	Approval	Information	Discussion	**Assurance**	Review
Link to key strategic objectives (KSOs):	**KSO1:** *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:					
	Date:		Decision:		

Next steps:	

Report to: Board of Directors
Agenda item: 35-26
Date of meeting: 09 July 2026
Report from: Jag Dosanjh-Elton, Non-executive Director
Report author: Jag Dosanjh-Elton, Non-executive Director
Katie Ally, Governance Officer
Date of report: 29 June 2026
Appendices: None

Sub-committee assurance report
Finance and Performance Committee

Key agenda items

- **Integrated Quality & Performance Report – Month 1 and outlook**
- **National Cost Collection – pre submission**
- **Transport contract**
- **East Grinstead Community Diagnostic Centre (CDC)**
- **MRI scanner**
- **Major projects milestones & resources plan**
- **Digital transformation incl. Patient Administration System (PAS)**
- **Information governance assurance (incl. Freedom of Information requests)**
- **Cyber security dashboard**
- **Estates assurance – critical infrastructure delivery**
- **Premises Assurance Model (PAM) – planning update**
- **Waste Services contract update**
- **Review of Board Assurance Framework and Organisational risk register**

Alert

- The committee received the Month 1 Integrated Quality & Performance report and received a month 2 verbal update. Month 1 performance remains below plan across RTT, cancer, and diagnostics, with underlying issues and recovery actions discussed. RTT performance is impacted by continued waiting list growth, particularly in Sleep (including external demand from Kent). The waiting list is 21,300 versus plan of 20,100. The committee noted targeted recovery actions are in place, including implementation of waiting list review recommendations, recruitment to address consultant gaps, and weekend working. These actions are expected to stabilise capacity and support recovery. The committee noted forecasting work with Business Intelligence Unit indicates that recovery is achievable if referral levels stabilise, but continued growth in demand would present a risk to delivery and require further intervention. The committee requested further assurance to determine the extent to which pressures are driven by demand versus efficiency to better target recovery actions.
- 52-week performance was achieved in Month 1 but is forecast to deteriorate, with rising risk driven by growth in the 40–51 week cohort. 65-week waits remain focused in Plastics and Oral and Maxillofacial Surgery. Mitigations are in place, but short-term deterioration risk remains high. The committee requested a further update on the implementation and impact of agreed waiting list review actions, to support assurance regarding delivery and the recovery trajectory.

- Cancer performance is below plan across all standards, driven by capacity constraints (particularly Head & Neck), diagnostic delays, and increased pathway complexity. Recovery actions are in place and expected to support Faster Diagnosis Standard delivery; however, 62-day and 31-day standards are forecast to remain below trajectory in the short term.
- Theatre utilisation remains below the 85% target at 81-82%, recovery actions are in place including strengthened data validation and the introduction of standby patient pathways, particularly for skin services. Early signs of recovery are evident, previous performance impacts associated with Electronic Patient Record have been resolved however, pace of recovery is impacted by resourcing constraints.
- Staffing levels are slightly above plan in Month 1, with vacancy rates at 6.8%, remaining below the 8% target. Workforce pressures persist in key areas including Plastics, Canadian Wing and Theatres.
- Average time to hire improved. Bank and agency usage has decreased, contributing to improved cost control and workforce efficiency, while sickness absence remains slightly above 4% and turnover has increased marginally, posing a potential risk to stability.
- Appraisal compliance has seen a slight decline overall, although the number of overdue appraisals has reduced. There continues to be management oversight and workforce engagement, particularly in areas with lower completion rates
- The committee noted the recently developed Basics Performance dashboard and received assurance that appropriate governance oversight and executive accountability arrangements are in place to monitor compliance, identify areas for improvement, and escalate sustained underperformance where required
- Annual leave utilisation is at approximately 17% by the end of Month 2, with variation across directorates. This is being actively monitored through performance and workforce oversight arrangements to ensure leave is managed effectively without adverse impact on service capacity.
- The Trust reported a Month 1 deficit of £0.248m, slightly better than the planned deficit of £0.252m, with a cash balance of £14.1m.
- Income is in line with plan but remains variable, with underperformance in CDC, Plastics, and daycase activity partially offset by increased sleep outpatient activity.
- The Cost Improvement Programme (CIP) has achieved plan to date, supported in part by non-pay underspends. However, there is a recognised risk that elements of the programme remain insufficiently defined or may not fully deliver within the year. Strengthened grip and control is in place to ensure that underspends are not released inappropriately and that delivery remains on track.
- The committee noted the gap of c£2.5m acknowledging that delivery will require a step change in productivity, particularly within key areas such as Local Anaesthetic Unit, alongside tighter ownership of schemes and consideration of alternative actions
- Pay expenditure is above plan by £0.17m, driven mainly by the impact of pay awards and slower delivery of planned efficiency measures, with a small additional impact from industrial action.
- Non-pay expenditure is favourable by £0.16m, reflecting reduced spending across areas such as Digital, Estates and Theatres, helping to offset pressures in pay budgets.
- The Archie PAS programme remains on track for a planned November 2026 go-live; however, the RAG rating has deteriorated to Red/Amber due to emerging risks across key workstreams. Workforce capacity pressures and reliance on operational staff supporting concurrent improvement priorities present further delivery risk. In addition, funding for the Digital Transformation Programme is

currently confirmed only until December 2026, creating a significant risk should there be any delays.

Assure

- The committee supported the requirement for the Efficiency Steering Group to strengthen its focus on monitoring in-year delivery and full-year forecasts, working with Senior Responsible Officers and leads to identify and implement mitigating actions where required. This will include a review of expenditure across the Trust to ensure all areas are contributing to the overall efficiency target.
- The committee received assurance that East Grinstead CDC remains rated Green/Amber, with the building now watertight. The committee asked how build quality is being assessed and was advised that an independent Mott MacDonald review would be shared with the committee at a later date.
- The 2026/27 activity and income plan has been agreed with the Integrated Care Board and is not expected to be impacted by the revised build timeline.
- The committee noted the MRI scanner project is progressing with design development and site planning underway. Work continues to secure additional funding with governance arrangements in place to oversee delivery.
- The committee noted the Sussex Pathology Network (SPN) project update and the associated risks. Progress with a developing system-wide plan strengthened partnership working and regular oversight in place. Risks relating to funding pressures, estate limitations were noted, with further detail on the future model replacement plans to be brought back to the committee.

Advise

- The committee received and approved the proposed process for submission of the National Cost Collection, noting the outlined timescales, learning from previous submissions, ongoing development of the methodology, and the interim arrangements in place to address current gaps, which will be further progressed ahead of the next submission cycle
- The committee received and noted the Estates assurance report, taking assurance from the progress being made against the Trust's critical infrastructure plan and delivery of the estates capital programme. The committee was assured that schemes remain aligned to key risks within the Estates and Facilities risk register and are supporting the reduction of backlog maintenance, while improving the safety, resilience and compliance of the Trust estate.
- The committee was assured that procurement of the waste contract is progressing through a robust collaborative tender, with risks managed via interim arrangements. The new model will support compliance, efficiency, and sustainability, with final approval to be sought in due course.
- The committee noted reasonable assurance in relation to information governance performance, with no breaches reported for Subject Access Requests and a reduction in overdue Freedom of Information responses. Training compliance remains strong at 91%, although continued focus is required to address outstanding FOI timeliness and maintain high standards.
- The committee received assurance that work is underway to develop a Cyber Security Dashboard to improve visibility of performance, risks and compliance. While the current version is illustrative, feedback has been provided to strengthen metrics, resilience measures, and supply chain assurance, with further development planned to support robust assurance.
- The committee received assurance on a robust procurement process for the award of the contract for Taxis, Couriers, Histopathology and Blood Samples transport services, and approved the award subject to KPIs and strengthened performance and demand controls.

Risks discussed and new risks identified
The committee received the Board assurance framework (BAF) and Organisation risk register (ORR).

The committee received assurance on the BAF and ORR, noting that key strategic risks remain appropriately identified, although the majority are outside of risk appetite. Areas requiring improvement were highlighted, including the timeliness and accuracy of risk updates, alignment with current performance trajectories, and completion of outstanding actions. Work is underway to strengthen oversight, refresh the risk position, and improving the quality of reporting.

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

Report cover-page					
References					
Meeting title:	Board of Directors				
Meeting date:	09/06/2026	**Agenda reference:**	**36-26**		
Report title:	Strategy and culture assurance				
Sponsor:	Jo Emmanuel, Non-executive director				
Author:	Peter O'Donnell, Non-executive director and 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 committee has reviewed the options for the strategic way forward for the care of children and young adults at QVH, in line with the QVH Strategy 2025-2030 and supports a hybrid model of elective practice, with enhanced triage and process management for non-elective activity, as the current preferred option, however, System-level collaboration is needed to develop the long-term strategy. - There is proactive and positive engagement with GPs and Primary Care Networks across Sussex with strong interest expressed in services, especially the direct access pathways offered by the Community Diagnostic Centre (CDC). - There has been considerable progress against the QVH Digital Strategy in the last 18 months. Capital funding is limited and the programme team continues to seek additional national and regional funding opportunities. The committee has encouraged further consideration of the AI and robotic technology opportunities and further development of the tangible outcome measures of the strategy. - The committee received assurance on the delivery of the Research and Innovation Strategy, noting the progress in establishing research infrastructure, strengthening governance arrangements, and developing a clearer understanding of the Trust's research baseline and growth opportunities. Development of the innovation agenda remains at an earlier stage, with work underway to establish supporting infrastructure and address capacity and expertise gaps. - The committee acknowledged the progress that has been in made establishing the Trust's risk management framework, however, it encouraged further consideration of how the conversations around risk can be strengthened; risks are well managed but it is felt that this could be better articulated.				
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:				
	Date:		Decision:	
Next steps:				

Report to: Board of Directors
Agenda item: 36-26
Date of meeting: 09 July 2026
Report from: Jo Emmanuel, Non-executive director
Report author: Peter O'Donnell, Non-executive director and committee Chair
Ellie Simpkin, Governance manager
Date of report: 23 June 2026
Appendices: None

Sub-committee assurance report
Strategy & culture committee – 2 June 2026

Key agenda items

- **Review of Strategic Partnership Board report**
- **Digital strategy update**
- **Engagement with GPs**
- **Children's model of care**
- **Research & Innovation update**
- **Draft strategic partnership Memorandum of Understanding (MOU)**
- **Board Assurance Framework (BAF) & organisational risks**

Alert

- The committee has reviewed the options for the strategic way forward for the care of children and young adults at QVH, in line with the QVH Strategy 2025-2030. A Children's Model task and finish group was established to define a high quality and sustainable way forward for the Trust, supported by input from the South Thames Paediatric Network (STPN). The task and finish group developed a number of potential options to explore and has recommended a hybrid model for elective practice with enhanced triage and process management for non-elective activity. The committee has supported this model as the current preferred option, however, it noted that System-level collaboration is needed to develop the long-term strategy for paediatric care at QVH. Oversight of the implementation of the model will be provided by the Quality & safety committee. The committee has requested a further update on the strategic approach in nine months' time.

Assure

- There is proactive and positive engagement with GPs and Primary Care Networks across Sussex with strong interest expressed in services, especially the direct access pathways offered by the Community Diagnostic Centre (CDC). This work is being supported by the CDC Clinical Lead, a community GP who is working for two days a week on a two year fixed term basis. The committee noted that work is progressing towards direct integration of documentation from QVH into GP systems as part of the Trust's digital transformation programme which will complete in 2026/27.

- There has been considerable progress against the QVH Digital Strategy in the last 18 months. Capital funding is limited and the programme team continues to seek additional national and regional funding opportunities. In recognition of emerging pressures, priorities and threats, a Digital Transformation Board has been created to ensure priorities are aligned to Trust need including cost improvement. The committee has encouraged further consideration of the AI and robotic technology opportunities and how QVH can work with System partners on this. The committee also suggested that there is further work to do to connect the Trust's Digital strategy and Green Plan and on the development of the tangible outcome measures of the strategy.
- The committee received assurance on the delivery of the Research and Innovation Strategy, noting the progress in establishing research infrastructure, strengthening governance arrangements, and developing a clearer understanding of the Trust's research baseline and growth opportunities. Development of the innovation agenda remains at an earlier stage, with work underway to establish supporting infrastructure and address capacity and expertise gaps. Positive progress is being made in developing local, academic and commercial partnerships, increasing clinician engagement in research activity, and raising the profile of research and innovation across the Trust.
- The report to the private Board meetings of Royal Surrey NHS Foundation Trust and Ashford and St Peter's Hospitals NHS Foundation Trust (RSFT/ASH) proposing expansion of the existing Group to include QVH as a strategic partner has been shared with the committee for transparency. The committee agreed that the report demonstrates that QVH is well-run and it was helpful to see the opportunities articulated.

Advise
- The committee has reviewed the draft MOU for the strategic partnership which is due to be approved by the Boards of all three trusts in July 2026.

Risks discussed and new risks identified
The committee reviewed BAF risks which relate to the long term sustainability of the Trust, leadership capacity and workforce, noting the key action being taken to address gaps in assurance. The scores for all of these BAF risks remain the same.

The committee acknowledged the progress that has been made inestablishing the Trust's risk management framework, however, it encouraged further consideration of how the conversations around risk can be strengthened; risks are well managed but it is felt that this could be better articulated.

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

Report cover-page					
References					
Meeting title:	Board of Directors				
Meeting date:	09/07/2026		**Agenda reference:**	**37-26**	
Report title:	Audit and risk assurance				
Sponsor:	Jagjit Dosanjh-Elton, Non-Executive director and committee Chair				
Author:	Jagjit Dosanjh-Elton, Non-Executive director and committee Chair Ellie Simpkin, Governance manager				
Appendices:	Appendix one – Audit & risk committee annual report 2025/26				
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 for 2025/26 is that the Trust has an adequate and effective framework of governance, risk management and internal control. - The external auditors, Azets, presented their draft annual audit findings for the year ending 31 March 2026. They have issued an unmodified audit opinion on the accounts. No significant weakness has been identified including in relation to the Value for Money assessment. - The Trust's Annual Governance Statement concludes no internal control issues have been identified in the year, reflecting the sustained progress made to address the financial control and governance issues identified last year. - The Counter Fraud Functional Standard Return (CFFSR) resulted in an overall rating of green, indicating full compliance. - Requirements of the Fit & Proper Persons Test framework have been met and there are no issues to report to date. Annual checks for Board members have been undertaken, all of which have been satisfactory. - The committee received moderate assurance on the effectiveness of QVH's System and partnership arrangements including the Sussex Provider Collaborative. Assurance is currently limited by a lack of demonstrated delivery impact and discussion was had on the need for clear criteria against which effectiveness is being assessed. - The committee has reviewed the minor updates made to the Trust's Standing Orders, Scheme of Delegation, Reservation of Powers and Standing Financial Instructions and recommends the revisions to the Board for approval. - The Audit & risk committee has produced its annual report which summarises the work undertaken by the committee in 2025/26. 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:	Deep dive on the sustainability BAF undertaken				
Organisational 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: 37-26
Date of meeting: 09 July 2026
Report from: Jagjit Dosanjh-Elton, Non-Executive director and committee Chair
Report author: Jagjit Dosanjh-Elton, Non-Executive director and committee Chair
Ellie Simpkin, Governance manager
Date of report: 29 June 2026
Appendices: None

Sub-committee assurance report
Audit & risk committee – 24 June 2026

Key agenda items

- **Internal audit Annual Report & Head of Internal Audit Opinion 2025/26**
- **External audit year end report 2025/26 (ISA 260 & VFM findings)**
- **Trust Annual Report, Accounts & Annual Governance Statement 2025/26**
- **2025/26 Year end financial position**
- **Key matters from Board, sub-committees & Executive committee for quality & risk**
- **Board Assurance Framework (BAF) - update on key strategic risks**
- **BAF deep dive – Sustainability**
- **BAF deep dive update – Estates**
- **Assurance on effectiveness of System/partnership arrangements**
- **Provider Capability Assessment – update**
- **Assurance report on processes**
- **Financial assurance**
- **Audit & risk committee annual report 2025/26**
- **Local Counter Fraud Annual report 2025/26**
- **Annual review of compliance with Fit & Proper Persons policy**
- **Annual review of Standing Orders, Standing Financial Instructions, Reservation of Power & Scheme of Delegation**
- **Waiting list review**
- **Internal and external audit contract extensions**

Alert

- The committee received moderate assurance on the effectiveness of QVH's System and partnership arrangements, including the Sussex Provider Collaborative. There are routes for QVH to influence System decision-making, receive assurance on shared risks, and escalate relevant interdependencies. The System risk assessment has been reviewed and RAG-rated, with ongoing oversight required as programmes move from planning into delivery. The committee noted that assurance is currently limited by a lack of demonstrated

delivery impact, and discussion was had on the need for clear criteria against which effectiveness is being assessed.
- Findings of an independent Waiting List Assurance Review have outlined recommendations to strengthen governance, reporting and oversight of elective care. Oversight of the implementation of the resulting action plan will be provided by the Finance & performance and Quality & safety committees. The Audit &risk committee will receive an update on the progress made in six months' time.

Assure
- Azets presented their draft annual audit findings for the year ending 31 March 2026. They anticipated issuing an unmodified audit opinion on the accounts. The committee was pleased to note that the audit process has been positive on all sides. No significant weaknesses were identified in relation to the Value for Money assessment.
- The Head of Internal Audit Opinion for 2025/26 is that the Trust has an adequate and effective framework of governance, risk management and internal control.
- The Trust's Annual Governance Statement (AGS) 2025/26 has concluded that no significant internal control issues have been identified during the year, reflecting the sustained progress made to address the financial control and governance issues identified in 2024/25.
- The Local Counter Fraud Service has provided its annual report to the committee, which demonstrates the work completed against the 2025/26 work plan. The Counter Fraud Functional Standard Return (CFFSR) resulted in an overall rating of green, with improved access to and completion of training.
- Targeted action has been taken to address the areas assessed as partially compliant in the 2025 Provider Capability Self-Assessment. Improvements have been made during 2025/26, including in strategy, access, productivity and financial oversight. Some risks remain, including financial sustainability, operational performance pressures and dependency on delivery of the strategic partnership. Guidance for the 2026 assessment is still awaited.
- The committee received a report which set out how the Trust obtains assurance regarding the effectiveness of its organisational processes, systems of internal control and management of risk, providing an overview of the sources of assurance available to the Board and how these operate across executive portfolios. The committee highlighted the importance of embedding processes and systems in day-to-day operations.
- Requirements of the Fit & Proper Persons Test framework have been met and there are no issues to report to date. Annual checks for Board members have been undertaken, all of which have been satisfactory.
- Internal audit reviews of the BAF & Risk Management and Key Financial Controls – Accounts Payable both received reasonable assurance outcomes, with management actions agreed to address identified areas for improvement.

Advise
- The procurement team is in the process of developing a visual dashboard which will improve assurance reporting on the key areas of contract awards, use of waivers and compliance with the No PO No Pay Policy.
- An annual review of the Standing Orders, Scheme of Delegation & Reservation of Powers and Standing Financial Instructions has been undertaken. No substantive amendments are proposed, and the committee recommends them to the Board for approval.
- The committee has made recommendations to the Board and the Council of Governors in relation to the extension of the internal audit and external audit contracts.

Risks discussed and new risks identified
The cyber strategic risk has been separated from the digital risk and added as a standalone risk on the BAF. The committee reviewed the first iteration, which has a current score of 12.

The committee undertook a deep dive of the sustainability BAF. While the risk and assurance relating to the Trust's strategic partnership were well reflected, the committee noted that the next deep dive should take a broader view of future sustainability, with the partnership considered as one element of this.

An update was provided on the deep dive of the estates BAF, which was originally undertaken by the committee in March 2026. The committee noted the action being taken to address control and assurance gaps. The committee highlighted the importance of developing evidence-based assurance reporting and understanding the residual risk to the organisation, taking into account the currently available capital funding as discussed at the previous Committee meeting.

Discussion was had on the importance of ensuring that the BAF accurately reflects current performance and operations to ensure its serves it purpose in informing the strategic direction of the organisation.

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

Report cover-page					
References					
Meeting title:	Board of Directors				
Meeting date:	09/07/2026		**Agenda reference:**	**37-26**	
Report title:	Audit & risk committee annual report 2025/26				
Sponsor:	Jag Dosanjh-Elton, committee Chair				
Author:	Ellie Simpkin, Governance manager				
Appendices:	None				
Executive summary					
Purpose of report:	The Audit & risk committee annual report summarises the work carried out by the Committee in 2025/26, some of which has informed the Trust's Annual Governance Statement				
Summary of key issues	Key matters raised by the committee include: - The Trust's external auditor, Azets, issued an unmodified audit opinion on the financial statements for the year ended 31 March 2026. No significant weakness were identified including in relation to the Value for Money assessment. - The Annual Governance Statement concludes no internal control issues have been identified in the year reflecting the sustained progress made to address the financial control and governance issues identified last year. - The Head of Internal Audit opinion has concluded that there is an adequate and effective framework for risk management, governance and internal control. - The Counter Fraud Functional Standard Return resulted in an overall rating of green, indicating full compliance. - The Trust has complied with the provider, standard and additional license conditions with the NHS England formally lifting the additional license requirements in March 2026. - The Committee noted the review on raising concerns which concluded the number of concerns raised remains the same as prior year with a drop in concerns raised to the Chief Nursing Officer potentially due to the removal of anonymity. - The Committee welcomed the updated Business Assurance Framework and the effectiveness of actions implemented to manage the risk on Finance, Regulation and Sustainability. The Trust's estates and cyber risk continue to be key areas of focus.				
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:	BAF for regulation				
Organisational risk register:	Risks discussed reflected on the organisational risk register				
Regulation:	Annual governance statement				
Legal:	None				
Resources:	None				
Assurance route					

Previously considered by:	Audit & risk committee			
	Date:	24/027/26	Decision:	Submit to Trust Board
Next steps:				

Report to: Board of Directors
Agenda item: 37-26
Date of meeting: 09 July 2026
Report from: Jag Dosanjh-Elton, committee Chair
Report author: Ellie Simpkin, Governance manager
Date of report: 03 June 2026
Appendices: None

Audit & risk committee annual report 2025/26

Introduction

The Audit & risk committee annual report summarises the work carried out by the committee in 2025/26, which has partly 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 2025/26, the committee has met on four occasions. Committee member attendance will be reported in the Annual report and accounts 2025/26, and is included below:

Audit & risk committee Register 2025-26				
Name	**24 June 2025**	**01 Sept 2025**	**05 Jan 2026**	**02 March 2026**
Paul Dillon-Robinson	Y	Y		
Jagjit Donsanjh-Elton			Y	Y
Russell Hobby	A	Y	Y	A
Peter O'Donnell	Y	Y	A	Y

Key matters

In 2025/26 the committee has reported to the Board on the following:

Internal control and compliance

There has been sustained progress to address the financial control and governance issues which were reported to the committee back in November 2024 and resulted in one significant weakness identified in the 2024/25 external audit VFM Value for Money assessment. The committee is assured that improvements to the

effectiveness of the finance, workforce, procurement and contract management control environment are being embedded across the Trust. An internal audit review of financial management received a ‘reasonable assurance’ outcome which demonstrates that processes are designed and, in many parts, operating effectively. The committee has received assurance on the compliance with Trust’s governing documents. There have been no reported breaches in 2025/26.

The Trust’s Annual Governance Statement 2025/26 concludes no internal control issues have been identified in the year reflecting the sustained progress made to address the financial control and governance issues identified last year.

Use of Single tender waivers
The number and value of single tender waivers for contracts over £30k has materially decreased over the year and the committee has received assurance that due process is being followed. This will be an area that the committee will continue to monitor in 2026/27.

Internal audit
In 2024/25 the committee challenged the time being taken to implement some management actions from internal audit, noting that staff resourcing has been a limiting factor. There has been sustained improvement in 2025/26 and the committee has been pleased to note that the implementation of management actions from internal audits is generally good. In 2025/26 six internal audit reviews concluded with a reasonable outcome with two receiving partial assurance (Substantive Medical and Dental Job Planning and Cyber Assessment Framework – Data Security Protection Toolkit 2024/25).

The Head of Internal Audit opinion 2025/26 has concluded that there is an adequate and effective framework for risk management, governance and internal control.

Risk management
The Trust’s risk management framework continues to embed across the organisation. There are areas of good practice including active corporate and clinical directorate risk champions and monthly risk surgeries. The Executive committee for quality and risk (ECQR) is maintaining oversight of local and organisation risk registers and regularly reviews the Board Assurance Framework (BAF). There is still work to do on the effectiveness on the risk management process to ensure that the tools are being used to actively inform and manage risk management actions and controls. An internal audit of the BAF and risk management received a reasonable assurance outcome.

Security management
Security management services are being delivered in line with their annual plan, with new contracts for the Local Security Management Specialist and onsite security provision in place. There is dependence on the availability of digital resource to deliver some of the key works required. The Trust needs to ensure that it is clear on the level of risk it holds and that there are appropriate mitigations in place.

Policies
The annual review of compliance with the policy for policies has shown improved engagement from policy authors is resulting in a reduction in the number of out of date policies, however, there is still work to do. Risk stratification of out of date policies is now regularly undertaken.

Raising concerns
The annual review of raising concerns demonstrated that staff are using a variety of routes to speak up and the committee is assured there are sufficient mechanisms in place. Bullying and harassment remained the most common theme across all concerns raised. The committee noted that departmental level cultural deep dives led by the Organisational development team is a key mechanism through which any fundamental deep-rooted concerns would be identified.

Business continuity
The committee has received assurance that QVH has appropriate Business Continuity processes in place to deal with unexpected incidents and to react proportionately when events occur.

Standard of Business Conduct
The annual review of compliance with Standards of Business conduct policy reported that during 2025/26, no members of staff were disciplined or formally investigated for a breach of the policy, however, the spot checks and an internal audit of job planning highlighted challenge with missing declarations for private practice and directorships and incomplete declarations amongst medical staff. The Local Counter Fraud Service is due to report on a compliance exercise on declarations of interest which will include a focus on consultant declarations.

Local Counter Fraud
An improvement in the uptake of counter fraud training means that the Trust's Counter fraud functional standards (CFFSR) return for 2025/26 has assessed the Trust as overall rating of Green. Internal audit and the Local Counter Fraud Service have provided useful benchmarking reports on Cost Improvement Programmes and themes and trends on fraud referrals. The committee was assured that the Executive team has used these reports to help inform 'continuous improvement'.

Collaboration
The committee has received an update on System collaboration and risk and noted the level of collaboration is appropriate and that related risks are reflected in the Trust's own organisational risk register.

Well Led
In preparation for the Trust's next well-led review, a self-assessment was been completed to support the development of the scope for the review and areas of focus. Since the Trust's Well-Led review in 2023 there has been a programme of transformational change. The areas for improvement identified through the self-assessment will be addressed either through internal programmes of work which are still embedding or through the partnership.

Risks
Cyber security risk is a significant risk for all organisations and recognised as complex. Whilst the committee received assurances on the measures being taken to manage this risk, its focus was on the internal audit independent assessment of the Trust's own evaluation under the Cyber Assessment Framework which was rated as very high risk/low confidence. The committee undertook a deep dive of the digital BAF which provided assurance that good progress has been made to deliver the 2024/25 Data Security Protection Toolkit (DSPT) improvement plan. The expectation is that the submission in June 2026 for the 2025/26 DSPT assessment will achieve 'Standards Met'. The committee has supported the suggestion that a separate BAF is developed for the Trust's cyber risk.

The Trust's estates continues to be a key area of risk. The committee undertook a deep dive of the estates BAF and whilst it acknowledged robust processes are in place to manage the risk, it noted the review required a broader perspective on the various types of estates risks. In particular there is a need to understand how the risks and the risk management differ by location/clinical area to clearly identify and assess the residual risk being carried. This will be taken forward during 2026/27.

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 committees review the Integrated Quality & Performance reports to support triangulation of assurance and issues and evidence-based assurance.

In order to support the Audit & risk committee in delivering its functions, the Quality & safety and Finance & performance committees have provided annual assurance reports on the key governance, risk management and control. The key matters raised are summarised below:

Finance & performance committee
During 2025/26 the committee has seen an improvement in financial control, forecasting of the Trust's financial position and planning for the future. Sustaining this grip and control will be important in order for the Board to have confidence in financial assurance and reporting, particularly given the financial challenge which the Trust faces moving into 2026/27. The delivery of the Trust's Cost Improvement Programme (CIP) is a key area of oversight for the committee.

The progress being made to deliver the Trust's planned estates critical infrastructure improvements and mitigate the risk continues to be a key areas of focus for the committee. The Estates executive sub-committee is now established and providing assurance reporting to the Executive Leadership Team. The Trust's approach to the Premises Assurance Model is an area that the committee is keen to see develop to ensure strengthened assurance.

The committee has stressed the importance of ensuring that the risks are accurately recorded on risk registers and that rationale for the mitigated scoring is clear.

Quality & safety committee
Areas of focus for the committee during the period have included the work of the Task and Finish group to improve compliance with the Mental Capacity Act, the Trust's clinical harm review process and implementation of the Trust's Continuous Improvement methodology (The QVH Way). The committee has also considered the patient safety and quality implications associated with the EPR 'Archie' implementation. There has been regular reporting on the progress and improvements made on Health and Safety compliance and assurance that the current challenges with the estates infrastructure are being managed appropriately with mitigations in place to avoid patient harm or impact on the quality of patient care.

Throughout the year the committee has triangulated Trust reporting with independent reports such as the Patient Led Assessments of the Care Environment (PLACE) results, Healthwatch visits, the Children and Young People Survey 2024, the GMC national training survey and the National Inpatient and Cancer patient Survey results 2024.

Key issues and risks

Notable issues and risks bought to the Committees attention in the year include:

- The challenge to deliver the Trust's 2025/26 financial plan (including the cost improvement plan) and the areas of risk and uncertainty in the business plan for 2026/27.
- Challenges in achieving operational targets for the number of patients waiting over 62 days for cancer treatment and 52 week waits.
- The ongoing challenge to reduce the number of patients waiting in excess of 65 weeks. The Finance & performance committee has sought further assurance on the accuracy of performance data relating to long waiting patients, the monitoring of pathways, and the operational governance and oversight more broadly. The Quality & safety committee has been reassured that there are no quality concerns arising from long waits, however, there have been complaints about wait times. An independent review on this issue will be shared with the Audit and risk committee.

Committee effectiveness
The Audit & risk committee has undertaken an annual review of its effectiveness, considering the effectiveness of committee members, 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 2026. The results were overall positive and the committee has discussed how it works with the Board sub-committees to best escalate and share relevant matters.

The committee has undertaken the annual review of its terms of reference.

A Governor working group for the committee 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:	09 July 2026		**Agenda reference:**	**38-26**	
Report title:	Bi-annual Safe Staffing and Nursing Workforce Review				
Sponsor:	Liz Blackburn, Acting Chief Nursing Officer				
Author:	Liz Blackburn, Acting Chief Nursing Officer				
Appendices:	None				
Executive summary					
Purpose of report:	The workforce review is presented to the Trust Board for assurance as to the nurse safe staffing levels within inpatient areas in the Trust. It is the responsibility of the Chief Nursing Officer to advise the Board on safe staffing levels for nursing in line with national guidance and for the board to see evidence of this assurance.				
Summary of key issues	The Trust has undertaken a comprehensive, evidence-based review of nurse staffing establishments, confirming alignment with national guidance (NQB, NICE) and patient acuity requirements. Key highlights: • Staffing models have been safely adjusted following inpatient ward reconfiguration and estate works, with no adverse impact on patient safety or quality indicators. • Key quality metrics (falls, pressure ulcers, MET calls) have remained stable, providing assurance that staffing changes have not compromised care standards. • Improved rostering practices and tighter controls on temporary staffing have enhanced efficiency and workforce deployment across all inpatient areas. • A reduction of £0.3m in nursing spend has been achieved year-on-year, alongside reduced reliance on bank and agency staffing. • Strengthened governance through the Temporary Staffing Oversight Group, IQPR reporting, and greater visibility of CHPPD metrics. CHPPD remains higher than many peers, reflecting the Trust's specialist case mix, with triangulation of multiple measures ensuring robust staffing decisions.				
Recommendation:	Board is requested to: • **note** that we deploy safe staffing levels in all our inpatient areas • **note** that we meet the benchmarks recommended by RCN, ICS and NICE • **note** the staffing levels and skill mix are effectively reviewed				
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:	Links to KSO1, KSO2, KSO3, KSO4				
Organisational risk register:	None				
Regulation:	Health & Social Care Act 2008 and National Quality Board Guidance				
Legal:	As above				
Resources:	No additional resources identified within this report				
Assurance route					

Previously considered by:	ELT			
	Date:	22/06/2026	Decision:	Noted. Forward to QSC
	Q&S			
	Date:	30 June 2026	Decision:	Approved

Report to: Board of Directors
Agenda item: 38-26
Date of meeting: 09 July 2026
Report from: Liz Blackburn, Acting Chief Nursing Officer
Report author: Liz Blackburn, Acting Chief Nursing Officer
Date of report: 11 June 2026
Appendices: None

Bi-annual Safe Staffing and Nursing Workforce Review

Purpose

The purpose of this paper is to provide an overview of safe nurse staffing levels including right staff, right skills and right place. It aligns with directives from NHS England/ Improvement (NHSE/I), the National Quality Board (NQB) and the Care Quality Commission (CQC).

At QVH, the Chief Nursing Officer (CNO) is responsible for ensuring that there is optimal nurse staffing levels to patient acuity and dependency in all inpatient areas of the organisation and provides a six monthly review to present to the board for assurance.

Background

All NHS Trusts are required to deploy sufficient, suitably qualified, competent, skilled and experienced staff to meet care and treatment needs safely and effectively. This is reinforced by guidance from the National Quality Board (NQB) *Safe and sustainable and productive staffing.* Key national reports such as the Francis Inquiry and the Berwick report outlined ways in which the NHS can improve care and raised the issue of staffing levels. The Francis report found that inadequate staffing levels at Mid Staffordshire led to the poor quality of care.

In 2014, the National Institute for Health and Care Excellence (NICE) published a safe staffing for nursing in adult inpatient wards in acute hospitals guideline (SG1) aimed at ensuring that patients receive the nursing care they need, regardless of the ward, time of the day, or the day of the week.

The QVH has five inpatient areas with a total of 52 beds (this includes 2 flexible inpatient paediatric beds). To support safe staffing decisions, we use the Safer nursing care tool (SNCT) which is based on the Shelford Model, allowing us to calculate clinical staffing requirements based on patients' needs (acuity and dependency), together with professional judgement. This paper builds on the last review, taken to Board in January 2026 and reflects the impact of approved ward reconfiguration and staffing reductions.

These changes mean that professional nursing judgment, triangulated with evidence from tools such as Care Hours per Patient Day (CHPPD), benchmarking and nursing-sensitive indicators, will play a central role in ensuring safe and sustainable staffing decisions. It is worthy of note that the staffing numbers and fill rates are presented at Board via the monthly Integrated Quality Performance Review (IQPR), in addition, in the new financial year Board will also have oversight of the CHPPD metrics.

Context

National NHS nursing and midwifery vacancies currently stand at approximately 25,000-30,000 registered posts, representing a 6.0% vacancy rate across the planned workforce. While this reflects a drop from historical peaks of 10% to 12%, the scale of the remaining workforce gap continues to present a material risk to service delivery, quality of care and workforce sustainability across the NHS. The Trust overall vacancy rate in March 2026 reflects the national picture of 6.3%.

The paper presented to the Board in January 2026 set out and secured approval for the proposed bed reconfiguration and associated staffing levels, reflecting previously identified opportunities to improve efficiency in the deployment of nursing staff. Temporary ward relocations required to enable essential estate works were completed in March 2026, with inpatient wards returning to their original locations. The exception is the Head and Neck ward, where services remain co-located with the Canadian Wing. This arrangement has been primarily driven by sustained levels of sickness absence and maternity leave across both areas.

Patient safety has remained the overriding priority throughout the reconfiguration process. Ongoing monitoring demonstrates that key quality indicators, including pressure ulcers, falls and medical emergency team (MET) calls, have remained stable during the transition. This provides assurance that the implementation of efficiency measures, including revised staffing establishments and bed reconfiguration, has not adversely impacted the standard of care delivered.

The staffing review detailed in this paper sets out the nursing levels required to deliver safe care and outlines the quality metrics monitored. There is continued monitoring of temporary staffing through the Temporary Staffing Oversight Group, and a reduction in nurse staffing costs has been realised.

National Benchmarking

CHPPD is a workforce metric that calculates the average number of care hours provided to each patient over a 24-hour period by registered nurses and healthcare assistants (ie, 24 reflects a nurse to patient ratio of 1:1). CHPPD is a nationally benchmarked metric through the NHSE/I 'Model Hospital' that assesses staffing efficiency against peer organisations regionally and nationally.

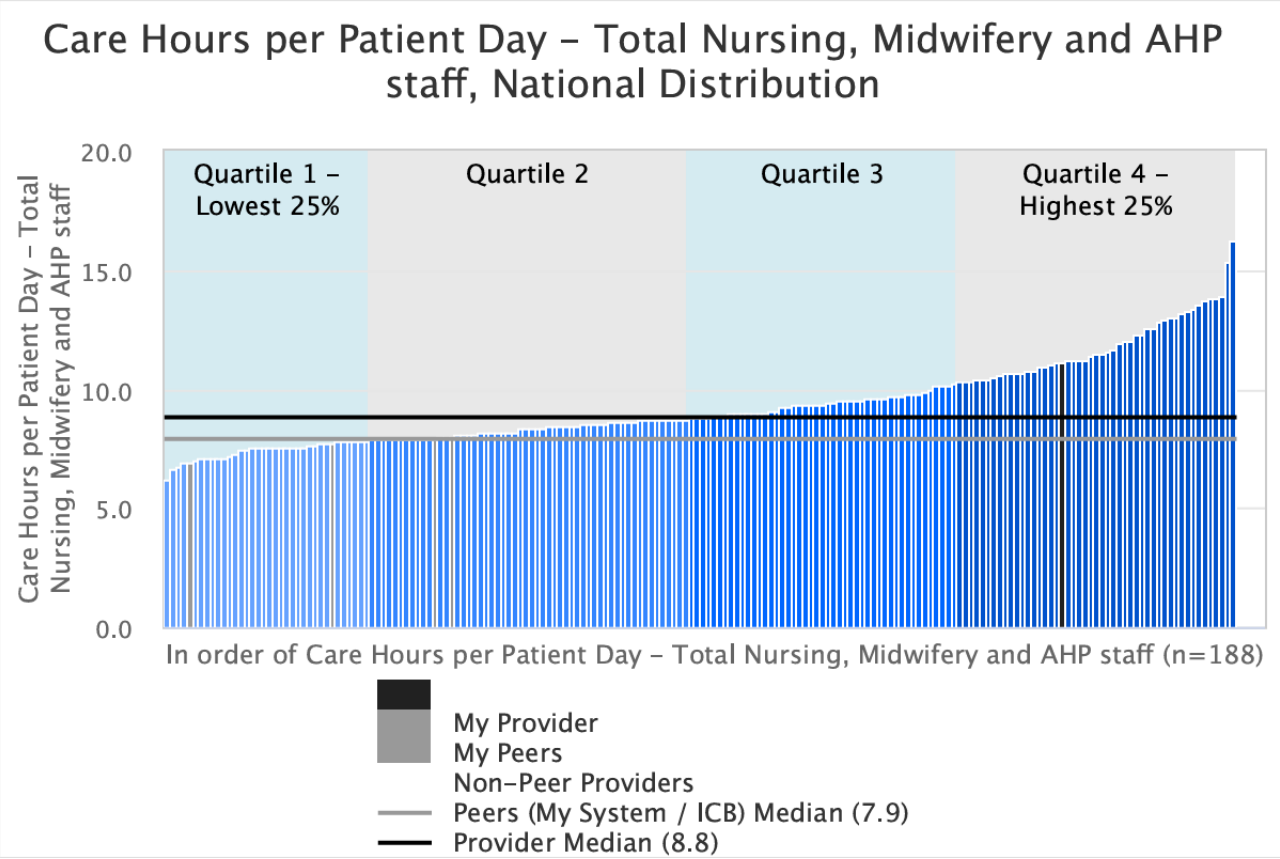
Table 1 - Trust CHPPD between October 2025 and March 2026.

Wards/Unit	Oct 2025	Nov 2025	Dec 2025	Jan 2026	Feb 2026	Mar 2026
Margaret Duncombe	8.83	8.91	9.18	8.61	9.25	10.49
Ross Tilley	6.71	7.42	8.11	7.54	7.02	6.56
Head and Neck	0*	0*	0*	0*	0*	12.73
Burns Unit	23.13	27.81	30.97	25.72	24.62	22.44
Critical Care Unit	45.48	44.05	56.49	40.41	55.74	41.00
OVERALL	**11.03**	**12.10**	**12.62**	**12.36**	**11.79**	**11.14**

*Head and neck ward closed and patient located on Canadian Wing.

The figure below indicates that QVH is positioned in Quartile 4 with a CHPPD of 11.1, representing a reduction from 12.1 in the previous reporting period. This suggests that the Trust is providing a higher number of care hours per patient day compared with most peer organisations within the system/ICB. It also reflects the Trust's specialist service profile, with overall CHPPD levels broadly comparable to those seen in other specialist Trusts.

Figure 2 provides a comparison analysis of QVH against peer and other provider organisations, using the Model Hospital data from March 2026.



It is important to note that CHPPD represents only one measure of workforce deployment. This paper therefore considers CHPPD alongside additional indicators, including staff-to-patient ratios, quality metrics, and professional judgement, to provide a more comprehensive assessment.

Establishment reviews

The establishment proposals for 2026/27 ensure compliance with national safe staffing standards:

- General inpatient wards (Canadian Wing): 1 RN per 8 patients.
- Head & Neck/ERAS: 1 RN per 4 patients, reflecting higher acuity.
- Burns Ward: 1 RN per 3 patients, in line with National Burns Care Standards.
- Peanut Ward: RCN guidance - 1 RN per 3 children under 2yrs, 1 RN per 4 children over 2yrs, consistently met with current model.
- Critical Care: 1:1 for Level 3 and 1:2 for Level 2 patients.

Both Burns and Peanut wards will continue to run outpatient services from within their clinical footprint. This requires flexibility in deployment and highlights the importance of professional judgment in determining whole-time equivalent (WTE) staffing.

Table 3 outlines our budgeted establishment for 2025/26 and agreed changes in 2026/27.

Ward	Funded establishment supporting ward clinical staffing (WTE)		Bank and Agency line (WTE)	**Total (WTE**	2026/27 establishment with 22% uplift*		**Total**
	RN	HCA			RN	HCA	
Canadian Wing	27.07	12.44	1.83	**41.34**	21.13	10.85	**31.98**

Head and Neck	9.36	2.01	No B&A line	**11.37**	10.25	5.74	**15.99**
Peanut (inc PAU)	11.51	3.80	1.65	**16.96**	14.10	4.17	**18.27**
Burns (inc EBAC)	14.36	7.21	7.40	**28.97**	17.06	4.11	**21.17**
CCU	15.88	6.0	2.29	**24.17**	17.68	6.39	**24.07**
TOTALS				**122.81**			**111.48**

*The uplift is based on a national formula designed to provide cover for anticipated staff absences. However, the establishment is not fully recruited to this level.

The establishment outlined above reflects the funded clinical workforce required to deliver the ward rota, specifically for direct patient care roles. It does not include the full multidisciplinary funded establishment, such as administrative staff, the discharge coordinator, Advanced Care Practitioner, clinical educators or burns care advisor. This staffing model is based on the current principle that ward managers remain in a supervisory (non-rostered) capacity, in line with best practice guidance for leadership and oversight in inpatient areas.

Incidents and quality metrics
All incidents related to quality metrics such as numbers of fall, category two pressure ulcers and MET calls have been reviewed and none have been identified as being a result of unsafe staffing levels. Throughout the monitoring period there have been no significant increases in such metrics.

Table 4 gives an overview of the numbers of falls, pressure ulcers and MET calls.

	Oct 2025	**Nov 2025**	**Dec 2025**	**Jan 2026**	**Feb 2026**	**Mar 2026**
PUs acquired at QVH (CAT2+)	0	0	0	0	0	1
Patient falls	2	2	2	1	3	1
MET calls	6	11	9	11	3	15

A further review of all incidents with the category ‘lack of staff’ has been undertaken. A total of 15 incidents were reported between October 2025 and Mar 2026 with no harm noted for each incident. The main theme identified related to staffing on the Critical care unit, with staffing reported as ‘unsafe’ due to nurse to patient ratios taking in to account patient acuity levels. An establishment review of staffing for CCU and Head and Neck forms part of the Better Value Programme for 2026/27.

The recent bed reconfiguration and associated adjustments to staffing models have led to reports of staff feeling less confident in their ability to provide safe patient care, particularly in relation to perceived changes in nurse-to-patient ratios. In response, significant engagement has taken place with clinical teams to reinforce understanding of national guidance and appropriate staffing metrics. A Band 7 development day provided a valuable forum for further discussion, enabling staff to explore these concerns in more depth and to gain greater visibility of the current financial context.

In addition, a consistent theme relating to staff wellbeing has emerged, with increased reports of stress and burnout. These ongoing concerns are also reflected in the staff survey results, which show a decline in the proportion of staff recommending the Trust as a place to work. However, it is

important to note that positive performance has been maintained in measures relating to patient-centred care.

Financial overview
In addition to the formal change in the nursing establishment through the safer staffing review, the nursing leadership team have worked to improve rostering planning, with the intention of matching staffing levels with patient volumes and acuity. This has had the effect of reducing the overall cost and worked Whole Time Equivalents (WTE) of both qualified nurses and healthcare assistants (HCAs).

After taking into account pay awards and other planning assumptions, there has been a year-on-year reduction of £0.3m in the total nursing spend and a 26 WTE reduction between 2024/25 and 2025/26, as set out in table 4 below.

Table 5

	£000	WTE
2024/25 Spend uplifted to 2025/26 AfC rates	**18,407**	**342.00**
Better value reductions:		
£50 per bank shift	(232)	
Burns patient RMN	(239)	(5.09)
Share of 2% vacancy factor	(368)	(6.84)
Known additional costs:		
B2-B3 additional cost	115	
Rebanding	84	
Additional Theatre Sessions	144	30.31
Expected cost	**17,912**	**360.39**
Actual cost	**17,607**	**334.33**
Difference	**(305)**	**(26.06)**

The Trust's Better Value Programme for 2025/26 had already planned for a material reduction in cost (£0.8m), through reducing the bank incentive, a reduction of exceptional registered mental health nurse (RMN) spend and a general vacancy factor. Furthermore, there were other known cost pressures (£0.3m) from changes in bandings and also from additional theatre sessions. However, even after taking these into account, the total actual nursing cost was £0.3m lower than the previous year.

Actions arising from previous report
An update on the actions form the previous report is highlighted below:

- *Reconfigure Bed Layouts*
  - Adjust inpatient areas to reflect the proposals outlined in this paper - **Complete**
- *Update Roster Templates*
  - Create new templates that match the proposed staffing requirements for each area – **In progress and on track to be completed by Q2.**
- *Maintain Tight Control on Temporary Staffing*
  - Continue monitoring and limiting the use of agency and bank staff to ensure cost efficiency - **Ongoing**
- *Recruitment Approach*
  - Run internal adverts only for nursing and healthcare assistant vacancies - **Complete**
  - All nurse vacancies must be approved by the CNO before proceeding - **Complete**
- *Cost-Saving Measures*

- Identify and implement additional strategies to achieve the required financial savings - **Ongoing**
- Monitor financial savings achieved through the efficiencies programme, begin tracking once bed reconfiguration is complete – **In progress and ongoing through 26/27**
- Provide updates to the Finance and Performance Committee to ensure transparency and alignment with organisational goals - **Complete**

There will be continued monitoring of the impact on quality and safety outcomes through the IQPRs. The triangulation will also ensure that staffing requirements will continue to deliver high quality care and workforce efficiency. In addition, there are four points throughout the day where staffing and safety is reviewed, at 08.00, 10.00, 15.00 and 20.00 via the site handover and bed meetings chaired by the Site Practitioner team with multidisciplinary input.

Conclusion

This paper provides clear assurance that the Trust has established and is maintaining safe, effective, and sustainable nurse staffing levels, aligned to national standards, patient acuity, and organisational requirements following inpatient reconfiguration.

The review confirms that staffing establishments are robust, evidence-based, and underpinned by recognised methodologies, including SNCT, CHPPD, and professional judgement. Efficiency measures implemented through the estates works and associated bed reconfiguration have delivered tangible financial benefits, including a reduction in temporary staffing expenditure and an overall decrease in nursing costs, without compromising patient safety or quality of care.

Quality indicators have remained stable throughout the period of change, demonstrating that the Trust's approach to workforce optimisation is both safe and effective. Strengthened governance arrangements, including enhanced oversight of rostering, temporary staffing, and workforce controls, provide further confidence in the sustainability and resilience of the staffing model.

The Board is asked to take assurance that safe staffing arrangements are in place.

Recommendation

Board is requested to:

- note that we deploy safe staffing levels in all our inpatient areas
- note that we meet the benchmarks recommended by RCN, ICS and NICE
- note the staffing levels and skill mix are effectively reviewed

Report cover-page					
References					
Meeting title:	Board of Directors				
Meeting date:	19/06/2026		**Agenda reference:**	**39-26**	
Report title:	Biannual update on Digital Strategy				
Sponsor:	Tamara Everington, Chief Medical Officer				
Author:	Bill Gordon, Chief Digital Information Officer				
Appendices:	None				
Executive summary					
Purpose of report:	To provide the Board with an update on achievement against Digital Strategy at QVH				
Summary of key issues	• There has been considerable and successful achievement against the QVH Digital Strategy in the last 18 months • In recognition of emerging pressures, priorities and threats, a Digital Transformation Board has been created alongside the Digital Steering Board to ensure aligned to Trust strategic priorities including Better Value schemes • Whilst extremely challenging, replacement of the Patient Administration System (PAS) is planned for November 26. As with EPR, plans are being developed with broad collaboration to enable transformed ways of working • Introduction of Archie EPR has enabled over 400,000 in context links to other systems and reduced paper by 40%. Optimisation work in progress will enable our journey to paperless • The Feedback Medical 'Bleepa' software product is supporting new symptom-based pathways of care for the CDC and providing a pilot for NHS Online • Cyber resilience has been progressed through achievement of Windows 11 migration and other detailed work which has ensured that the Trust is now 'standards met' for the Data Security Protection Toolkit (DSPT). A new Cyber BAF and Dashboard have been developed to support ongoing monitoring				
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:	BAF Digital, new BAF Cyber				
Organisational risk register:	IT, Digital / Data and Information Governance risks				
Regulation:	NHSE, CQC, DTAC, DSPT				
Legal:	GDPR				
Resources:	In house IT team with outsourced provision of a range of functions. Team of contractors supporting digital transformation through time-limited funding. Further funding applications pending.				
Assurance route					
Previously considered by:	ELT Strategy & Culture Committee				
	Date:	26/05/26 02/06/26	Decision:	Submit to Trust Board	
Next steps:					

Report to:	Board of Directors
Agenda item:	39-26
Date of meeting:	09 July 2026
Report from:	Tamara Everington, Chief Medical Officer
Report author:	Bill Gordon, Chief Digital Information Officer
Date of report:	21 May 2026
Appendices:	None

Digital Strategy Update

Introduction

QVH has delivered a major step change in digital maturity over the past 12–18 months, anchored by the successful go live of the Archie Electronic Patient Record (EPR) in November 2025. This represents the Trust's largest ever digital transformation programme and establishes a foundation platform for future innovation, integration and efficiency. However, QVH has historically suffered by having an overall low level of digital maturity and this should be seen as only the first step, with an ambitious programme of work along with the optimisation and de-duplication of clinical and operational systems and processes still to be delivered.

Executive summary

Our digital strategy launched in May 2025 with an ambitious vision to transform how we deliver care through technology. Twelve months on, we have made meaningful progress, but the operating environment has become significantly more challenging with increased productivity ambitions needing to be delivered within a constrained financial context.

Our strategy has been built around five core pillars and aligned with the NHS 10 Year Health Plan's three big shifts: hospital to community, analogue to digital, and sickness to prevention. Progress has been made within each pillar, but it is recognized that ongoing achievement must be closely aligned to key strategic objectives to be prioritised and progressed well.

Digital Strategy Progress

QVH's Digital Strategy was purposefully aligned with the overall objectives of the Trust and subsequent developments including creation of the Digital Transformation Board have ensured developments are aligned to key strategic objectives.

The introduction of the Archie EPR enabled success across all five of these pillars and has been core to the delivery of our strategy to date.

For each of the pillars of the digital strategy progress is as below:

Patient Outcomes and experience

- Actively participating in the People's Panel and the Implementation of the Digital inclusion framework for Sussex
- Successful Implementation of the Archie Electronic Patient Record
- Expansion of work with the Sussex Wide Shared Care Record (Plexus) and Sussex Wide Patient Portal (Patients Know Best – PKB)
- Completed development and implementation of the new version of the in-house TRIPS Telemedicine System
- Progression of the NHSE funded CDC clinical software deployment of Feedback Medical's Bleepa solution

Staff Experience

- As part of the Archie EPR, engagement with Staff through developed surveys ascertained the need for additional digital skills
- The Archie EPR programme identified over 150 Digital Champions who were key to go-live and became energised through delivery
- Training needs analysis was undertaken, and several learning modules were developed for Archie, successful completion was mandatory prior to gaining access to Archie
- Work for digital training needs assessment and development of staff is still in progress and will continue throughout 2026
- The Chief Medical Officer is now the SRO for Digital Transformation as well as Digital in general at Board level to ensure sustained progress alongside the Chief Digital Information Officer as the Lead

Interoperability

- Key to improving interoperability was the implementation of the EPR, this now enables sharing of more patient information with other organisations and patients
- The next stage to build on is the implementation of a modern replacement Patient Administration System, which is scheduled to be delivered by the end of 2026. Data Migration analysis and detailed design work is already underway to realise further benefits and functionality
- 40% reduction in paper being generated due to Archie EPR
- Approximately 400,000 patient in-context links to other key Trust clinical systems from Archie EPR, e.g. Evolve, Sectra PACS etc.
- Resources have been identified to further exploit PKB, Plexus, and AI, by bringing the digital transformation programme together for QVH. The Archie EPR team will work with the core Digital team to progress these at pace

Operational Transparency

- The Trust intranet has been successfully replaced with improvement in accessibility, content and function
- The Trust's out-of-date Telephony system is being migrated to modern infrastructure

- Migration to Microsoft Office365 has commenced for all staff and promotion of and training in the use of the NHSE provided Copilot Chat app is underway
- Windows 10 went end of life in Q4 2025 and the Windows 11 migration programme is almost completed. There are some devices that still require Windows 10 and extended support has been purchased from Microsoft
- Co-developed with procurement the digital and cyber requirements and included them in the procurement policy to ensure compliance in the supply chain to minimise risk to the organisation

Efficient and Reliable

- E-consenting is one of the priorities for the Digital Transformation Programme as this would support elimination of paper in an outpatient setting. Opportunities are being explored to progress this within a clinically led outpatient experience evaluation
- Paper has already been significantly reduced as part of the EPR implementation and a priority for digital transformation is for the organisation to become paper light both onsite and in spoke sites
- Upgraded patient check in and room optimisation functionality is procured and development in progress but contingent on PAS replacement
- Ambient Voice Recognition extending the use of our G2 speech recognition tool is being explored and tested
- Education through SASH supported library services is supporting promotion of the use of NHSE Copilot Chat AI functionality for administrative tasks

Several schemes are applicable across multiple pillars of the strategy which demonstrates their overall alignment with the strategy. As the strategy is a living document, it needs to be continuously reviewed to ensure it remains appropriate and reflects the changing priorities of the QVH, our patients, external partners, and the local / national landscape.

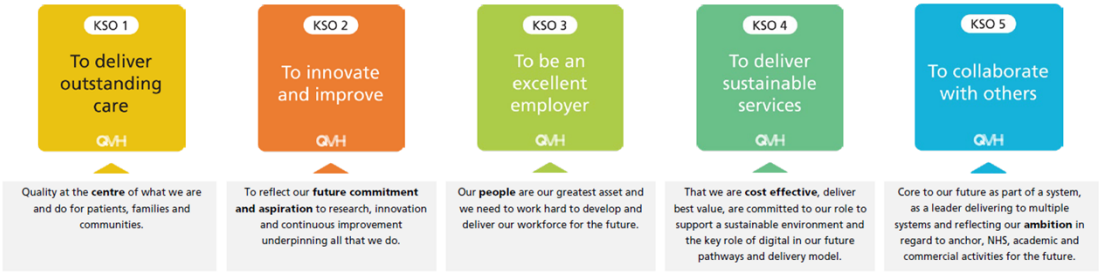
Year One: Key Achievements

Year Two: Strategic Priorities

The EPR Programme Board was chaired by the Chief Medical Officer and following review, key digital transformation priorities for QVH were discussed and subsequently agreed at the Executive Leadership Team meeting. To facilitate progress there was transition of oversight to a new Digital Transformation Board.

Identified digital transformation opportunities were scrutinised to ensure alignment to the Strategy and to the Trust's Key Strategic Objectives. The DTB now reports monthly to the Executive Leadership Team and subsequently to the Finance and Performance Committee. Better value opportunities associated with some of the schemes will be reported through the Efficiency Group.

5 key themes were identified in prioritisation which were then matched to the Trust's five key strategic objectives (KSOs).



- Productivity - KS01 / KS02 / KS03 / KS04 / KS05
- Patient Experience/safety - KS01 / KSO2 / KS05
- AI - KS01 / KS02 / KS03 / KS04 / KS05
- Financial - KS02 / KS04 / KS05
- Strategic - KS01 / KS02 / KS03 / KS04 / KS05

The Trust's Digital Transformation programme is therefore strongly aligned to both organisational and digital strategy.

AI is one of the primary areas of focus for the Trust, with national matched funding for key areas such as Ambient Voice and the allocation of Microsoft Copilot licences expected to be available in the autumn of 2026. As part of the DTB we will be implementing Ambient Voice technology and leveraging the full licenses of Copilot across the Trust for both clinical and operational improvements and efficiencies.

A review of the programme's priorities was held in December 2025 via the then EPR Programme Board.

- The programme is centred on the Electronic Patient Record (EPR), which is the primary enabler across all five digital pillars.
- It delivers across all strategic areas, including clinical quality, patient experience, workforce productivity, financial sustainability, and system collaboration.
- Significant progress is being made in delivering a digital-first care model, improving patient engagement, and reducing reliance on paper-based processes.

Most of the portfolio directly delivers the commitments set out within the Digital Strategy. A small number of projects such as the Federated Data Platform or Better Value initiatives represent emerging or enabling programmes which extend beyond

the original scope of the strategy and reflect evolving national priorities and local opportunities.

Themes have been prioritised based on the strategy and KSOs. Listed below are the agreed projects grouped by the strategy pillars. Many projects will deliver in several pillars but for simplicity they are listed in one of the pillars below:

Patient outcomes and experience

- Electronic Discharge Notifications (EDN) for the safe and integrated transfer of patient information to other organisations
- Increased use of our Patient Portal (PKB) and Shared Care Record (Plexus) to share information with patients and clinicians

Staff experience

- Electronic Discharge Notifications (EDN) for the safe transfer of patient information to other organisations
- Extend the use of our speech recognition software with the introduction of AI and Ambient Voice technology
- Review of the devices in use within the Trust by clinicians based on location and need to support optimisation of end user experience

Interoperability

- The implementation of a new Patient Administration System (PAS), which is the next phase of EPR progression
- Increase the use of our Patient Portal (PKB) and Shared Care Record (Plexus) to share information with patients and clinicians
- Additional EPR functionality for Theatres, CCU and Prescribing in Outpatients and Paediatrics

Operational transparency

- Development of an Ophthalmology EPR business case to enable efficiency, connectivity, partnership and compliance with National Registry reporting requirements
- Electronic consent to facilitate reduction of paper in the outpatient environment at QVH and at spoke sites

Efficient and reliable

- Extend use of Bleepa with inbuilt automation for asynchronous care pathway management
- Financial Savings including the reduction in printing and transformation from paper based to digital correspondence and communications with our patients

ID	Project	Purpose	Status	Planned Completion
1	EPR Optimisation	User focused changes following the go-live in Nov 25	In Progress	Ongoing as part of BAU
2	Archie PAS	Replacement of iSoft PAS with Altera PAS	In Progress	Nov-26
3	Patient Knows Best (PKB)	Patient documentation delivered via PKB	In Progress	May-26 and ongoing

4	Patients aged 16 & 17 (ePMA 1)	Inclusion of patients 16/17 years old not in Peanut within ePMA	In Progress	Jun-26
5	Paediatric ePMA (ePMA 2)	Expansion of ePMA to provide for Paediatrics	In Progress	Oct-26
6	Artificial Intelligence	Exploration of how AI can increase efficiency within QVH. Will include Ambient AI technology, use of Microsoft Copilot.	Discovery	Ongoing and TBC
7	Federated Data Platform	Use of NHSE FDP to aid planning and statutory returns	In Progress	Nov-26
8	eConsent	Implement eConsent solution	In Progress	Nov-26
9	Financial Improvements	Savings that can be made through efficiency and changing working practices	In Progress	Sep-26
10	Hardware for Clinicians	Ensuring clinicians have the appropriate hardware to allow them to work effectively	In Progress	Jun-26
11	EDN	Production of an EDN to national guidelines and secure delivery to GPs via DocMan	In Progress	Jun-26
12	Archie EPR Order Comms	Using Order Communications for ordering and results for Radiology/ Pathology within Archie EPR	Discovery	Jun-26
13	Electronic Kiosks	Replacement of electronic kiosks for patient check ins in Outpatient areas. On hold until PAS implementation is complete.	On hold	TBC
14	RIS - procurement	Replacement of Magentus CRIS system. This is a joint Surrey/ Sussex consortium	In Progress	TBC
15	Sussex Pathology Network	Implementation of pan Sussex Laboratory Information System (LIMS) and ICE	In Progress	Q1 27

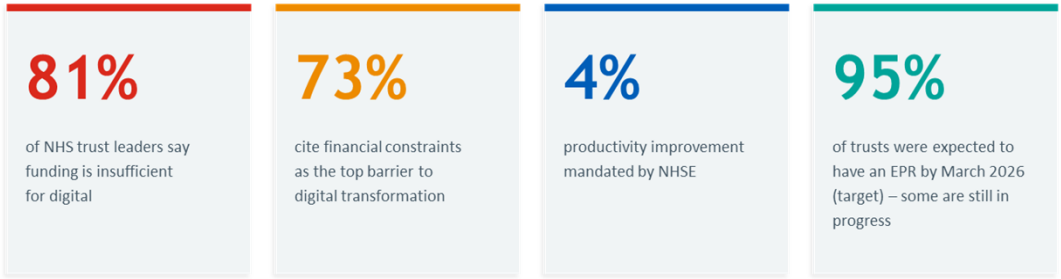
The programme therefore provides comprehensive coverage of all five digital pillars:

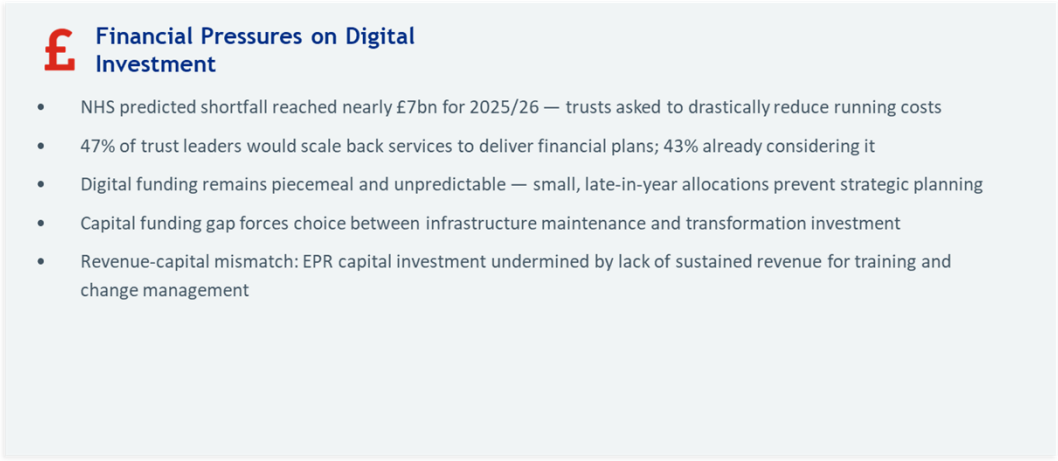
Digital Pillar	Contribution from Portfolio
Patient outcomes & experience	PKB, EDN, ePMA, eConsent, FDP, kiosks, patient communications
Staff experience	EPR optimisation, FDP, hardware rollout, AI, training-related initiatives
Interoperability	PAS, Order Comms, FDP, PKB, RIS, Sussex Pathology Network
Operational transparency	PAS, FDP (emerging), reporting and BI outputs
Efficient & reliable	Financial improvements, FDP, EPR optimisation, automation, AI

This confirms clear alignment with strategic ambition to use digital to improve patient outcomes, staff experience, interoperability, and efficiency. There is broad and balanced support across all five objectives, particularly through digital enablement of clinical pathways and system integration which should increase efficiency and staff satisfaction.

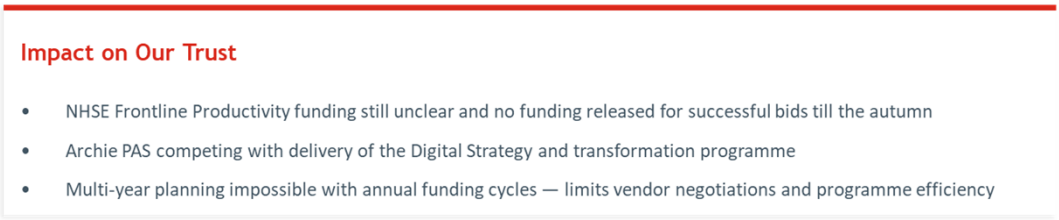
Trust Objective	Portfolio Contribution
Quality of care (KSO1)	EPR, ePMA, EDN, Order Comms improve safety and clinical workflows
Innovation & improvement (KS02)	AI, digital optimisation, research-enabling data
People (workforce) (KS03)	Hardware, EPR usability, AI reducing admin burden
Financial sustainability (KS04)	Digital communications, paper reduction, system consolidation
Partnerships & system working (KS05)	RIS, Sussex Pathology, FDP, PKB, interoperability initiatives

The Funding Challenge
In the last decade, the Wachter report identified historical and ongoing underinvestment in digital within the NHS describing a vision for the future. Whilst there has been investment in NHS digital, this has not achieved recommended levels and has not kept pace with broader digital advancement within business.





A shift in digital resourcing approach and delays to decision making from the centre has implications for QVH.



Competing Demands
QVH faces a challenging balancing act: improving services, boosting performance, and transforming digitally — all while reducing costs by at least 1% and achieving >4% productivity gains.

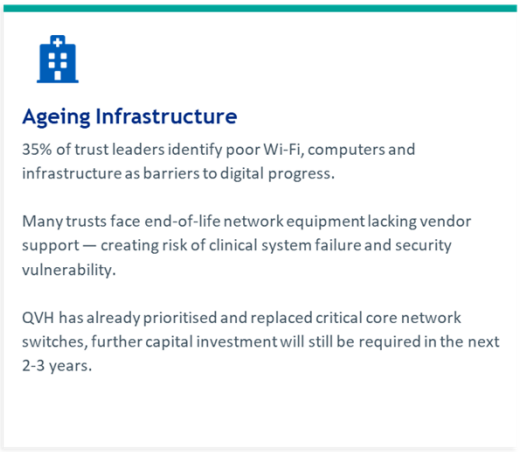
Workforce & Digital Skills Gap
It is recognised that there is a range of digital skills across staff working within the NHS. Within this there is opportunity but also risk and this will need careful consideration within future planning.

The Skills Challenge

- 87% of NHS decision-makers identify a digital skills gap
- 24% report culture of resistance to change among staff
- 27% cite incompatibility with existing systems
- NHSE workforce reductions risk losing specialist digital expertise

Infrastructure & Cyber Security

Global disruption and conflict are accelerating cyber threat which was already growing with advances in technology. The Trust must ensure infrastructure and staff capability supports safety and efficiency, but it will not be easy to keep pace with a commercial criminal market, particularly when holding a wide range of data assets.



Potential benefits of AIEnhanced Clinical Diagnosis

AI can:

- Accelerate analysis of medical images, aiding early detection of diseases like cancer and stroke, improving accuracy.
- Provide decision-support tools that can assist clinicians with treatment recommendations.
- Enable the use of triage tools allowing prioritisation urgent cases and reduce waiting times in outpatient clinics.
- Analyse patient data (genomics, history, lifestyle) to tailor treatments (personalised medicine) and support precision approaches to cancer and chronic disease care.

Operational Efficiency

AI can:

- Automate routine administrative tasks – appointment scheduling, coding and billing and can optimise patient flow, reducing waiting times and freeing both administrative and clinical staff time.

- It can aid clinical documentation creation (e.g. speech-to-text notes and Ambient Voice).
- Optimise resources with predictive modelling (e.g. bed demand, staffing needs, theatre utilisation.
- Enable wearable devices and apps to detect deterioration early.

Potential Drawbacks and Risks

- Data privacy concerns and algorithm bias threaten patient safety and equity in AI healthcare applications.
- AI systems require large datasets which increases cyber risk
- Without strong governance and guardrails there is a risk of misuse or breaches
- AI trained on incomplete or biased datasets may cause misdiagnosis of certain ethnic groups and widen existing health inequalities.
- Risk of staff becoming dependent on the recommendations of the AI tool
- AI deployment can be slow, costly and technically complex
- Fear of job displacement especially in administrative roles
- Need for increased digital literacy and oversight with new skills and training required

AI can improve outcomes, increase efficiency and reduce pressure on NHS services but success depends on careful implementation alongside clinicians, ensuring that there is equity and transparency and the appropriate investment in workforce skills and infrastructure.

Key Risks & Mitigations

- There is limited capital funding of £1.4m across digital for 26/27 to deliver PAS and wider digital programmes with the current trajectory on course for funding to run out in December 26. The Programme Team continue to seek additional national and regional funding via Frontline Productivity, Wayfinder and other programmes
- There is high demand for digital change and limited capacity within the small core QVH digital team which is reliant on collaborative working with external contractors to deliver many functions. The Digital Transformation Board must ensure that the team focus on key priorities for the Trust. Opportunities must be taken in management of change to bring supporting skills into the core team
- Other risks are outlined within the Digital BAF and on the Trust Risk Register
- A new Cyber BAF and Cyber Dashboard is in development along with an overarching Cyber strategy. This deliverable has been enabled with funding from NHSE and supported by external cyber specialists and is expected to be completed by the end June 2026.

Recommendation

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

Report cover-page					
References					
Meeting title:	Board of Directors				
Meeting date:	09/07/2026		**Agenda reference:**	**40-26**	
Report title:	Board Assurance Framework (BAF)				
Sponsor:	Jamie O'Callaghan, interim Company secretary Executive risk leads				
Author:	Jamie O'Callaghan, interim Company secretary				
Appendices:	Appendix one- BAF summary Appendix two- BAF				
Executive summary					
Purpose of report:	To present the Board Assurance Framework (BAF) for review. The report includes the introduction of a new Cyber strategic risk, which was considered by the Audit and Risk Committee in June 2026 and is presented to the Board for the first time.				
Summary of key issues	A summary of each of the BAF risks is set out within appendix one, including current scores against risk appetite and key highlights. The BAF now comprises ten strategic risks following the addition of a standalone Cyber strategic risk. The Cyber risk was previously included within the Digital strategic risk but has been separated to ensure appropriate Board oversight and focus following consideration by the Audit and Risk Committee in June 2026. Of the ten strategic risks, the highest current scores relate to Estates, Finance and Leadership Capacity (all scoring 16), with Sustainability and Strategy scoring 15. Nine of the ten risks are currently outside of their stated risk appetite, with Workforce being the only risk reported as within the defined appetite range. The Cyber strategic risk has a current score of 12 and reflects the increasing threat posed by cyber security incidents, legacy infrastructure, third-party dependencies and limitations in specialist cyber capacity and funding. A DSPT CAF improvement programme is in place, independent testing has been undertaken and cyber governance arrangements are established. However, legacy systems and asset register completeness remain areas requiring ongoing attention. Assurance ratings for nine risks are amber, demonstrating that there are issues which require monitoring and addressing. The Quality strategic risk has a green assurance rating, demonstrating that there are no serious issues and that controls are considered effective. There have been no changes to risk scores since the previous Board review.				
Recommendation:	The Board is asked to: • **Review** the Board Assurance Framework and confirm that it appropriately reflects the principal risks that may impact delivery of the Trust's strategic objectives. • **Identify** any strategic risks, assurance gaps or areas requiring further scrutiny through the Board's sub-committee structure. • **Approve** the inclusion of the standalone Cyber strategic risk within the Board Assurance Framework.				
Action required	**Approval**	Information	Discussion	**Assurance**	Review
	KSO1:	**KS oval O2:**	**KSO3:**	**KSO4:**	**KSO5:**

Link to key strategic objectives (KSOs):	*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:	Revised BAF to support delivery of KSO's				
Organisational risk register:	Links to organisational risks included in BAF				
Regulation:	CQC well led				
Legal:	None				
Resources:	None				
Assurance route					
Previously considered by:	Responsible sub-committees				
	Date:	May and June 2026	Decision:		
Next steps:					

Report to: Board of Directors
Agenda item: 40-26
Date of meeting: 09 July 2026
Report from: Jamie O'Callaghan, interim Company secretary
Executive risk leads
Report author: Jamie O'Callaghan, interim Company secretary
Date of report: July 2026
Appendices: Appendix one- BAF summary
Appendix two- BAF

Board Assurance Framework (BAF)

Introduction and background

The Board Assurance Framework (BAF) sets out the principal risks that may threaten delivery of the Trust's strategic objectives. It enables the Board to monitor progress against those objectives, focus on the key risks facing the organisation, and gain assurance that appropriate controls and mitigating actions are in place. The BAF also supports the Board in identifying areas where further assurance or action may be required.

The Board approved the current strategic risks within the BAF at its meeting on 13 November 2025. The BAF summary is attached at appendix one and the detailed BAF is attached at appendix two.

All BAF risks have an assigned lead committee and have been reviewed through the relevant committee structure during March, April, May and June 2026. Committee reviews have considered the adequacy of controls, assurances, action plans and risk ratings.

During 2026, the Finance and Performance Committee and the Audit and Risk Committee identified cyber security as an area requiring greater strategic focus and oversight. As a result, a standalone Cyber strategic risk has been developed. The risk

was reviewed by the Audit and Risk Committee in June 2026 and is presented to the Board for approval as an addition to the Board Assurance Framework. Previously, cyber-related matters were captured within the Digital strategic risk.

Following inclusion of the Cyber strategic risk, the BAF comprises ten principal strategic risks covering access, cyber security, digital transformation, estates, finance, leadership capacity, workforce, quality, regulation, and sustainability and strategy

Executive summary

Heat map

The Board should note that the heat map has been updated to reflect the inclusion of the Cyber strategic risk. Based on its current score of 12, Cyber is positioned alongside Access, Digital and Regulation within the "Possible/Major" category.

Likelihood	*Consequence*				
	Negligible	**Minor**	**Moderate**	**Major**	**Catastrophic**
Almost certain					
Likely				**Estate** **Finance** **Leadership capacity**	
Possible			**Workforce** **Quality**	**Cyber** **Digital** **Access** **Regulation**	**Sustainability & strategy**
Unlikely					
Rare					

A summary of each BAF risk is provided in appendix one, including risk ratings, assurance assessments, alignment to risk appetite, key controls and recent developments.

The BAF now contains ten strategic risks. The highest scoring risks continue to relate to Estates, Finance and Leadership Capacity, each with a current score of 16. Sustainability and Strategy remains a significant strategic risk with a current score of 15.

Nine of the ten strategic risks are currently assessed as operating outside their stated risk appetite. Workforce remains the only strategic risk assessed as being within the agreed appetite range.

The new Cyber strategic risk has a current score of 12 and reflects the increasing threat posed by cyber attacks, legacy infrastructure, third-party supplier dependencies and limitations in specialist cyber capacity and funding. A Cyber Assessment Framework (CAF) improvement programme is in place, independent testing has been undertaken and cyber governance arrangements continue to be strengthened. Legacy systems and completeness of the asset register remain areas requiring ongoing management attention.

Assurance ratings for nine strategic risks are amber, indicating that there are issues requiring monitoring and management action. The Quality strategic risk continues to be rated green, demonstrating that controls and assurances are considered effective.

There have been no changes to risk scores since the previous Board review.

Recommendation

The Board is asked to:

- **Review** the Board Assurance Framework and confirm that it appropriately reflects the principal risks that may impact delivery of the Trust's strategic objectives.
- **Identify** any strategic risks, assurance gaps or areas requiring further scrutiny through the Board's sub-committee structure.
- **Approve** the inclusion of the standalone Cyber strategic risk within the Board Assurance Framework.

Ref	Title/ description	Score			Trajectory/ direction of travel	Assurance rating	Risk appetite	Highlights
		Inherent	Current	Target				
1	**Access** There is a risk that the Trust will not deliver against its operational plan and national access standards Caused by rise in waiting lists; increased demand; national changes; support to the wider Sussex system Resulting in patients waiting longer than we would like for treatment; potential patient harm/ poor experience; widening health inequalities; the Trust not achieving its operational plan; reputational damage; increased oversight	16	12	8	⟷	Amber (indicates that there are some issues that need to be monitored and addressed)	This risk is currently outside of risk appetite, with a higher score. The risk appetite for this area is cautious (4-6)	• The score remains the same as at last review. • Further assurance concerns identified regarding 65-week waits and cancer performance; recovery plans have been refreshed. • Independent waiting list review completed and recommendations incorporated into action plans. • Key assurance required on the impact of health inequalities work for patients.
2	**Cyber** There is a risk that the Trust may experience a significant cyber security incident; Caused by Increasing cyber threats, legacy infrastructure, reliance on third-party suppliers and limitations in specialist cyber capacity and funding; Resulting in disruption to clinical and operational services, compromise of patient or staff data, patient safety impacts, financial loss, regulatory non-compliance, and reputational damage.	16	12	8	⟷	Amber (indicates that there are some issues that need to be monitored and addressed)	This risk is currently outside of risk appetite, with a lower score. The risk appetite for this area is seek (15-20)	• New risk added June 2026 • DSPT CAF framework in place with improvement plan (“Approaching Standards”) • Cyber threats actively monitored with governance oversight • Independent testing undertaken with remediation tracked • Legacy systems and asset register completeness remain risks
3	**Digital** There is a risk that the Trust may not be able to deliver its clinical, operational and financial objectives due to insufficient digitisation including the benefits of the EPR programme Caused by constraints of capital and revenue funding to support people and resources required to deliver digital transformation including lack of funding for EPR roles past December 2025 Resulting in non-alignment with the national priority to move from analogue to digital; reputational damage; potential non-realisation of benefits; impact on service delivery and quality	20	12	12	⟷	Amber (indicates that there are some issues that need to be monitored and addressed)	This risk is currently outside of risk appetite, with a lower score. The risk appetite for this area is seek (15-20)	• Risk has met its target score • All actions in DSPT and CAF remediation plan are completed • The funding request for the EPR programme team from December 2025 was successful (action) • EPR ‘Go Live’ was a success with no negative patient impact caused
4	**Estates** There is a risk that the Trust’s estate deteriorates further to the point where it is no longer safe Caused by ageing estate; poor quality of previous work completed; limited capital resource to address critical infrastructure challenges; maintenance and repair backlog; estates team resource challenges; lack of compliant ventilation Resulting in harm to individuals; Potential impact on service delivery; services no longer being delivered	20	16	12	⟷	Amber (indicates that there are some issues that need to be monitored and addressed)	This risk is currently outside of risk appetite, with a higher score. The risk appetite for this area is minimal (1-3)	• The score remains the same as at last review • Estates safety funding approved; further funding for 2026/27 outstanding • Limited capital funding continues to constrain delivery • Recruitment progress made, with remaining gaps in specialist roles • Further assurance required on backlog maintenance and compliance programmes

	from the QVH site; financial loss; reputational damage.							
5	**Finance** There is a risk that the Trust will not deliver the full value of its £7.5m cost improvement plan for 2025/26 and cost improvement plans for future years; deliver a breakeven position for 2025/26 and for future years and/ or that the working cash balance will reduce to lower than £1m Caused by the Trust's significant cost improvement target of £7.5m for 2025/26 including the requirement for corporate service cost reductions; changes to the funding regime including capping of income levels; significant activity levels, and financial pressures across other NHS organisations delaying payments Resulting in the Trust not being financially sustainable for the future	20	16	12	⟷	Amber (indicates that there are some issues that need to be monitored and addressed)	This risk is currently outside of risk appetite, with a higher score. The risk appetite for this area is minimal (1-3)	• The score remains the same as at last review • Good progress has been made in delivering the 2025/26 cost improvement programme, however, a higher proportion than planned is being delivered non-recurrently • The medium term financial plan has been submitted but more work is required • The business plan for 2026/27 has been submitted • Assurance is required that further recurrent savings can be made • Internal audit on compliance with governing documents and policies concluded reasonable assurance with considerable progress and strengthening of controls
6	**Leadership capacity** There is a risk that there will not be leadership capacity to deliver the strategic partnership, key strategic objectives and key projects Caused by three interim executive roles including Chief executive officer; turnover in Board level roles and organisational memory loss; Chair finishing term at end of December 2025 Resulting in closure of services/ site; regulatory intervention; reputational damage; non-delivery of recurrent annual financial, productivity and efficiency savings	20	16	8	⟷	Amber (indicates that there are some issues that need to be monitored and addressed)	This risk is currently outside of risk appetite, with a higher score. The risk appetite for this area is minimal (1-3)	• The score remains the same as at last review • The interim Chair is in post • Plans are progressing to recruit to NED roles • Proposal received from RSASP demonstrates a delay in shared Chair and CEO from the initial plan of March 2026 • Acting CEO leaving the Trust in early October 2026 and revised leadership arrangements are being confirmed as part of the proposed strategic partnership. •
7	**Workforce** There is a risk that the Trust is unable to fulfil its commitment to being an excellent employer and may not have a workforce fit for the future Caused by significant organisational change; uncertainty; the Trust's significant cost improvement target; requirement for corporate service cost reduction; leadership capacity and managers capability Resulting in staff turnover; single points of challenge and lack of resilience; challenges with recruitment and retention; challenges with organisational culture; a negative effect on staff wellbeing and motivation; non-delivery of key strategic objectives and projects; impact on quality	15	9	6	⟷	Amber (indicates that there are some issues that need to be monitored and addressed)	This risk is currently within the range of risk appetite. The risk appetite for this area is open (8-12)	• The score remains the same as at last review • Staff sickness stable with increase in long-term absence • Training and development strong, with positive feedback on managers' training • Appraisal rates improving but below target • Staff survey and feedback highlight concerns around morale and speaking upand behaviour framework

8	**Quality** There is a risk that the Trust may not consistently deliver high quality, safe and effective care Caused by failure to ensure that clinical structure enables prioritisation of quality, safety and effectiveness in care; productivity increases constrict time to care and train, financial constraint compromises progress in estate, systems and equipment supporting care, frequent and rapid organisational changes distracts from sustainable quality Resulting in poor patient experience and outcomes; potential harm; reputational damage	20	9	6	⟷	Green (indicates that there are no serious issues and the controls are effective)	This risk is currently outside of risk appetite, with a higher score. The risk appetite for this area is minimal (1-3)	• The score remains the same as at last review. • No significant quality concerns identified from the cost improvement programme. • Strong governance and oversight remain in place, with patient experience continuing above target. • Further assurance required on PSIRF arrangements, speaking up culture and Well-Led review outcomes
9	**Regulation** There is a risk that the Trust may not be able to meet its regulatory requirements Caused by scale; cost improvement plans; corporate savings; turnover at Board level; additional licence conditions; non-compliance; leadership capacity; national changes to requirements Resulting in damage to reputation; non-removal of additional licence conditions; regulatory intervention	20	12	8	⟷	Amber (indicates that there are some issues that need to be monitored and addressed)	This risk is currently outside of risk appetite, with a higher score. The risk appetite for this area is minimal (1-3)	• The score remains the same as at last review • The number of out of date policies has reduced, with no key corporate policies out of date • A revised 'policy for policies' is in place; further assurance is required regarding its effectiveness and embedding • No known breaches of governing documents reported since Q4 2024/25 • Internal audit concluded reasonable assurance with strengthening of governance and controls
10	**Sustainability and strategy** There is a risk that the Trust will not secure long term sustainability Caused by inability to secure a strategic partnership; Challenges with progression of engagement with shortlisted partners; a potential breakdown in relationship between the Board and the Council of Governors; leadership capacity and resilience challenges; significant national changes; changes to the commissioning of services; changes to service specifications; staff morale; time constraints; differing views of key stakeholders on options Resulting in sustainability challenges for patient services/ site; priority shift of QVH Strategy 2025-2030; regulatory intervention; reputational damage; non-delivery of recurrent annual financial, productivity and efficiency savings	20	15	10	⟷	Amber (indicates that there are some issues that need to be monitored and addressed)	This risk is currently outside of risk appetite. The risk appetite for this area is open (8-12)	• The score remains the same as at last review • Strategic partnership progressing with governance and engagement in place • Stakeholder engagement ongoing; further development of shared communications required • Timeline progressing but remains challenging • Further assurance required on governance, benefits realisation and Well-Led review

BAF001 - ACCESS

KSO1	KSO2	KSO3	KSO4	KSO5	Overall Assurance Rating (RAG)	Q3- 2025/26	Q4- 2025/26	Q1- 2026/27			
✓			✓	✓							

BAF

Risk description

Risk:

There is a risk that the Trust will not deliver against its operational plan and national access standards

Caused by:

Rise in waiting lists; increased demand; national changes;

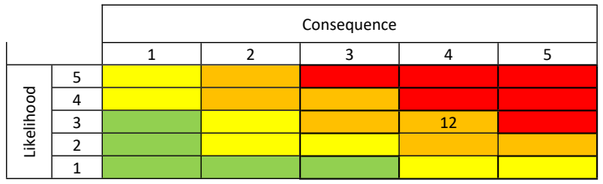
Resulting in:

Patients waiting longer than we would like for treatment; potential patient harm/ poor experience; widening health inequalities; the Trust not achieving its operational plan; reputational damage; increased NHS oversight

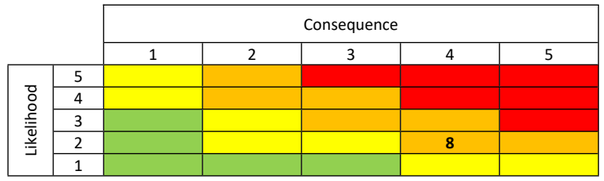
Responsible committee	Finance and performance committee	**Date Risk Added:**	13 November 2025		
Principal Exec – Risk Owner	Chief operating officer	**Date Risk last reviewed:**	2 July 2026		
Risk Handler(s)	Deputy Chief operating officer	**Date Risk last formally discussed:**	14 May 2026	**Group**	Trust Board

Inherent Score

Current Score



Target Score



Direction of travel since last review		**Target date**	31 March 2027
		Risk tolerance	Current risk score outside of risk appetite (higher) (cautious)

Controls (what are we doing about risk)	Assurances and RAG rating (how do we know if it's working)	Gaps in assurance (what additional assurance is needed)
Monitoring against the operational plan 2025/26 weekly internally and externally with action plans for improvements	1st line: Review of cancer action plan by Cancer Board monthly. In Q4, QVH has been working with the Surrey and Sussex Cancer Alliance to map the skin cancer pathway. A revised action plan incorporating QVH and SSCA actions was presented to Cancer Board in April 2026. FDS and 62 day cancer performance has shown improvement in 2025/26 however the overall cancer position is challenged in M1, June 2026 Amber Updated recovery plans are being progressed due to performance challenges driven by increased demand, capacity challenges demand in Sleep, Skin and Oral and Maxillo Facial Surgery services, capacity constraints within Plastic Surgery and the need to strengthen operational grip and control across some care pathways. Enhanced operational oversight is in place supported by strengthened leadership and a clear focus on improving patient access and recovering performance, July 2026 Amber / Red	Non-RTT waits oversight and reporting – this is being reported on from M11 2025/26 and will continue in 2026/27. NHSE strategic review of breast reconstruction- the Trust has indicated wanting to be a key player within this.

	2nd line: Monthly reporting and monitoring through the IQPR demonstrates ongoing challenges with 65 week waits, 52 week waits and 18 week wait performance. For cancer, 31 day performance remains challenged. Amber/ Red (see action 2 and 8) 3rd line: Internal audit on faster diagnosis standards demonstrates reasonable assurance with a good control framework in place, September 2025, Green LUNA Data Quality Assessment demonstrates high confidence levels at 99.7%, May 2026, Green National Oversight Framework rating by NHSE. The Trust was rated 42/ 134 trusts for performance overall for Q4 2025/26, June 2026 (fall in performance). Amber	
Governance and oversight incl. twice weekly tracking list meeting, weekly operational performance meeting, system capacity meeting, monthly access and responsiveness meeting	2nd line: Monthly alert, assure, advise reporting to the ECQR from the Access and Responsiveness executive sub-committee demonstrates grip and control, appropriate oversight and escalation, September 2025, Green Independent review of waiting list management and governance carried out in March/April 2026, with recommendations highlighting key areas for improvement required in some services. June 2026. Amber/Red. (See Action 10)	
Clinical harm review process with CMO reviewing patients over 78 weeks. Metrics and learning on harm from delays in cancer pathways shared at Cancer Board	1st line: Weekly review of long waiting cancer patients in place. No confirmed moderate or greater than moderate harm confirmed, but noting longer wait impact for patient experience, June 2026, Amber (see action 4) Process established within cancer care pathways for harm from delays to be clinically evaluated resulting in targeted action and shared learning reported to Cancer Board. Reporting through Quality Committee to ECQR and by exception to Quality & Safety Committee demonstrates targeted action and shared learning, Amber (see action 4)	Clinical Lead for Cancer has responsibility and oversight of progress in this metric. As at April 2026 there are 39 patients on a skin pathway awaiting a clinical harm review, and 14 on a head and neck pathway awaiting a clinical review.
Health inequalities priorities improving data collection around ethnicity and processes for patients under the mental capacity act	1st line: Annual report to Board on addressing health inequalities demonstrated improvement in ethnicity data capture, priorities and key risks including resource constraints. Key assurance still required is related to the impact for patients, September 2025, Amber (see actions 3, 6 and 7) Paper on health inequalities discussed at quality and Safety Committee in Q4 2025/26 with progress on developing a HI dashboard.	Data for patients with other protected characteristics due to patient administration system. Impact on health inequalities work for patients.

	HI Focus Areas identified doe progression relating to Deprivation / DNA impact in regard to both PTL reporting and targeted review for Medway spoke site patients. Amber (See Action 11)	
Access policy, booking policy, training manual for appointments staff, EPRR policies in place	2nd line: Internal review of policies demonstrates the majority of operational policies are in date and have been reviewed against most recent guidance, with one operational policy outstanding to be reviewed in April. Green EPRR annual assurance to Board demonstrates Substantial compliance November 2025, Green 3rd line: Internal audit on faster diagnosis standards demonstrates reasonable assurance with a good control framework in place, September 2025, Green	

Actions	**Timescale**	**Lead**	**Status** (complete, on track, off track, not yet started)
1. Improvements to teledermatology pathway to improve capacity within skin. QVH part of Sussex dermatology transformation work to look at single point of access from 2027.	April 2026	COO	Complete
2. QVH to inform the NHSE strategy regarding commissioning of breast reconstruction services across the South East. Internally, continue prioritisation of long waiting patients.	September 2026	COO	Off track
3. Use the Health Inequalities Task and finish Group to continue to prioritise ethnicity recording, and to work through actions to reduce inequalities where these are known, e.g children with long waits.	February 2026	CNO	Complete
4. Completion of clinical review of harm for cancer patients with long waits	January 2026	CMO	Complete
5. Develop oversight and reporting for non-RTT waits	April 2026	COO	Complete
6. Health inequalities data for patients with protected characteristics	February 2026	CNO	Complete
7. Provide assurance about the impact on health inequalities work completed to date and yet to be completed for patients	February 2026	CNO	Complete
8. Revisit action plans to address issues with 65 week waits to address any internal pathway challenges	May 2026	COO	In progress as per 10 – further work required for trajectory confirmation,
9. Revisit action plans to improve cancer performance to meet 2026/27 plan	May 2026	COO	In progress – further work required for trajectory forecast.
10. Further review of actions required for 8 to incorporate waiting list review recommendations	June 2026	DCOO / COO	Complete
11. Targeted HI work programme	September 2026	CNO	On track

Links to Organisational Risk Register	Risk 77 (patients coming to harm whilst waiting for treatment), 88 (compliance with standards in relation to performance)

BAF002 - CYBER

KSO1	KSO2	KSO3	KSO4	KSO5	Overall Assurance Rating (RAG)	Q1- 2026/27	Q2- 2026/27	Q3- 2026/27	Q4- 2026/27		
✓	✓		✓	✓							

BAF

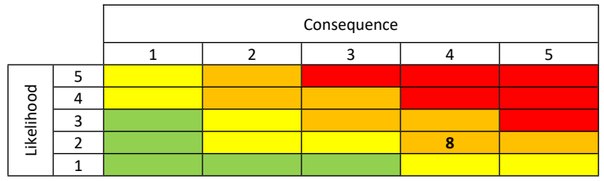
Risk description
Risk:
There is a risk that the Trust may experience a significant cyber security incident;
Caused by:
Increasing cyber threats, legacy infrastructure, reliance on third-party suppliers and limitations in specialist cyber capacity and funding;
Resulting in:
Disruption to clinical and operational services, compromise of patient or staff data, patient safety impacts, financial loss, regulatory non-compliance, and reputational damage.

Responsible committee	Audit and risk committee	**Date Risk Added:**	03 June 2026		
Principal Exec – Risk Owner	Tamara Everington, Chief medical officer	**Date Risk last reviewed:**	03 June 2026		
Risk Handler(s)	Bill Gordon, Chief digital information officer	**Date Risk last formally discussed:**	n/a (new)	**Group**	Trust Board

Inherent Score

Current Score

Target Score



Direction of travel since last review	⟷	Target date	31 December 2026
		Risk tolerance	Current risk score outside of risk appetite with a lower score (seek)

Controls (what are we doing about risk)	Assurances and RAG rating (how do we know if it's working)	Gaps in assurance (what additional assurance is needed)
CAF-aligned DSPT framework CAF-aligned Data Security and Protection Toolkit (DSPT) framework in place, with an annual submission and an agreed improvement plan.	1st line: Regular reporting to the Audit & Risk Committee on progress against the DSPT CAF improvement plan demonstrates continued delivery of planned actions and strengthening of cyber controls, Green 2nd line: Annual DSPT CAF submission confirms the Trust is "Approaching Standards", with a formally documented improvement plan in place and monitored through governance arrangements, Amber	Full assurance will only be achieved once all DSPT CAF improvement actions are completed and independently validated. Ongoing assurance is required that improvements are embedded and sustained beyond the reporting period.
Cyber Security Operations Centre (CSOC) monitoring Cyber Security Operations Centre (CSOC) monitoring in place for national cyber alerts, with formal processes for review and response	1st line: Reporting to the Audit & Risk Committee demonstrates that cyber security alerts are reviewed, acknowledged and responded to within required national timescales, Green 2nd line:	Continued assurance is required that monitoring arrangements remain effective as the cyber threat landscape evolves. Limited independent assurance over the effectiveness of third-party monitoring arrangements.

	Regular updates to governance committees demonstrate continued oversight of cyber threats and appropriate escalation processes, Green	
Independent cyber security testing Annual independent cyber security testing undertaken by appropriately accredited external providers.	3rd line: Annual independent cyber security testing demonstrates that technical controls are subject to external scrutiny, with identified issues tracked through formal remediation plans and reported to the Audit & Risk Committee, Green	Assurance is point-in-time and dependent on testing cycles, with gaps between formal reviews. Full assurance dependent on timely completion and validation of remediation actions arising from testing.
Vulnerability and patch management Formal vulnerability and patch management processes in place, supported by infrastructure modernisation and system upgrades.	1st line: Regular reporting to the Audit & Risk Committee demonstrates active management of cyber vulnerabilities, including progress in addressing legacy systems and implementing system upgrades, Amber 2nd line: Oversight through governance arrangements demonstrates that remediation plans are in place and being monitored, Green	Residual risk remains from legacy systems and technical debt where full remediation has not yet been achieved. Ongoing assurance required that vulnerability management processes are consistently effective across all systems.
Information Asset Register Information Asset Register programme in place to identify and manage digital and connected medical assets.	1st line: Programme reporting demonstrates progress in developing a comprehensive Information Asset Register, including identification of digital and connected medical assets, Amber 2nd line: Alignment with DSPT CAF requirements demonstrates that asset management controls are being developed in line with national standards, Amber	Full assurance cannot be provided until the Information Asset Register is complete, validated, and regularly maintained. Limited assurance over the security of all network-connected assets, including medical devices, until full visibility is achieved.
Cyber incident response and exercising Cyber incident response and business continuity arrangements tested through scheduled cyber tabletop exercises	1st line: Reporting to the Audit & Risk Committee demonstrates that cyber incident response arrangements are tested through scheduled tabletop exercises, with learning identified and tracked, Green 2nd line: Executive oversight demonstrates that lessons learned from exercises are incorporated into organisational processes, Green	Assurance is based on planned and periodic exercises; further testing is required to ensure sustained organisational readiness. Ongoing assurance required that lessons learned from exercises are embedded consistently across services.

Actions	**Timescale**	**Lead**	**Status** (complete, on track, off track, not yet started)
1. Completion of DSPT CAF improvement plan and embedding of controls	30 June 2026	CDIO	In progress
2. Ongoing reporting of cyber security position to Audit & Risk Committee	Ongoing	CDIO	Ongoing
3. Annual independent cyber security testing and review of outcomes	30 June 2026	CDIO	In progress
4. Completion and validation of the Information Asset Register for essential functions	31st October 2026	CDIO	In progress
5. Delivery of annual scheduled cyber incident tabletop exercise and tracking of agreed actions	31st July 2026	CDIO	Pending
6. Continued infrastructure modernisation to reduce cyber risk from legacy systems	Ongoing	CDIO	Ongoing

Links to Organisational Risk Register	Digital risk register / BAF

BAF003 - DIGITAL

KSO1	KSO2	KSO3	KSO4	KSO5	Overall Assurance Rating (RAG)	Q3- 2025/26	Q4- 2025/26	Q1- 2026/27			
✓	✓		✓	✓							

BAF

Risk description

Risk:
There is a risk that the Trust may not be able to deliver its clinical, operational and financial objectives due to insufficient progress in digitisation
Caused by:
Constraints of capital and revenue funding to support people and resources required to sustain, develop and transform digital working including lack of funding for digital transformation roles past December 2026 with loss of some roles end June 2026;
Resulting in:
Nonalignment with the national priority to move from analogue to digital; reputational damage; potential non-realisation of benefits from digitisation; impact on service delivery and quality

Responsible committee	Finance and performance committee	**Date Risk Added:**	13 November 2025		
Principal Exec – Risk Owner	Tamara Everington, Chief medical officer	**Date Risk last reviewed:**	3 June 2026		
Risk Handler(s)	Bill Gordon, Chief digital information officer	**Date Risk last formally discussed:**	14 May 2026	**Group**	Trust Board

Inherent Score

Current Score

Target Score

Direction of travel since last review	⟷	**Target date**	31 December 2026
		Risk tolerance	Current risk score outside of risk appetite and imminent risk of deterioration end June 2026

Controls (what are we doing about risk)	Assurances and RAG rating (how do we know if it's working)	Gaps in assurance (what additional assurance is needed)
Digital strategy incl. alignment of digital transformation with EPR programme	1st line: Regular reporting on Digital Transformation through monthly IQPR and progress updates on the Digital Transformation Programme to the FPC, Green 2nd line: Biannual reporting through ELT to the Strategy and Culture Committee with reflection on clinical governance components in the Quality and Safety Committee, report provided for discussion at SCC 2 June 2026, Green	Review of digital strategy required as strategic partnership develops Development of the data strategy working with system partners SMART strategic objectives aligned to prioritisation and available funding subject to ongoing review and as funding opportunities arise.
Digital policies and procedures	1st line: Policy report to ECQR demonstrates no digital policies out of date, however, this will need to be kept under regular review Green 2nd line:	Pending RSM DSPT/CAF assurance report June 2026

	DSPT and CAF annual submission for standards met demonstrates the Trust is approaching standards (not met). All actions in the improvement plan were completed in February 2026. RSM audit review June 2026 Amber	
Organisational resilience in the event of digital systems failure	1st line: Regular review / refresh as needed of business continuity plans to ensure ongoing service provision in the event of system failure Red 2nd line: Scheduled EPRR simulation events to test resilience. Lessons learnt with actions following unplanned outage. Red	Systematic process aligned to Information Asset review to be developed to ensure assets, especially essential system assets have an in date BCP. Review lessons learnt from unplanned outage. Plan EPRR simulation events.
Horizon scanning for digital funding with NHSE incl. commissioning intentions	1st line: Discussion with NHSE about medium term planning- no confirmation about future funding, bids submitted to Frontline Productivity and Wayfinder calls May 2026, Green 3rd line: Commissioning intentions for 2026/27 demonstrate a continued commitment to driving digital transformation and plans to address duplication in digital infrastructure with opportunities to share costs and functions across the system for implementation from 1 April 2026, ongoing discussions with new ICB Lead, Amber	Trust reliant on external funding to progress. Internal funding agreed until 31 December 2026. Engagement with ICB Digital Strategic Commissioning Enablement Lead.
Workforce with specialist digital and technical skills to support digitisation	1st line: Core Trust IT require further development of specialist technical skills. Contractors and internal staff on secondment to support Digital Transformation Programme programme internally funded until December 2026 with some stepdown from June 2026. Amber 2nd line: Outsourced functions to 3rd party providers through managed service contracts. Contract monitoring processes in place, Green	Time limited resource with no confirmation of long-term funding. Internal funding agreed until December 2026. Management of change to include identification of skills requirements for specific roles by October 2026.

Actions	**Timescale**	**Lead**	**Status** (complete, on track, off track, not yet started)
1. Digital strategy will need to be refreshed as partnership / system strategy develops, data strategy to develop with system	1 December 2026	CDIO	Pending
2. SMART objectives to be refreshed as strategic priorities evolve / funding becomes available	1 December 2026	CDIO	Pending
3. Review of RSM DSPT/CAF assurance report June 2026, address any required actions	30 June 2026	CDIO	Ongoing
4. Ongoing engagement with NHSE and ICB around funding intentions for digital	31 March 2027	CDIO	Ongoing
5. Management of change to include identification of skills requirements for specific roles by October 2026.	31 October 2026	CDIO	Ongoing
6. Regular reporting to the Finance and performance committee	31 March 2027	CDIO	In progress / ongoing
7. Ensure digital policies are consistently updated and approved through governance routes	31 March 2027	CDIO	Complete / ongoing
8. Systematic process aligned to Information Asset Register review to ensure BCPs for essential systems are in place and updated. Review lessons learnt from unplanned outage. Plan EPRR simulation events.	1 December 2026	COO/CDIO	Pending
Links to Organisational Risk Register	138 (failure to deliver EPR programme)		

BAF004 - ESTATES

KSO1	KSO2	KSO3	KSO4	KSO5	Overall Assurance Rating (RAG)	Q3- 2025/26	Q4- 2025/26	Q1 2026/27			
✓			✓								

BAF

Risk description

Risk:

There is a risk that the Trust's estate deteriorates to the point where it is no longer safe

Caused by:

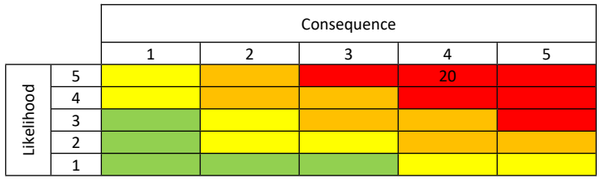
Ageing estate; poor quality of previous work completed; limited capital resource to address critical infrastructure challenges; maintenance and repair backlog; estates team resource challenges; lack of compliant ventilation

Resulting in:

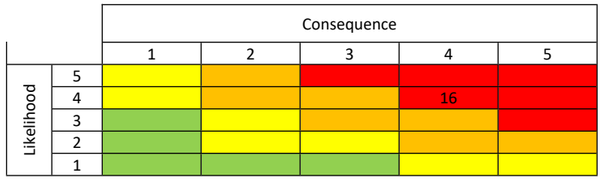
Harm to individuals; Potential impact on service delivery; services no longer being delivered from the QVH site; financial loss; reputational damage.

Responsible committee	Finance and Performance committee	**Date Risk Added:**	10 November 2025		
Principal Exec – Risk Owner	Chief People officer	**Date Risk last reviewed:**	10 June 2026		
Risk Handler(s)	Interim Director of Estates and Facilities	**Date Risk last formally discussed:**	14 May 2026	**Group**	Trust Board

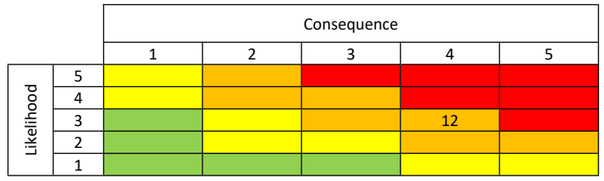
Inherent Score



Current Score



Target Score



Direction of travel since last review	⟷	Target date	31 March 2027
		Risk tolerance	Current risk score outside of risk appetite (higher) (minimal)

Controls (what are we doing about risk)	Assurances and RAG rating (how do we know if it's working)	Gaps in assurance (what additional assurance is needed)
Estates policies and processes in place to support compliance with statutory requirements	1st line: Regular reporting on the Trust's estate to the Finance and Performance committee demonstrates that works are completed are in line with statutory requirements, June 2026, Green 2nd line: Regular report regarding out of date policies to the ECQR. Following the E&FSC meeting on 26th March, only 2 estate policies will be out of date. June 2026, all policies up to date Green (see action 6)	Planned backlog works to be completed including fire and heating systems multi-year plans and the schemes added following the receipt of £2.8m of additional estates safety funding. June 2026 – funding still to be received from NHSE The last six facet survey was completed in 2023- an updated detailed six facet survey is required by 31.7.26. June 2026 – in progress Authorised engineer (AE) for electrical appointed and review on electrical compliance to be completed. June 2026 – AE report outstanding, has been followed up with AE.

	Policy log demonstrates that key estates policies are in place to support compliance with statutory requirements, March 2026. June 2026 Policies are all in date. Green (see action 6) Premises Assurance Model (PAM) completed annually and reported to the Finance and Performance committee and the Board demonstrates significant improvement from the previous year with action planning for further improvements underway, New digital collection system is in the process of being launched March 2026. June 2026, PAM has been updated for 2026, with additional questions and evidence of compliance requirements. Submission is by September 2026. Amber. 3rd line: Authorised engineer (AE) review on water compliance was completed in September 2025 and the report is being actioned. Authorised engineer (AE) review on ventilation compliance was completed in December 2025 and the report is being actioned.	Authorised engineer (AE) for medical gases appointed and review on medical gas compliance to be completed. PAM improvement action plan to be implemented. June 2026, PAM to be completed for 2026. Histology water action plan to be completed. June 2026, being reviewed as part of overall estates compliance plan and work planned for 2026/27.
Estates capital funding plan to ensure prioritisation of works in line with risks	1st line: Regular reporting on the Trust's estate to the Finance and Performance committee demonstrates limited funding available to appropriately address critical infrastructure risks, March 2026, Amber (see action 2). Receipt of the additional £2.8m of estates safety funding in 2025/26 and £3.6m in 2026/27 required to support estates critical infrastructure work. June 2026 – funding not yet received from NHSE for 2026/27. Amber 2nd line: Review of estates budget by management accountant demonstrates that the directorate is overspent on its allocated budget at this stage of the year due to unplanned and unforeseen issues, March 2026, Amber (see action 2). June 2026, capital budget is limited for 2026/27, awaiting estates safety funds for 2026/27 to support delivery of essential maintenance. Amber Regular reporting on financial performance through the IQPR demonstrates that the estates capital budget fully spent at March 2026, Green (see action 7) 3rd line: £2.8m of estates safety funding received in November 2025, Green (see action 2)	QVH does not meet the NHS new hospital programme criteria so there is no assurance regarding a future rebuild, however the current site is uneconomic to keep repairing. At the current time Estates Safety Fund bids provides the only realistic mechanisms for tackling our backlog maintenance challenges. The Trust has been successful with our estates safety bids
Business continuity plans for dealing with a range of issues, for example critical infrastructure failure	2nd line: EPRR annual assurance to Board demonstrates full compliance, Green	Lack of EPRR lead There is a need to review estates specific business continuity plans. June 2026, review underway, with specific actions to ensure plans are in place.

		There are limited mitigations regarding emergency plant in the event of a critical failure as there is no in-built resilience. There is no normal load plus one for critical plant which is not in line with HTM guidance Reliance on key individuals to enact business continuity plans. June 2026, on-call arrangements and business continuity plans to be supported by contractors whilst there remains gaps in the estates establishment.
Asbestos management plan in place to meet the statutory requirement of CAR 2012 (Control of Asbestos Regulations)	1st line: Regular review of Management Plan by estates leadership incl. visual inspection of asbestos areas demonstrates a requirement to remove certain asbestos contained roofing materials (ACM's) within six months. Amber. June 2026, work has been completed on a replacement roof for the estates building. 3rd line: The Management Plan is reviewed annually by an external specialist contractor. Review undertaken in November 2025. Green Regular testing (refurbishment and demolition surveys) to identify asbestos prior to any building or repair works being undertaken, demonstrates no works to be undertaken in unsafe environment, November 2025, Green	Assurance from annual review of Asbestos Management Plan D Additional roofing actions have now been prioritised and funded.
Estates team and key roles with appropriate qualifications to manage the Trust's estate	1st line: Review of team demonstrates that key roles are in place including Associate Director of Estates and Facilities, Project managers and Compliance Manager, however there are gaps in expertise relation to electrical and mechanical, March 2026. June 2026, Fire Safety Officer, Waste Compliance Manager and Compliance Co-ordinator roles have been appointed / have started in their roles. Mechanical and electrical specialist roles remain unfilled, with reliance on contractors due to these gaps. Amber (see action 4)	Lack of qualified persons in roles incl authorised persons such as electrical and mechanical. June 2026 – Authorised engineer in place for electrical. Ongoing recruitment to vacant roles underway. Partnership opportunities and solutions to be explored.

Actions	**Timescale**	**Lead**	**Status** (complete, on track, off track, not yet started)
1. Statutory Fire advisor role to be recruited to	31 March 2026	ADEF	Successful candidate started May 2026 - completed

BAF004 - ESTATES

2. Seeking additional funding from NHSE for funding for critical infrastructure risks	30 June 2026	DEF	Notification on 10 June funding approved - complete
3. Arrange for a six facet survey to be completed	31 July 2026	DEF	Contract awarded
4. Appointment of authorised engineer (AE) to be completed	31 July 2026	DEF	Replacement of AEs being undertaken by DEF
5. Review of estates specific business continuity plans	31 July 2026	ADEF	Underway – reviews of plans / updates being undertaken by ADEF / DEF
6. All estates policies to be updated in line with requirements	31 March 2026	ADEF	Completed
7. Continued oversight of estates capital spend to support year end position	31 March 2026	CFO	Completed
8. Complete Estates Bench marking compliance review 9. Compliance report for electric, water, ventilation, fire to be produced	30 June 2026 31 July 2026	DEF DEF	On track On track
Links to Organisational Risk Register	153 (spread of fire), 139 (electrical fire), 47 (failure of electrical systems), 48 (fire alarm), 49 (fire dampers), 53 (heating and hot water)		

BAF005 - FINANCE

KSO1	KSO2	KSO3	KSO4	KSO5	Overall Assurance Rating (RAG)	Q3- 2025/26	Q4- 2025/26	Q1- 2026/27			
✓	✓	✓	✓	✓							

BAF

Risk description

Risk:

There is a risk that the Trust will not deliver the full value of its £7.5m cost improvement plan for 2026/27 and cost improvement plans for future years; deliver a breakeven position for 2026/27 and for future years and/ or that the working cash balance will reduce to lower than £1m.

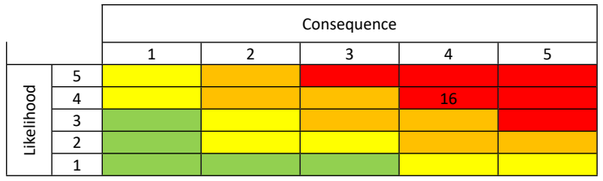
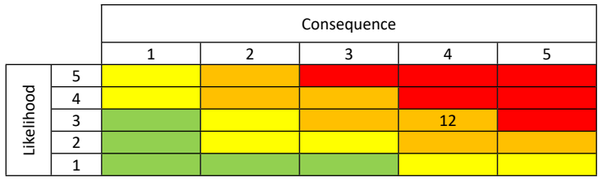
Caused by:

The Trust's significant cost improvement target of £7.5m for 2026/27 including the requirement for corporate service cost reductions; changes to the funding regime including capping of income levels; significant activity levels, and financial pressures across other NHS organisations delaying payments.

Resulting in:

The Trust not being financially sustainable for the future.

Responsible committee	Finance and performance committee	**Date Risk Added:**	13 November 2025		
Principal Exec – Risk Owner	Chief Finance Officer	**Date Risk last reviewed:**	15 June 2026		
Risk Handler(s)	Deputy Chief Finance Officer	**Date Risk last formally discussed:**	14 May 2026	**Group**	Trust Board

Inherent Score	Current Score	Target Score
		
	Direction of travel since last review	**Target date** 31 March 2027
		Risk tolerance Current risk score outside of risk appetite (higher) (minimal)

Controls (what are we doing about risk)	Assurances and RAG rating (how do we know if it's working)	Gaps in assurance (what additional assurance is needed)
Efficiency Steering Group (ESG) is charged with overseeing the Better Value Programme, including the identification of productivity and efficiency opportunities, ensuring that approved schemes are developed through to implementation including the completion of QIAs where necessary. The ESG is also responsible for the tracking and reporting of delivery of schemes and any remedial actions where needed.	1st line: Reporting on progress of the cost improvement programme through the Efficiency Steering Group, Finance and Performance committee and Board. This shows the delivery against the programme and illustrates the level of development of the programme along with completion of individual POAPs, Amber (see action 1) 2nd line	Assurance that recurrent savings can be made. Currently, some non-recurrent in 2026/27 and savings yet to be identified for 2026/27.

	Regular reporting on finance through the IQPR. This demonstrates delivery against programme and key corrective actions being taken, but with more being delivered non-recurrently than planned, June 2026, Amber (see action 1)	
Regular oversight of overall financial position incl. regular reporting to the Resources and Financial Control Groups	1st line: Regular reporting and review of financial management arrangements, including revenue, capital, VAT, NI, ERS, balance sheet items and cash flow actuals & forecasts and the accounting treatment of significant transactions, Green 2nd line: Regular reporting on divisional financial performance, through the IQPR demonstrates that to date, the Trust remains on track for its breakeven target, June 2026, Green	
Financial policies including Standing Financial Instructions, Scheme of Delegation, Contract policy and Procurement policy	1st line: Regular reporting to the Audit and Risk committee regarding compliance with policies including waiver report and PO compliance report. This demonstrates a reduced number of waivers supporting better value for money and the percentage of non-PO's being less than 1% of invoices, June 2026, Green 2nd line: Regular report regarding out of date policies to the ECQR demonstrates no finance policies being out of date, June 2026, Green 3rd line: Internal audit on compliance with governing documents and policies concluded reasonable assurance with considerable progress and strengthening of controls, September 2025, Green	Assurance that staff across the organisation understand their responsibilities. Assurance that the compliance position has materially improved long term. Quarterly reviews demonstrate compliance to date.
Medium term financial plan in development to support a forward view	The Trust has submitted its 5 year MTFP which has been accepted and has the plan for 2026/27 along with indicative plan for the following 2 years. but significant amounts of internal and system work are still to be undertaken, Green The plan for 2027/28 and onwards will need to additional work in the future to further develop the plans and take account of changes in year. This will also need to be built to deal with changes to national expectations and financial control environment. Amber (see action 3)	
Annual business planning process incl. budget setting	1st line: Business plans are submitted to Finance Performance committee and Board which each year in the 2026/27 plans going forward demonstrates planned breakeven position, however this is not without risk, June 2026, Amber (see action 1) Report to ELT on the business planning approach for 2027/28 along with learning from the previous years planning process, October 2026, Green	

BAF005 - FINANCE

	2nd line: Fortnightly review of business planning progress by business planning group worked well and will be continued in the 2027/28 planning and will be used again to monitor delivery and triangulation of plans Will need to be further developed for 2027/28, June 2026, Amber	

Actions	**Timescale**	**Lead**	**Status** (complete, on track, off track, not yet started)
1. Continued identification of cost improvement programmes and conversion of non-recurrent to recurrent schemes	Ongoing	CFO	Ongoing
2. Develop Governance handbook to support staff across organisation	30 September2026	CS	First draft Complete
3. Medium term financial plan development following 1st year of the plans	Q3/Q4 2026/27	CFO	Plan for year 2 to be updated and refreshed for 2027/28 planning.
Links to Organisational Risk Register	161 (cash balance), 148 (CIP), 149 (ERF assumptions), 144 (delivery of breakeven plan)		

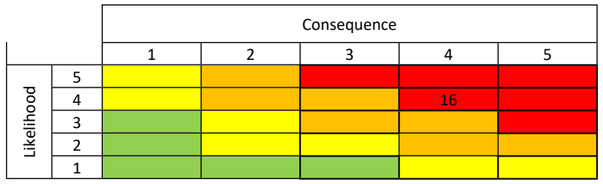
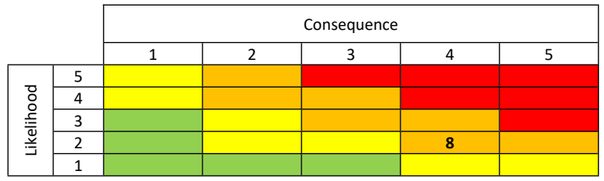
BAF006 – LEADERSHIP CAPACITY

KSO1	KSO2	KSO3	KSO4	KSO5	Overall Assurance Rating (RAG)	Q3- 2025/26	Q4- 2025/26	Q1- 2026/27			
✓	✓	✓	✓	✓							

BAF

Risk description
Risk:
There is a risk that there will not be leadership capacity to deliver the strategic partnership, key strategic objectives and key projects
Caused by:
Four interim executive roles including Chief executive officer; turnover in Board level roles and organisational memory loss; three Non-executive directors coming to end of terms in June 2026
Resulting in:
Closure of services/ site; regulatory intervention; reputational damage; non-delivery of recurrent annual financial, productivity and efficiency savings

Responsible committee	Strategy and culture committee	**Date Risk Added:**	13 November 2025		
Principal Exec – Risk Owner	Chief executive officer	**Date Risk last reviewed:**	01 July 2026		
Risk Handler(s)	Chief executive officer	**Date Risk last formally discussed:**	14 May 2026	**Group**	Board

Inherent Score	**Current Score**	**Target Score**
		
	Direction of travel since last review 	**Target date** ~~July~~ October 2026 **Risk tolerance** Current risk score outside of risk appetite (higher) (minimal)

Controls (what are we doing about risk)	Assurances and RAG rating (how do we know if it's working)	Gaps in assurance (what additional assurance is needed)
Key Board level roles being filled incl. executive portfolios covering all areas of operational business	1st line: Review of Board roles demonstrates all roles currently filled with some executive roles being filled by interims to ensure the required level of experience required. An interim Chair is now in post until October 2026, Amber Board succession plan presented to the Nomination and remuneration committee in March 2025 demonstrates a limited succession pipeline for key roles, March 2025, Red (see action 2) Chief strategy officer role has been filled on an interim basis, April 2026, Green 3rd line: Discussions with partners demonstrate commitment for shared Chair and CEO being in post by October 2026, Amber	Three Non-executive directors (NEDs) left the Trust on 1 July- the Trust is onboarding 2 new NEDs Board skills and maturity matrix to be reviewed in June 2026 Acting CEO to leave QVH in early October. Revised leadership arrangements are being confirmed as part of the proposed strategic partnership.
Programme of work to deliver strategic partnership incl. timeline	1st line:	

BAF006 – LEADERSHIP CAPACITY

	Reporting to the Strategy and Culture committee outlining the timeline demonstrates that the Trust is meeting milestones, however the timeline remains challenging with external factors being a risk, February 2026, Amber Transition and implementation plan was shared with Strategy and culture committee in February 2026, demonstrates commencement of workstreams and finance and governance reviews, Amber 3rd line: Review of NHSE timeline demonstrates alignment with QVH timeline, October 2025, Amber	
Monitoring of progress against strategic projects incl. project management office function in place to support this	1st line: Update to Board to confirm the EPR Go Live has been a success with no patient cancellations, November 2025, Green 2nd line: Reporting on major projects to the Finance and performance committee through the PMO and IQPR demonstrates the EG CDC being rated as Green/ Amber, the Bognor CDC being rated as Amber/ red March 2026, Amber (see action 4)	
Key strategic objectives and priorities	1st line: Reporting to the Board demonstrates good progress against the key strategic objectives and priorities for 2025/26, March 2026, Green Key strategic objectives for 2026/27 due to be approved by the Board in May 2026. KSOs are aligned to national and QVH specific strategic priorities, May 2026, Green	

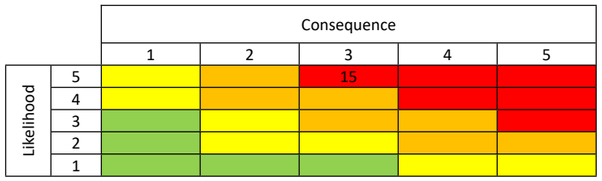
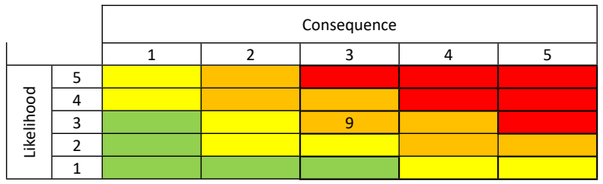
Actions	**Timescale**	**Lead**	**Status** (complete, on track, off track, not yet started)
1. Shared Chair and CEO to be in post by March 2026	~~March 2026~~ October 2026	CEO	On track- date changed to October 2026 in line with RSASP timeline in proposal
2. Explore opportunities for sharing corporate services and key roles	September 2026	CEO	On track
3. Interim Chair arrangements from January 2026 to be agreed	December 2025	SID, CS	Complete- interim Chair appointed
4. Project benefits realisation tracking to be developed	March 2026	DCSO	Complete
5. Non-executive director arrangements from June 2026 to be agreed	January 2026	Interim Chair, CS	Complete- out to recruitment for two Non-executive roles. Interviews scheduled for early June 2026
6. Board skills and maturity matrix to be reviewed	~~June 2026~~ August 2026	Interim Chair, CS	On track- date changed as new NEDs started on 1 July and need to include in review
7. Confirm Chief finance officer cover from June 2026	May 2026	CEO	Complete- shared interim CFO with RSFT
8. Confirm and action revised leadership arrangements from October 2026	October 2026	CEO	On track

Links to Organisational Risk Register	11 (relationship between Board and Council of Governors)

BAF007 - PEOPLE

KSO1	KSO2	KSO3	KSO4	KSO5	Overall Assurance Rating (RAG)	Q3- 2025/26	Q4- 2025/26	Q1- 2026/27			
		✓									
BAF	**Risk description** Risk: There is a risk that the Trust is unable to fulfil its commitment to being an excellent employer and may not have a workforce fit for the future Caused by: Significant organisational change; uncertainty; the Trust's significant cost improvement target; requirement for corporate service cost reduction; leadership capacity and managers capability Resulting in: Staff turnover; single points of challenge and lack of resilience; challenges with recruitment and retention; challenges with organisational culture; a negative effect on staff wellbeing and motivation; non-delivery of key strategic objectives and projects; impact on quality										

Responsible committee	Strategy and culture committee	**Date Risk Added:**	13 November 2025		
Principal Exec – Risk Owner	Chief people officer	**Date Risk last reviewed:**	26 May 2026		
Risk Handler(s)	Deputy Chief people officer	**Date Risk last formally discussed:**	14 May 2026	**Group**	Board

Inherent Score	Current Score	Target Score
		
	Direction of travel since last review 	**Target date** July 2026 **Risk tolerance** Current risk score within risk appetite (open)

Controls (what are we doing about risk)	Assurances and RAG rating (how do we know if it's working)	Gaps in assurance (what additional assurance is needed)
Staff wellbeing support and programmes incl. occupational health, EDI champions, Vivup, Wellbeing team initiatives, monthly newsletter promoting annual wellbeing calendar ands wellbeing events and support	1st line: Data showing staff sickness and type. Data shows c.4% sickness level with an increase in long term sickness, October 2025. Sickness data shows sickness at 4.2% for April 2026, with long-term sickness being a driver of the sickness rates Amber Reporting to CTSG demonstrates progress towards using continuous improvement methodology to improve culture and challenges experienced by EDI champions with engagement, October 2025. CTSG will be re-focussed from April 2026, with a clear focus on speaking up and psychological safety, May 2026 Amber 2nd line:	EDI groups not up and running. As partnership work progresses, link to partner organisation staff networks to be utilised. Responses to CTSG survey will determine focus of group. January 2026, DCPO meeting with ACEO to review CTSG focus. March 2026 – CTSG to focus on speaking up 2025 staff survey closed 28 November. Data due for publication in March 2026. March 2026 – staff survey results published. Areas of focus shared with triumvirate leadership team to support departmental managers with their prioritisation. Execs to lead with trust wide areas for improvement.

	2024 Staff survey results published in March 2025 with a 57% response rate, demonstrate disabled staff have a less positive experience than non-disabled staff and staff do not always feel confident action will be taken if they speak up. 2025 staff survey published in March 2026 and reported to the Strategy and Culture Committee and Board in May 2026 Amber People Pulse Survey for 2025/26 (up to January 2026) was responded to by 474 staff. In Q4 139 (10.7%) staff completed the People Pulse Survey. The Q4 results demonstrated an improvement in mood and motivation. Q1 2026/27 People Pulse Survey results will be reported to the Strategy and Culture Committee in August 2026 Amber	May 2026 – staff survey results presented to Strategy and Culture Committee and Board. Further analysis to be undertaken where there are significant deteriorations in results. Directorates and corporate departments are presenting their priority areas to executive directors on 27 May 2026. Follow up paper to be taken to the Strategy and Culture Committee in August 2026. To note, turnover hasn't increased in 2026/27.
Staff development and training incl. coaching, mentoring, change management workshops, resilience workshops	1st line: Executive sub-committee for Workforce regular assurance report to ELT includes staff development and training data, demonstrates a good take up from clinical and medical staff, but less from corporate staff, December 2025. Assurance report taken to ELT in April 2026, with good compliance for statutory and mandatory training. Workshops continue to be provided, along with coaching and mentoring Green Apprenticeship Levy report presented to the Finance and performance committee in September 2025 demonstrates that our spend has increased as well as the number of apprentices and types of apprenticeships, but there needs to be a focus widening the diversity pool of apprentices. Paper detailing action plan to improve diversity taken to ELT in November 2025. Communication plan is in place and work on the action plan May 2026 Green 2nd line: Mandatory and statutory training compliance reported monthly through IQPR, demonstrates 92% compliance overall with improvement required in some specific areas such as Resus, October 2025. MAST compliance stable from November 2025 to May 2026 Green	
Managers training programme, prioritising bands 6-8a- two day programme including policies and softer skills such as supporting staff to speak up and holding difficult conversations	1st line: 2 cohorts underway with feedback / evaluation undertaken after each training day. Positive feedback received from participants, December 2026. Cohorts booked throughout 2026/27, March 2026. Positive feedback received from ongoing delivery og managers training programme May 2026 Green	Managers training programme commenced October 2025. Assurance will be in manager and staff feedback, ER cases, FTSU increases. March 2026 – feedback from cohorts demonstrating growth in confidence. Cohorts continue through Q4 of 2025/26. Evaluation feedback will continue to be reviewed. Cohorts are booked throughout 2026/27 with positive feedback being received.
Behaviour framework and implementation including embedding into 1:1's, appraisals, team charters, interview processes	1st line: Data related to number of appraisals completed is reported monthly in the IQPR, demonstrates the average compliance rate is 81% against the 90% target, February 2026. Completion rates continue to be monitored through IQPRs with focus on those over 3 months out of date. IQPR data for M12 2025/26 shows compliance at 83% and an improving trajectory. Appraisals out of date by more than 3 months is decreasing, May 2026 Amber	Executive Directors have a focus on working with their SLTs to improve the appraisal completion rates, reported monthly in their executive performance report.

	Employee relations team weekly review of employee relations cases, demonstrates focus points for specific support and interventions required, October 2025. May 2026 – weekly review meetings continue, with thematics from cases triangulated with other data Green (see action 1) 2nd line: Organisational cultural assessment undertaken to be presented to the Board in November 2025, demonstrates that there are micro cultures and ongoing focus required to embed behavioural framework. Presented to Board in November, with ongoing work to support culture development (December 2025). Update on areas of consideration and next steps presented to Strategy and Culture Committee in March 2026 . V2 of the report will be presented to the Strategy and Culture committee in Q2 2026/27 and will compare to V1 Green	
Mechanisms in place for staff to provide feedback incl. Staff Survey, Quarterly People Pulse Surveys, Freedom to Speak Up Service, 'Tell Liz', 'Ask Abigail'	2nd line: 2024 Staff survey results published in March 2025 with a 57% response rate, demonstrate disabled staff have a less positive experience than non-disabled staff and staff do not always feel confident action will be taken if they speak up. 2025 staff survey results published in March 2026, with a 56% response rate and a small decline in some areas for speaking up, and increase in some areas, with focussed work underway to prioritise areas of decline Amber People Pulse Survey for Q2 was responded to by 14% of staff which demonstrated a decline in mood and motivation. People Pulse Survey for 2025/26 (up to January 2026) was responded to by 474 staff. In Q4 139 (10.7%) staff completed the People Pulse Survey. The Q4 results demonstrated an improvement in mood and motivation. Pulse survey is currently live for completion during April 2026. The Q1 People Pulse Survey results will be presented to the Strategy and Culture Committee in August 2026 Amber 3rd line: FTSU Guardian report presented to the Board in July 2025 demonstrated that more staff are speaking up but some staff still wishing to stay anonymous due to concerns about the consequence. FTSU report and Raising concerns report presented to the Board in February 2026, with some staff still wishing to stay anonymous. Updated report presented to the Board in April 2026 Green	Ongoing action plans from staff survey. Once 2025 staff survey results are available in March 2026 (once embargo is lifted), specific action plans will be worked on with departments March 2026 – staff survey results published with reports sent to departments. Workshops in place for supporting managers to understand results and work with their teams on areas of focus. May 2026 – staff survey results presented to Strategy and Culture Committee and Board. Further analysis to be undertaken where there are significant deteriorations in results. Directorates and corporate departments are presenting their priority areas to executive directors on 27 May 2026. Follow up paper to be taken to the Strategy and Culture Committee in August 2026. To note, turnover hasn't increased in 2026/27

Actions	**Timescale**	**Lead**	**Status** (complete, on track, off track, not yet started)
1. Ongoing promotion and embedding of behaviour framework and values through workshops, staff survey action plans and team charters.	March 2026	Head of Leadership and OD	Completed Workshops delivered in October and November 2025 and January 2026. Will continue through 2026/27
2. Communication and engagement plan to encourage non-clinical staff to apply for Charity funded training to support their development	March 2026	Head of Leadership and OD	Completed Comms will continue through 2026/27
3. Communication and engagement plan to encourage a wider diversity of apprenticeship applicants	March 2026	Head of Leadership and OD	Completed

			Action plan presented to ELT November 2025 with ongoing work in place and a comms plan agreed Comms will continue through 2026/27
4. Link into to partner organisations to join/ support EDI networks	April 2027	Chief People Officer	Underway / on track, with discussions ongoing with Chief People Officers of partner organisations
5. Organisational culture review incl. associated programmes of work	September 2027	Chief People Officer	Presented to Board in November 2025 with ongoing programmes of work. Update paper presented to Strategy and Culture Committee in March 2026. Updated culture report will be presented to the Strategy and Culture Committee and Board at the end of Q2 when all the updated data is available.
6. Staff survey detailed analysis	August 2026	Chief People Officer	On track – directorates and corporate departments presenting to Executive Directors May 2026 with priority areas / actions. Paper to go to Strategy and Culture Committee August 2026
Links to Organisational Risk Register	133 (hard to recruit to roles)		

BAF008 - QUALITY

KSO1	KSO2	KSO3	KSO4	KSO5	Overall Assurance Rating (RAG)	Q3- 2025/26	Q4- 2025/26	Q1- 2026/27			
✓	✓		✓								
BAF	Risk: There is a risk that the Trust may be unable to consistently deliver high quality, safe care Caused by: Pressures on workforce capacity, increasing patient demand, variation in clinical practice, infrastructure limitations or less effective governance arrangements Resulting in: Patient harm, poor patient experience, regulatory action, financial impact and reputational damage										

Responsible committee	Quality and safety committee	**Date Risk Added:**	13 November 2025		
Principal Exec – Risk Owner	Chief medical officer / Chief nursing officer	**Date Risk last reviewed:**	16 April 2026		
Risk Handler(s)	Deputy Chief nursing officer	**Date Risk last formally discussed:**	14 May 2026	**Group**	Board

Inherent Score	Current Score	Target Score
		
	Direction of travel since last review 	**Target date** 31 March 2027 **Risk tolerance** Current risk score outside of risk appetite (higher) (minimal)

Controls (what are we doing about risk)	Assurances and RAG rating (how do we know if it's working)	Gaps in assurance (what additional assurance is needed)
Quality impact assessments - to assess risk to quality and safety from cost improvement and productivity programme initiatives	1st line: Review of all QIA (completed by directorate lead) by CNO and CMO demonstrates no significant quality and safety concerns to date from CIP programme, February 2026, ongoing review of longer-term effects through IQPR Green 2nd line: Quality and safety sub-committee of Board and executive sub-committee for quality in place with oversight of quality and safety matters. Green Incident reporting through Datix demonstrates no significant quality and safety issues because of cost improvement programme initiatives to date, February 2026, Green	QIAs have not systematically been completed for productivity initiatives (theatre productivity QIA complete). The co-dependence of initiatives has not been assessed through a QIA process. Creation of combined Quality and Equality impact assessment policy

	3rd line: Friends and family test responses demonstrate that the recommendation rate was 94.45% (target 90%) for December 2025 Green	
Incidents - consistent reporting of incidents with learning including thematic review supported by clinical governance framework. Patient safety incident response framework (PSIRF) approach in place and central incident reporting through the Learning from Patient Safety Events (LfPSE) platform	1st line: Summary incident reports collated and actively managed through directorates and groups reporting into Quality Committee Green Exec/ Board level time scheduled for presence in clinical areas observing and listening to patients / team members, ongoing, Amber 2nd line: Quality and safety sub-committee of Board and executive sub-committee for quality in place with oversight of quality and safety matters Green Monthly review of incident evaluation at ECQR demonstrates effectiveness of primary processes, Green Governance meeting surveillance including IPC, safeguarding, medical devices, health & safety to understand impact of incidents on patient safety and outcomes, Green Demonstration of learning through morbidity & mortality meetings, governance meetings, IQPR and the Clinical Learning Forum, Green 3rd line: Biannual quality review by the ICB raised no quality concerns, Q3 in 2025/26, Green Internal audit review of incident management during August 2025. Outcome received and submitted to Audit & Risk Committee, action plan underway Amber	Currently no PSIRF lead, however, there are appropriate trained PSIRF investigators and PSIRF principles are followed. There is a backlog of historical incidents which may have been reviewed but are not yet closed, a working group is actively addressing this. Ongoing work required to ensure leadership visibility within services to enable learning, support and improvement.
Complaints process - in line with national guidance and quality priority for 25/26. Process in place to hear patient voice and respond in a timely fashion	1st line: Summary complaint reports collated and actively managed through directorates and groups reporting into Quality Committee, Green 2nd line: Quality and safety sub-committee of Board and executive sub-committee for quality in place with oversight of quality and safety matters Green Responsiveness to patient complaints is embedded within assurance on 2025/26 quality priorities, Green Patient stories to Board, November 2025, Green Annual Complaints Report, July 2025, Green 3rd line: Reporting demonstrates that there have not been any complaints escalated to the PHSO during 2024/25 and 2025/26 to date, February 2026, Green	

BAF008 - QUALITY

Speaking up mechanisms - including Direct to line manager, Freedom to Speak Up Guardian, Tell Liz, Ask Abigail, Whistleblowing ensure opportunities for an open and honest culture in which quality of care can thrive	1st line Continuous and consistent utilisation of speak up mechanisms with good real-time feedback on response received by people speaking up reported to Quality & Safety Committee, Green 2nd line: Reporting to the Audit and risk committee demonstrates that there are numerous channels available for staff to speak up. Progress is being made to drive opportunities for improvement through key strategic priority 3: 'Enhance inclusive collaborative culture including behaviours framework and speaking up' reported monthly through IQPR Green 3rd line: Reports from FTSU guardian to Board demonstrate an increase in speak ups since the independent guardian has been in post, however, further strengthening of speaking up through internal routes was recommended by the FTSU guardian, May 2026, Amber	Staff survey results demonstrate a decline in the percentage of staff who feel safe to speak up and confidence that concerns will be addressed, June 2025. Action plan and monitoring required. Biannual Raising concerns paper identified a reduction in 'Tell CNO' enquiries which may be linked to lack of anonymity, to review and monitor for next paper. July 2026
Clinical audit - plan to identify risks to quality, safety and effectiveness of care	1st line: Quality and Compliance Team regularly monitoring against audit and effectiveness standards. Green Preparedness for regulatory body review is embedded in Ward to Board business as usual plans and scrutiny. Amber 2nd line: Quality and safety sub-committee of Board and executive sub-committee for quality in place with oversight of quality and safety matters Green Reporting on compliance with audit programme and NICE guidelines through ECQR demonstrates that where the Trust is not compliant, there are mitigations in place to manage the risks, February 2026, Green Board Seminar including focussed discussion on CQC preparedness, April 2026, Green 3rd line: Audit embedded in 2025/26 quality priorities and therefore reporting into Quality Account, Green	Constraints in IT resources limiting optimal data collection through digital systems need to be addressed. Ongoing work to ensure CQC preparedness across the Trust
Safe staffing procedures in place to ensure staffing fill rate does not fall below 98%.	1st line: Daily monitoring of staffing levels by HoNs demonstrates safe staffing levels. Staffing fill rate does not fall below 98%, October 2025, Green 2nd Line Quality and safety sub-committee of Board and executive sub-committee for quality in place with oversight of quality and safety matters, November 2025, Green	Reconfiguration of nursing staff complete and review of the impact on quality is required October 2026

	Six monthly report to Board demonstrates procedures are in place and inpatient staffing levels are safe, and have been reviewed in line with cost improvement plans, January 2026, Green 3rd line: NHSE Oversight of safer staffing processes and compliance, Green	
Digital transformation - Archie EPR implementation included extensive clinical engagement which must continue through transition to Archie PAS and other digital transformation priority programmes	1st line: CNIO in post with clinical safety capability supporting maintenance of hazard log and clinical safety case, further Clinical Safety Officers (CSOs) trained and supporting this work. CCIO in place and supporting improvement in end user experience, Green 2nd line: Third party vendor provided independent clinical safety assessment for Archie EPR to ensure areas of non-compliance with DCB1060 highlighted prior to go live, remaining actions completed by Archie EPR Programme Team. Internal CSOs trained and collaborating to support further digital transformation including PAS supported with mentorship from the third-party vendor, Green	Funding constraint in ongoing support for the digital transformation programme including clinical safety for 26/27
Clinical Governance reporting framework established	1st line: Dedicated clinical governance staff time to ensure consistent recognition and evaluation of quality and safety metrics, Green 2nd line: Quality and safety sub-committee of Board and executive sub-committee for quality in place with oversight of quality and safety matters, November 2025, Green Reporting through revised Quality, Safety and (clinical) Risk infrastructure to regularly evaluate achievement against metrics and learning from triangulated data, Green 3rd line: Report from Well-led review pending, due July 2026, Amber	Reflection on clinical governance structure and processes will be required on receipt of the Well-led review report.
Staff Training – Designated leadership in clinical professional learning. Electronic and face to face training environments.	1st line: Line manager oversight of training compliance through ESR, Green 2nd line: MAST training compliance monitored and acted upon through Quality committee, Green 3rd line: Provider assurance framework includes oversight of training data, Green	
Clinical Risk Management – drives understanding and action on identified risk to quality and safety.	1st line: Inphase risk management system in place to manage risk, Green 2nd line: Quality and safety sub-committee of Board and executive sub-committee for quality in place with oversight of quality and safety matters, November 2025, Green IQPR, ECQR and local clinical governance meetings where risk evaluation takes place, Green	Lack of robust process for risks to be escalated and approved to the risk register. Limited ability to triangulate risk with other clinical governance data due to recording in separate systems (eg. Inphase/Datix). Ensure external audit of risk management completed

BAF008 - QUALITY

	3rd line: External auditing of risk management	

Actions	Timescale	Lead	Status (complete, on track, off track, not yet started)
1. Evidence of actions following staff survey address deficiencies in staff confidence to speak up needs to be addressed through behavioural framework initiatives and evidenced in regular reports	31 March 2027	CPO, CNO, CMO	In progress / ongoing
2. Quality and Equality Impact Assessment Policy being revised to incorporate QIA, EIAs and ongoing monitoring / assurance	31 August 2026	CNO, COO, CMO, CIP Leads	In progress
3. Review PSIRF policy and ensure resource in place to maintain effective and timely management of incidents following completion of the working group addressing historical incidents	31 October 2026	CNO, Head of Safety & Patient Experience	In progress
4. Biannual Raising concerns paper identified a reduction in 'Tell CNO' enquiries which may be linked to lack of anonymity, to review and monitor for next paper	31 July 2026	CNO, Head of Safety & Patient Experience	Pending
5. Weekly meeting between the CNO, Deputy CNO and Head of Quality & Compliance to review CQC preparedness	31 March 2027	CNO, Dep CNO, Head of Quality & Compliance	Ongoing
6. Reconfiguration of nursing staff and review of the impact on quality once in place to include care of patients in outpatient environment	31 October 2026	CNO	In progress
7. Funding applications submitted to NHSE to support ongoing digital transformation programme, result awaited	31 August 2026	CDIO, CMO	Pending
8. Reflection on clinical governance structure and processes will be required on receipt of the Well-led review report.	31 September 2026	CNO, CMO	Pending
9. Embedded risk management process and adherence to policy.	31 March 2027	Trust Secretary	In progress / ongoing
10. Exploration of quality management systems to enable triangulation of intelligence.	31 October2026	CMO, Head of Quality and Compliance, Company Secretary	In Progress
11. Senior leaders to dedicate time for visibility within services to enable learning, support and improvement.	31 September 2026	Executives & Senior Leaders	In progress / ongoing
12. Ensure external audit of risk management completed	31 March 2027	Company Secretary	Pending

Links to Organisational Risk Register	16 (mental capacity act), 17 (staff may not speak up with concerns), 38 (environment on peanut ward), 117 (medical devices), 125 (mental health provision), 189 (sustainability of key serv

BAF009 - REGULATION

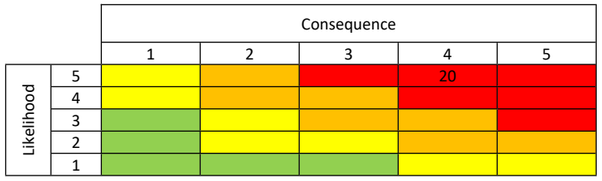
KSO1	KSO2	KSO3	KSO4	KSO5	Overall Assurance Rating (RAG)	Q3- 2025/26	Q4- 2025/26	Q1- 2025/26			
✓	✓	✓	✓	✓							

BAF

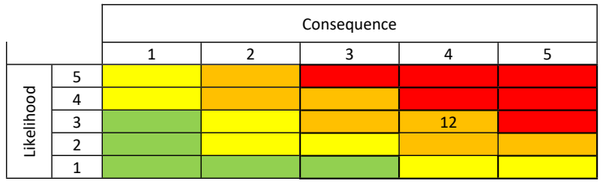
Risk description
Risk:
There is a risk that the Trust may not be able to meet its regulatory requirements
Caused by:
Scale; cost improvement plans; corporate savings; turnover at Board level; non-compliance; leadership capacity; national changes to requirements
Resulting in:
Damage to reputation; non-removal of additional licence conditions; regulatory intervention

Responsible committee	Audit and Risk committee	**Date Risk Added:**	13 November 2025		
Principal Exec – Risk Owner	Chief executive officer	**Date Risk last reviewed:**	10 June 2026		
Risk Handler(s)	Company secretary	**Date Risk last formally discussed:**	14 May 2026	**Group**	Trust Board

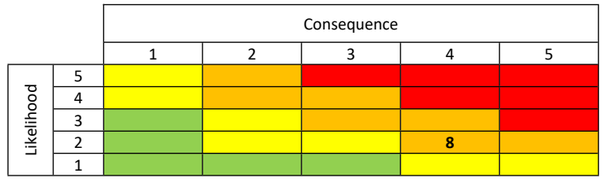
Inherent Score



Current Score



Target Score



Direction of travel since last review	⟷
Target date	July 2026
Risk tolerance	Current risk score outside of risk appetite (higher) (minimal)

Controls (what are we doing about risk)	Assurances and RAG rating (how do we know if it's working)	Gaps in assurance (what additional assurance is needed)
Key Trust policies in place aligned to statutory and regulatory requirements	1st line: Reporting to the ECQR demonstrates that a revised 'policy for policies' is in place and has been disseminated to staff. The revised policy for policies seeks to ensure consistency for policy management across the Trust, however further assurance is required to demonstrate improvements with policy management, July 2025, Amber (see action 1) Reporting to the ECQR demonstrates that a robust process is in place to ensure that policy owners are made aware when policies are expiring incl the deadline and process for updating them, December 2025, Green Oversight dashboard in place as of Q4 2025/6. Policies at 92% compliance as of June 30 2026, Green 2nd line:	Assurance that the 'policy for policies' has been embedded and driving improvements in policy management Assurance that progress is being made in updating out of date policies or taking them out of circulation if they are deemed to be duplicative/ no longer required

	Reporting to the ECQR on out of date policies demonstrates that of 239 active policies, 19 are out of date which is an decrease since the last review. No key corporate policies are out of date, June 2026, Green (see action 2) 3rd line: Internal Audit reported that 28 actions arising in 2025/26 had been implemented, including all high-priority actions, with remaining actions monitored through Audit & Risk Committee. June 2026, Green	
Governing documents in place including Trust Constitution, Scheme of delegation and reservation of powers, Standing financial instructions aligned to statutory and regulatory requirements	1st line: Reporting to the Audit and risk committee regarding compliance demonstrates no known breaches since Q4 2024/25, June 2026, Green 2nd line: Approved Annual Governance Statement conclusion for 2025/26 demonstrates no significant control issues. This is aligned to the Head of Internal Audit opinion, June 2026, G Green 3rd line: Head of Internal Audit Opinion 2025/26 concluded that there are areas with a generally sound system of internal control designed to meet the Trust's objectives and that controls are generally being applied consistently, although some improvements can be made, June 2026, Green The Trust received confirmation in March 2026 that its additional licence conditions have been removed due to the Trust's work on its strategy and strategic partnership and the strong relationship between the Board and Council of Governors, March 2026, Green	
Annual Provider Capability Assessment demonstrating Board awareness of gaps against key lines of enquiry from the Insightful Provider Board guidance	1st line: Provider capability assessment undertaken by the Board demonstrates a confirmed rating for quality of care and people and culture and a partially confirmed rating for other areas. The submission demonstrated action being taken to address gaps. An update on the progress against the gaps was taken to Audit & Risk committee in June 2026. June 2026, Amber (see action 5) 3rd line: Review of Provider capability assessment undertaken by NHSE and QVH received a rating of Amber/Green which is aligned to the Trust's own assessment, March 2026, Green	Review of progress against actions to address gaps- scheduled for June 2026
Code of Governance for NHS Provider trusts	2nd line: Annual review of compliance against the Code of Governance for NHS provider trusts to Board demonstrates one area of non-compliance during 2025/26, related to NED pay. This is compared to multiple areas of compliance being reported in previous years. March 2026, Green	

Actions	**Timescale**	**Lead**	**Status** (complete, on track, off track, not yet started)
1. Review of effectiveness of 'policy for policies'	July 2026	CS, executive team	On track
2. Continued oversight of management of out of date policies incl. priority areas	Ongoing	Policy owners	On track
3. Develop Governance handbook to support staff across organisation	March 2026	CS	First draft complete

BAF009 - REGULATION

4. Assurance to Audit and risk committee about compliance with governing documents	March 2026	CS, CFO	Completed
5. Review of progress against actions to address gaps within Provider capability assessment	June 2026	CEO, CS	Completed – June Audit & RIsk committee update paper
Links to Organisational Risk Register			

BAF010 – SUSTAINABILITY AND STRATEGY

KSO1	KSO2	KSO3	KSO4	KSO5	Overall Assurance Rating (RAG)	Q3- 2025/26	Q4- 2025/26	Q1- 2026/27			
✓	✓	✓	✓	✓							

BAF

Risk description

Risk:
There is a risk that the Trust will not secure long-term sustainability
Caused by:
Inability to progress the strategic partnership; Potential delays in progressing the partnership; Challenges with progression of partnership implementation and associated decision making; a potential breakdown in relationship between the Board and the Council of Governors; leadership capacity and resilience challenges; changes to the commissioning of services; changes to service specifications; staff morale; time constraints
Resulting in:
Sustainability challenges for patient services/ site; priority shift of QVH Strategy 2025-2030; regulatory intervention; reputational damage; non-delivery of recurrent annual financial, productivity and efficiency savings

Responsible committee	Strategy and Culture Committee	**Date Risk Added:**	13 November 2025		
Principal Exec – Risk Owner	Acting Chief Strategy Officer	**Date Risk last reviewed:**	15 June 2026		
Risk Handler(s)	Acting Chief Strategy Officer	**Date Risk last formally discussed:**	14 May 2026	**Group**	Board of Directors

Inherent Score

Likelihood \ Consequence	1	2	3	4	5
5				20	
4					
3					
2					
1					

Current Score

Likelihood \ Consequence	1	2	3	4	5
5					
4					
3					15
2					
1					

Target Score

Likelihood \ Consequence	1	2	3	4	5
5					
4					
3					
2					10
1					

Direction of travel since last review	⟷	**Target date**	December 2026
		Risk tolerance	Current risk score outside of risk appetite (higher) (open)

Controls (what are we doing about risk)	Assurances and RAG rating (how do we know if it's working)	Gaps in assurance (what additional assurance is needed)
Engagement with strategic partners- regarding partnership arrangements and implementation	1st line: Partnership steering group (internal established and considers engagement with partners, March 2026, Green Reporting on engagement with partners to Strategy and culture committee demonstrates that engagement is effective and that progress is being made against the plan, February 2026, Green 3rd line: Weekly partnership working group established between partners, January 2026, Green Regular meetings established between Chairs and CEOs, March 2026, Green	Joint Transformation committee across partners

	Lead Governor visit to RSFT May 2026, Green Further walk in workshop planned for staff and volunteers June 2026, Green	
Engagement with key stakeholder's incl. NHSE and ICB- regarding potential partnership arrangements and option appraisal process incl. staff, patients, members, Council of Governors, primary care partners	1st line: Reporting to the Strategy and Culture committee demonstrates wide ranging engagement undertaken internally and externally from September 2025, Green Communication and engagement plan for next phase has been agreed between partners from April 2026, Green Shared lines of communication for the phase April – June 2026 have been developed and agreed across all three partners, Green Development of further shared lines of communication required for the next phase (pending July 2026 Board meetings) across all three organisations, Amber	Stakeholder analysis across all partners to be completed
Timeline - Agreed timeline in place to keep track of key milestones incl. Chair and CEO in place by September 2026 and key decision-making points	1st line: Reporting to the Strategy and Culture committee outlining the timeline demonstrates that the Trust is meeting milestones, however the timeline remains challenging, June 2026, Amber (see action 1) Progress continues across programme workstreams, with commencement of workstreams and finance reviews from NHSE and RSFT CFO completed, Green 3rd line: Continued engagement with NHSE demonstrates alignment with key timelines, May 2026, Green	Decision making by partner Boards in early summer following the period of shared planning, analysis and assurance, RSFT/ ASPH Private Board meetings 3 and 4 June 2026 Outcome of QVH well led leadership and governance review in July 2026 Contingency planning in the event of a delay in implementing the partnership in July 2026 MoU to developed and approved by all three Boards in July 2026
Governance and oversight - Oversight by the Strategy and culture committee (SCC) and Board including input from Council of Governors and Strategic assurance group. Strategic direction by NHSE and ICB	2nd line: Ad-hoc Strategic Assurance Group (SAG) made of up internal key stakeholders in place to ensure critical decision making is appropriate and transparent, May 2026, Green 3rd line: Monthly QVH internal Partnership Steering Group in place from March 2026, Green Weekly Partnership working group between QVH and RSFT/ASPH in place from March 2026, Green	
Partnership implementation plan- incl. six key workstreams: Programme management, Corporate governance, Communication and engagement, Leadership and culture, Financial and planning alignment 2026/27, Clinical and corporate alignment	1st line: Reporting to Strategy and culture committee demonstrates that implementation plan is in place and progressing from February 2026, Green 2nd line: Six key workstreams have assigned executive senior responsible officers and risks have been identified with mitigations, March 2026, Green 3rd line:	Benefits realisation for partnership to be further developed Proposed governance structure for partnership not yet defined

BAF010 – SUSTAINABILITY AND STRATEGY

	Financial governance review of QVH undertaken by NHSE demonstrates no concerns. Recommendations will be monitored by the Partnership steering group, March 2026, Green Review of financial documents undertaken by partners Chief finance officer demonstrates no significant concerns, March 2026, Green Awaiting outcome of QVH Well-Led governance review July 2026, Amber	

Actions	**Timescale**	**Lead**	**Status** (complete, on track, off track, not yet started)
1. Continued engagement including internal and external stakeholders	Ongoing until implementation	DCSO	On track
2. Governance arrangements in place to support December decision making – including Board to Board meetings	November 2025	AJ/ LM	Complete
3. Development of FAQ document for staff and key stakeholders	December 2026	DCSO	Complete with ongoing updates as they arise
4. Development of transition and implementation (incl. Governance) plan for partnership	March 2026	CEO, DCSO, CS	Complete with ongoing updates as they arise
1. Timeline for transition planning needs to be agreed between partners	March 2026	Chair, CEO	Complete- agreed to work in parallel
2. Communication and engagement plan needs to be agreed between partners	March 2026	DCSO	Complete with ongoing updates as they arise
3. RSFT/ASPH Stakeholder analysis to be completed in July	July 2026	Acting CSO	On track
4. Arrangements to be made for QVH to join partners Transformation committee	August 2026	Acting CSO	On track
5. QVH well led review of leadership and governance	July 2026	CS	On track
6. Benefits realisation for partnership draft to be shared with SCC	August 2026	Acting CSO	On track
7. Contingency planning in the event of a delay in implementing the partnership	July 2026	Board	On track
8. Board sign off of partnership MoU across all three Trusts	July 2026	Board	On track

Links to Organisational Risk Register	132 (delivery of QVH Strategy 2025-2030), 189 (long term sustainability of key services), 208 (shared chair and ceo timeline), 223 (leadership capacity during partnership transformation), 224 (staff uncertainty and resistance to change), 225 (reduced leadership presence and visibility across QVH), 226 (finance and benefits), 234 (stakeholder confidence)

Report cover-page					
References					
Meeting title:	Board of Directors				
Meeting date:	09/07/2026		**Agenda reference:**	**41-26**	
Report title:	Standing orders (SOs), Scheme of delegation & reservation of powers (SoD RoP) and Standing financial instructions (SFIs)				
Sponsor:	Jamie O'Callaghan, interim Company secretary Ross Dunworth, interim Chief finance officer				
Author:	Jamie O'Callaghan, interim Company secretary 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 revised governing documents for Board approval (as recommended by the Audit & Risk Committee)				
Summary of key issues	• An annual review of the Standing Orders (SOs), Scheme of Delegation & Reservation of Powers (SoD RoP) and Standing Financial Instructions (SFIs) has been undertaken. • No substantive amendments are proposed as part of this review. • Minor updates have been made to reflect current dates only. • The documents remain fit for purpose and continue to provide an effective framework for the governance and operation of the Trust. • It is noted that amendments may be required in due course to reflect any strategic partnership arrangements with Royal Surrey NHS Foundation Trust and Ashford and St Peter's Hospitals NHS Foundation Trust. • The Audit and Risk Committee considered the documents on 24 June 2026 and recommended them to the Board for approval.				
Recommendation:	The Board is asked to **approve** the Standing Orders, Scheme of Delegation & Reservation of Powers, and Standing Financial Instructions.				
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:	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 & Risk Committee			
	Date:	24 June 2026	Decision:	
Next steps:				

Report to:	Board of Directors
Agenda item:	41-26
Date of meeting:	09 July 2026
Report from:	Jamie O'Callaghan, interim Company secretary, Ross Dunworth, interim Chief finance officer
Report author:	Jamie O'Callaghan, Company secretary, Jonathan Wharton, deputy Chief finance officer, Charles Kirabo, Head of procurement
Date of report:	11 June 2026
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 is required to review the Trust's governing documents (Standing Orders, Scheme of Delegation & Reservation of Powers, and Standing Financial Instructions) annually.

The Standing Orders, together with the Reservation of Powers and Scheme of Delegation (RoP SoD) and Standing Financial Instructions (SFIs), provide a comprehensive framework for the functions of the Trust. The RoP SoD and SFIs have effect as if incorporated into the Standing Orders.

A review of the documents has been undertaken by the Company Secretary and Chief Finance Officer. As part of this annual review, no substantive changes are proposed, with the exception of minor updates to reflect current dates.

The revised documents were considered by the Audit and Risk Committee on 24 June 2026. The Committee reviewed the proposed changes and recommended the Standing Orders, Scheme of Delegation & Reservation of Powers, and Standing Financial Instructions to the Board of Directors for approval.

Standing orders

No substantive amendments are proposed to the Standing Orders as part of this review, other than updates to dates where required and minor wording amendments:

- Under 3.8, additional wording added *'The chief medical officer shall also be responsible for effective professional leadership to the dental, pharmacist and healthcare science workforce but with management of these staff devolved into the clinical directorates.'*
- Under 3.9 additional wording added '*and Allied Health Professionals (AHPs*)'

Scheme of delegation and reservation of powers
No substantive amendments are proposed to the Scheme of Delegation and Reservation of Powers as part of this review, other than updates to dates where required and minor wording adjustments:

- Under Committee Delegation on page 10, Strategic Development Committee updated to Strategy and Culture Committee.

Standing financial instructions
No substantive amendments are proposed to the Standing Financial Instructions as part of this review, other than updates to dates where required.

Future amendments
It is noted that further amendments to these governing documents may be required in due course to reflect developments in relation to any strategic partnership arrangements with Royal Surrey NHS Foundation Trust and Ashford and St Peter's Hospitals NHS Foundation Trust.

Recommendation
The Board is asked to **approve** the Standing Orders, Scheme of Delegation & Reservation of Powers, and Standing Financial Instructions

Queen Victoria Hospital NHS Foundation Trust

Standing orders for the Board of Directors

Approved by the Board of Directors at its meeting on ~~10~~ 09 July 202~~5~~6

Contents

Introduction

Statutory framework

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

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

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

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

1 Interpretations and definitions

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

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

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

1.4 In these SOs:

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

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

Audit 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.

Chief Medical Officer

3.8 The 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 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. The chief medical officer shall also be responsible for effective professional leadership to the dental, pharmacist and healthcare science workforce but with management of these staff devolved into the clinical directorates.

Chief Nursing Officer

3.9 The Chief Nursing officer shall be responsible for effective professional leadership and management of nursing staff and Allied Health Professionals (AHPs) of the Foundation Trust. The Chief Nursing officer 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 and AHPs 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 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 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.

Queen Victoria Hospital
NHS Foundation Trust

Queen Victoria Hospital
NHS Foundation Trust

Reservation of Powers and Scheme of Delegation

Effective from 0910 July 2026

Approved by the Board of Directors at its meeting on 0910 July 2026

Contents

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
- Strategy~~ic development~~ and Culture 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; • Ensuring the production of annual governance statement for inclusion in trust's annual report; • Provision of annual reports; • Ensuring effective liaison with relevant counter fraud services regional team or NHS protect; and • Deciding at what stage to involve police in cases of misappropriation or other irregularities.	3.3.1
Responsible for the promotion of counter fraud measure within the trust and ensure that the trust co-operate with NHS protect in relation to the prevention, detection and investigation of fraud in the NHS.	3.6.2
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 protect 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 Protect 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

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

Approved by the Board of Directors July 2026~~5~~

Contents

1 INTRODUCTION TO STANDING FINANCIAL INSTRUCTIONS

1.1 Purpose of the Standing Financial Instructions

1.1.1 The Standing Financial Instructions ("**SFIs**") explain the financial responsibilities, policies and procedures to be adopted by Queen Victoria Hospital NHS Foundation Trust ("**the Trust**"). These SFIs detail the financial responsibilities, policies and procedures to be adopted by the Trust, They are designed to ensure that its financial transactions are carried out in accordance with the law, Government policy in order to achieve probity, accuracy, economy, efficiency and effectiveness in all financial matter concerning the Trust. These SFIs should be used in conjunction with the Reservation of Powers to the Board and the Delegation of Powers adopted by the Trust.

1.1.2 These SFIs together with the Standing Orders and supported by the Reservation of Powers and Schemes of Delegation (SoD), provide a suite of governance documents for the Trust to operate within, and set the rules under which Directors, Officers and third parties contracted to the Trust are required to work.

1.1.3 These SFIs have been complied under authority of the Board of Directors of the Trust. They have been reviewed by the Audit Committee and by the Board of Directors and have their full approval.

1.1.4 Any questions relating to the SFIs should be referred to the Chief Finance Officer, Deputy Chief Finance Officer or their nominated Officer. Any questions relating to the Standing Orders should be referred to the Company Secretary. The SFIs and SoD are formally adopted by the Board of Directors and shall be reviewed annually by the Trust.

1.1.5 For the avoidance of doubt, the SFIs and SoD apply to all Trust and Charitable Funds activity, including research and development, training and education, joint ventures and special purpose vehicles, unless specific exceptions are described in the sections of this document covering those areas.

1.2 Interpretation and definitions

1.2.1 Save as otherwise permitted by law, at any meeting of the Board of Directors the Chair of the Trust (or 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.

"**UK procurement financial thresholds**" are limits set that define which specific procurement rules apply during a procurement episode.

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;

(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, they 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 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 their functions effectively and efficiently and, in particular, that 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 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 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.

Competitive quotations

9.3.2 Quotations should be obtained from the number of firms/individuals shown in the SoD 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.,

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 Officers as set out within the SoD.

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.

9.10 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 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 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 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 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 the 'Light Touch Regime' (LTR) of the Procurement Act 2023. Any tendering for these services should be discussed with the Head of Procurement to identify the suitable 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 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.

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 Chief Finance Officer, the Chief People Officer and/or the Deputy 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:	09/07/2026	**Agenda reference:**	**42-26**		
Report title:	Company Secretary's report				
Sponsor:	Jamie O'Callaghan, interim Company secretary				
Author:	Jamie O'Callaghan, interim Company secretary				
Appendices:	Appendix one: Nomination and remuneration committee terms of reference				
Executive summary					
Purpose of report:	To provide the Board with assurance regarding the Trust's compliance with the Fit and Proper Persons Test (FPPT) requirements and to seek approval of the annual review of the Nomination and Remuneration Committee Terms of Reference.				
Summary of key issues	• The Audit and Risk Committee received assurance on 24 June 2026 that the Trust remains compliant with the NHS England Fit and Proper Persons Test (FPPT) Framework and associated legislative requirements. • Annual FPPT checks for all Board members, including checks of disqualified directors, charitable trustees, employment tribunal and insolvency registers, were completed with no issues identified. • The Trust Chair completed the annual FPPT assessment and submitted confirmation of the fitness of all Board members to the NHS England Regional Director before the 30 June 2026 deadline. • The Nomination and Remuneration Committee completed its annual review of its Terms of Reference on 14 May 2026 and recommended them to the Board for approval without amendment				
Recommendation:	The Board is asked to: • Note the compliance with Fit and proper persons (FPPT) requirements • Approve the Nomination and remuneration committee terms of reference as appended				
Action required	**Approval**	Information	Discussion	**Assurance**	Review
Link to key strategic objectives (KSOs):	**KSO1:**	**KSO2:**	**KSO3:**	**KSO4:**	**KSO5:**
	Outstanding patient experience	***World-class clinical services***	***Operational excellence***	***Financial sustainability***	***Organisational excellence***
Implications					
Board assurance framework:	BAF5- compliance				
Organisational risk register:	Organisational risk related to compliance with governing documents- the score has been reduced				
Regulation:	Code of governance Licence conditions Annual reporting manual				
Legal:	None				
Resources:	None				
Assurance route					
Previously considered by:	ELT, Audit and risk committee, Nomination and remuneration committee				
	Date:		Decision:		
Next steps:	NA				

Report to:	Board Directors
Agenda item:	42-26
Date of meeting:	09 July 2026
Report from:	Jamie O'Callaghan, interim Company secretary
Report author:	Jamie O'Callaghan, interim Company secretary
Date of report:	02 July 2026
Appendices:	Appendix one: Nomination and remuneration committee terms of reference

Company secretary's report

Introduction

This report provides assurance regarding the Trust's compliance with the NHS England Fit and Proper Persons Test (FPPT) Framework and presents the outcome of the annual review of the Nomination and Remuneration Committee Terms of Reference for Board approval. The report supports the Board in discharging its responsibilities for good governance, compliance with statutory and regulatory requirements, and oversight of Board committee arrangements

Annual review of compliance with Fit and proper persons (FPPT) requirements

The Audit and Risk Committee received the Annual Review of Compliance with FPPT Requirements report at its meeting on 24 June 2026. The report provided assurance regarding the Trust's compliance with the NHS England Fit and Proper Persons Test (FPPT) Framework and associated legislative requirements.

NHS England published a revised FPPT Framework for Board members in August 2023 following the recommendations of the Kark Review. While the statutory requirements under Regulation 5 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 remain unchanged, the framework provides a consistent approach to evidencing compliance. The Trust achieved full implementation of the framework by March 2024 and has maintained compliance since that time.

The Committee noted that annual FPPT checks had been completed for all Board members, including checks of the registers of disqualified directors, charitable trustees, employment tribunals and insolvency. All checks were satisfactory. The Committee also noted that Board member appraisals had been completed and that appropriate FPPT references had been obtained for Board-level appointments during the year.

The report concluded that the requirements of the FPPT Framework had been met and that there were no matters of concern to report. Any FPPT concerns raised during the year had been investigated appropriately.

Following review of the evidence for each Board member, the Trust Chair completed the annual FPPT submission and provided confirmation of the fitness of all Board members to the NHS England Regional Director before the 30 June 2026 deadline.

The Audit and Risk Committee was therefore assured that the Trust remained compliant with the requirements of the FPPT Framework.

Annual review of committee terms of reference

Nomination and remuneration committee

In accordance with good governance practice, the Nomination and Remuneration Committee undertakes an annual review of its Terms of Reference to ensure they remain current, effective and aligned with the Committee's responsibilities, the Trust's governance framework and relevant regulatory requirements.

At its meeting on 14 May 2026, the Committee completed its annual review of the Terms of Reference and concluded that they remain fit for purpose. The Committee agreed that no amendments were required and recommended the Terms of Reference to the Board for approval

These terms of reference are included as appendix one to this report for approval.

Recommendation
The Board is asked to**:**

- **Note** the compliance with Fit and proper persons (FPPT) requirements
- **Approve** the Nomination and remuneration committee terms of reference as appended

Terms of reference
Name of governance body
Nomination and Remuneration Committee
Constitution
The Nomination and remuneration committee (the Committee) is constituted as a statutory non-executive committee of the Trust's Board of Directors.
Accountability
The Committee is accountable to the Board of Directors for its performance and effectiveness in accordance with these terms of reference.
Authority
The Committee is authorised by the Board of Directors to: • Appoint or remove the chief executive, and set the remuneration and allowances and other terms and conditions of office of the chief executive. • Appoint or remove the other executive directors and set the remuneration and allowances and other terms and conditions of office of the executive directors, in collaboration with the chief executive. • Consider any activity within its terms of reference. • Seek relevant information from within the Trust. (All departments and employees are required to co-operate with any request made by the committee). • Instruct independent consultants in respect of executive director remuneration. • Request the services and attendance of any other individuals and authorities with relevant experience and expertise if it considers this necessary to exercise its functions.
Purpose

The purpose of the Committee is to:
• Determine the structure, size and composition (including the skills, knowledge, experience, diversity and development) of the Board of Directors, making use of the output of the board evaluation process as appropriate, and to make recommendations to the Board, as applicable, with regard to any changes.
• Work with the chief executive to identify and appoint candidates to fill all executive director and other positions that report to the chief executive.
• Work with the chief executive to decide and keep under review the terms and conditions of office of executive directors and other positions that report to the chief executive, including:
  • Salary, including any performance-related pay or bonus;
  • Provisions for other benefits, including pensions and cars;
  • Allowances;
  • Payable expenses;
  • Compensation payments.

- Determine remuneration packages and contractual terms of the executive management team in line with benchmarking and national guidance.

Duties and responsibilities

Duties (nominations)

- When a vacancy is identified, evaluate the balance of skills, knowledge and experience on the Board, and its diversity, including diversity of skills, experience and knowledge and in the light of this evaluation, prepare a description of the role and capabilities required for the particular appointment.
- Use open advertising or the services of external advisers to facilitate candidate searches.
- Give full consideration to succession planning, taking into account the future challenges, risks and opportunities facing the Trust and the skills and expertise required to meet them.
- Ensure that appointments and succession plans are based on merit and objective criteria and, within this context, promote diversity of gender, social and ethnic backgrounds, disability and personal strengths.
- Ensure that proposed appointees disclose any business interests that may result in a conflict of interest prior to appointment and that any future business interests that could result in a conflict of interest are reported.
- Ensure that proposed appointees meet the “fit and proper person test”, and confirm their awareness of the circumstances which would prevent them from holding office.
- Consider any matter relating to the continuation in office of any executive director including the suspension or termination of service of an individual as an employee of the Trust, subject to the provisions of the law and their service contract.

Duties (remuneration)

- Establish levels of remuneration which are sufficient to attract, retain and motivate executive directors of the quality and with the skills and experience required to lead the Trust successfully and collaborate effectively with system partners, without paying more than is necessary for this purpose, and at a level which is affordable for the Trust. To do this, the committee will:
    - Follow the national NHSE VSM (very senior manager) pay strategy and associated QVH VSM pay principles in respect of executive board directors and other positions that report to the chief executive.
    - Use market benchmarking analysis in the annual determination of remuneration of executive directors and other positions that report to the chief executive.
    - Be sensitive to pay and employment conditions elsewhere in the NHS, especially when determining annual salary increases.
    - Ensure that increases are not made where Trust or individual performance do not justify them.
    - Ensure that pay arrangements provide equal pay for work of equal value.
    - Take into account internal relativities between the executive team and with other senior posts, both Agenda for Change and non-Agenda for Change.
    - Ensure transparent processes so that individuals know how their pay might be increased and third parties can be clear that the processes are auditable and compliant.

  - Ensure that any performance-related element of executive directors' remuneration is transparent, stretching and designed to promote the long-term sustainability of the Trust. The committee will should take as a baseline for performance any required competencies specified in the job description for the post.
  - Monitor and assess the output of the evaluation of the performance of individual executive directors, and consider this as well as continuing professional and personal development plans when reviewing changes to remuneration levels.
- Recommend and monitor the level and structure of remuneration for senior management. The Board defines senior management this purpose as the first layer of management below Board level.

- The Committee will work with the chief executive to determine the remuneration of the other executive directors.

Responsibilities

On behalf of the Board of Directors, the Committee has the following responsibilities:

- To identify and appoint candidates to fill posts within its remit as and when they arise.
- In doing so, to adhere to relevant laws, regulations, trust policies and the principles and provisions regarding the levels and components of executive directors' remuneration as defined by section E of the Code of governance for NHS provider trusts.
- To be sensitive to other pay and employment conditions in the Trust and elsewhere in the NHS, especially when determining annual salary increases.
- To keep the leadership needs of the Trust under review at executive level to ensure the continued ability of the Trust to operate effectively in the health economy.
- To give full consideration to and make plans for succession planning for the chief executive and other executive directors taking into account the challenges and opportunities facing the Trust and the skills and expertise needed on the Board in the future.
- To sponsor the Trust's leadership development and talent management programmes to support succession plans and meet specific recruitment and retention needs.
- To ratify the process for medical and dental Clinical Excellence Awards
- To review executive team skillsets, identify any gaps and consider how they should be addressed

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 usually meet four times a year.

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.

The Board of Directors, Chief Executive and Chief People Officer may request additional meetings if they consider it necessary.

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

Conflicts of interest

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

Chairing

The Committee shall be chaired by the Chair of the Trust.

If the Chair is absent or has a conflict of interest which precludes their attendance for all or part of a meeting, the Committee shall be chaired by the senior independent director of the Trust.

Secretariat

The Company secretary, working closely with the chief people officer, shall be the secretary to the Committee and provide administrative support and advice to the Chair and membership. The duties of the secretary shall include but not be limited to:

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

Membership

Members with voting rights

The Committee shall comprise all non-executive directors of the Trust who shall each have full voting rights.

Ex-officio attendees without voting rights

- Chief Executive
- Chief People Officer

In attendance without voting rights

- The secretary to the Committee (for the purposes described above)
- Any other member of the Board of Directors, senior member of Trust staff or external advisor considered appropriate by the chair of the Committee.

Quorum

For any meeting of the Committee to proceed, three non-executive members of the Committee must be present.

A duly convened meeting of the Committee at which a quorum is present shall be competent to exercise all or any of the authorities, powers and discretions vested in or exercisable by the Committee.

Attendance

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

Attendees, including the secretary to the Committee, will be asked to leave the meeting should their own conditions of employment be the subject of discussion.

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

Papers

Meeting papers shall be distributed to members and attendees at least five clear days* prior to the meeting.

Reporting

The Secretary shall minute the proceedings and decisions of all meetings of the Committee, including recording the names of those present and in attendance. Draft minutes will be submitted for formal agreement at the next committee meeting. The Committee chair shall prepare a report of each Committee meeting for submission to the Board of Directors at its next formal business meeting.

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 before approval by the Board of Directors at its meeting in May 2027~~6~~.

* Definitions

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