Bundle Public Board 11 September 2025

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Jackie Smith, Trust Chair

59.25 Draft minutes of the public meeting held on 10 July 2025
Jackie Smith, Trust Chair
Approval

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Jackie Smith, Trust Chair
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65.25 Winter plan 2025/26
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- 65-25 (FC) Winter plan 2025-26
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- 66-25 ORR August 2025
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68.25 Gender Pay Gap report 2024/25
Helen Edmunds, Chief people officer
Approval

68-25 Gender pay gap report

68-25.1 Gender pay gap report

69.25 Ethnicity Pay Gap report 2024/25
Helen Edmunds, Chief people officer
Approval

69-25 Ethnicity pay gap report

69-25.1 Ethnicity pay gap report

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

70-25 ARC assurance report September 2025 FINAL

71.25 Quality and safety committee assurance
Shaun O'Leary, Non-executive director and committee Chair
Assurance

71-25 QSC assurance report September 2025 FINAL

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

72-25 FPC assurance report September 2025 FINAL

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

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

Queen Victoria Hospital
NHS Foundation Trust

Business Meeting of the Board of Directors

Thursday 11 September 2025

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

MEMBERSHIP
BOARD OF DIRECTORS
September 2025

Members (voting):

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

In full attendance (non-voting):

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

Annual declarations by directors 2025/26

Declarations of interests

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

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

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

Register of declarations of interests

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

Peter O'Donnell Non-Executive Director	Non-executive director for Nottingham Building Society Non-Executive Director at OneFamily	Nil	Nil	Nil	Nil	Nil	Nil	Nil
Shaun O'Leary Non-Executive Director	Nil	Nil	Nil	Chair and Trustee of St Wilfreds Hospice, Eastbourne	Nil	Nil	Nil	Nil
Russell Hobby Non-Executive Director	Director of 5 Lewes Crescent Mgt Co. Ltd Director of RVHB Ltd Non-executive director of ImpactEd	Nil	Nil	Chief executive officer of the Kemnal Multi Academy Trust	Nil	Nil	Nil	Nil

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

Jane Dickson Interim Deputy Chief Executive Officer	Non-Executive Director for Ashford and St Peters Hospitals NHS FT Director of Mull Moments (private holiday lettings company)	Nil	Nil	Nil	Nil	Nil	Nil	Nil
Aleema Shivji Associate Non-Executive Director	Director of 5 Westborne Villas Freehold Ltd and 5 Chatham Place Freehold Ltd	Nil	Nil	Nil	Nil	Nil	Nil	Nil
Vivek Chaudhri Associate Non-Executive Director	Director of Global AI Leaders Network Director of Purposeful AI	Nil	Nil	Nil	Nil	Nil	Nil	Nil

Fit and proper persons declaration

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

Register of fit and proper person declarations

	Categories of person prevented from holding office						
	The person is an undischarged bankrupt or a person whose estate has had a sequestration awarded in respect of it and who has not been discharged.	The person is the subject of a bankruptcy restrictions order or an interim bankruptcy restrictions order or an order to like effect made in Scotland or Northern Ireland.	The person is a person to whom a moratorium period under a debt relief order applies under Part VIIA (debt relief orders) of the Insolvency Act 1986(40).	The person has made a composition or arrangement with, or granted a trust deed for, creditors and not been discharged in respect of it.	The person is included in the children's barred list or the adults' barred list maintained under section 2 of the Safeguarding Vulnerable Groups Act 2006, or in any corresponding list maintained under an equivalent enactment in force in Scotland or Northern Ireland.	The person is prohibited from holding the relevant office or position, or in the case of an individual from carrying on the regulated activity, by or under any enactment.	The person has been responsible for, been privy to, contributed to, or facilitated any serious misconduct or mismanagement (whether unlawful or not) in the course of carrying on a regulated activity, or discharging any functions relating to any office or employment with a service provider.
Non-executive and executive members of the board							
Jackie Smith Trust Chair	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Paul Dillon-Robinson Non-Executive Director	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Peter O'Donnell Non-Executive Director	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Shaun O'Leary Non-Executive Director	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Russell Hobby Non-Executive Director	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Jo Emmanuel Non-Executive Director	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Tamara Everington Chief Medical Officer	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Simon Marshall Interim Chief Finance Officer	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Edmund Tabay Chief Nursing Officer	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Abigail Jago Acting Chief Executive Officer	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Helen Edmunds Chief People Officer	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Kirsten Timmins Chief Operating Officer	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Jane Dickson Interim Deputy Chief Executive Officer	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Aleema Shivji Associate Non-Executive Director	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Vivek Chaudhri Associate Non-Executive Director	N/A	N/A	N/A	N/A	N/A	N/A	N/A

Queen Victoria Hospital
NHS Foundation Trust

Business meeting of the Board of Directors
Thursday 11 September 2025
10.00-12.00

Agenda: session held in public		
WELCOME		
58-25	**Welcome, apologies and declarations of interest** *Jackie Smith, Trust Chair*	
STANDING ITEMS		**Purpose**
59-25	**Draft minutes of the public meeting held on 10 July 2025** *Jackie Smith, Trust Chair*	*Approval*
60-25	**Matters arising and actions pending from previous meetings** *Jackie Smith, Trust Chair*	*Review*
61-25	**Staff story** *Helen Edmunds, Chief people officer*	*Discussion*
62-25	**Chair's report** *Jackie Smith, Trust Chair*	*Assurance*
63-25	**Chief Executive's report** *Abigail Jago, acting Chief executive officer*	*Assurance*
PERFORMANCE		
64-25	**Integrated quality and performance report** *Kirsten Timmins, Chief operating officer* • **Estates update (Simon Marshall, interim Chief finance officer)** • **Research and Innovation update (Tamara Everington, Chief medical officer)** • **Annual assessment of addressing health inequalities (Edmund Tabay, Chief nursing officer**	*Assurance*
65-25	**Winter Plan 2025/26** *Kirsten Timmins, Chief operating officer*	*Approval*
GOVERNANCE, STRATEGY & RISK		
66-25	**Organisational risk register** *Leonora May, Company secretary* *All executive directors*	*Assurance*
ANNUAL REPORTS		

67-25	**Workforce Race Equality Standard (WRES) and Workforce Disability Equality Standard (WDES) annual reports 2024/25** *Helen Edmunds, Chief people officer*	*Approval*
68-25	**Gender Pay Gap report 2024/25** *Helen Edmunds, Chief people officer*	*Approval*
69-25	**Ethnicity Pay Gap report 2024/25** *Helen Edmunds, Chief people officer*	*Approval*
COMMITTEE ASSURANCE REPORTS		
70-25	**Audit & risk committee assurance** *Paul Dillon-Robinson, Non-executive director and committee Chair*	*Assurance*
71-25	**Quality and safety committee assurance** *Shaun O'Leary, Non-executive director and committee Chair*	*Assurance*
72-25	**Financial, workforce and operational performance assurance** *Peter O'Donnell, Non-Executive Director and committee Chair*	*Assurance*
MEETING CLOSURE		
73-25	**Any other business (by application to the Chair)** *Jackie Smith, Trust Chair*	*Discussion*
MEMBERS OF PUBLIC		
74-25	**Questions from members of the public** *We welcome relevant, written questions on any agenda item from our staff, our members or the public. To ensure that we can give a considered and comprehensive response, written questions must be submitted in advance of the meeting (at least three clear working days). Please forward questions to Leonora.may1@nhs.net clearly marked "Questions for the board of directors". Members of the public may not take part in the Board discussion. Where appropriate, the response to written questions will be published with the minutes of the meeting.* *Jackie Smith, Trust Chair*	

	Minutes (DRAFT)	
Meeting:	**Board of Directors (session in public)** **10.00-12 noon 10 July 2025** **Education Centre, QVH**	
Present:	Paul Dillon-Robinson (PDR)	Non-executive director (meeting Chair)
	Peter O'Donnell (POD)	Non-executive director (voting) [MS Teams]
	Shaun O'Leary (SOL)	Non-executive director (voting)
	Jo Emmanuel (JE)	Non-executive director (voting)
	Simon Marshall (SM)	Interim Chief finance officer (voting)
	Tamara Everington (TE)	Chief medical officer (voting)
	Edmund Tabay (ET)	Chief nursing officer (voting)
	Kirsten Timmins (KT)	Chief operating officer (voting)
	Helen Edmunds (HE)	Chief people officer (non-voting)
	Abigail Jago (AJ)	Acting Chief executive officer (voting)
	Aleema Shivji (AS)	Associate Non-executive director (non-voting)
	Vivek Chaudhri (VC)	Associate Non-executive director (non-voting)
	Leonora May (LM)	Company Secretary (minutes)
In attendance:	Jackie Doherty (JDo)	Freedom to Speak Up Guardian, The Guardian Service
Apologies:	Jackie Smith (JS)	Trust Chair (voting)
	Russell Hobby (RH)	Non-executive director (voting)
	Jane Dickson (JD)	Interim deputy Chief executive officer (non-voting)
Members of the public:	6 members of staff, 12 governors and one member of public (for patient story)	

34-25	**Welcome, apologies and declarations of interest** PDR Chaired the meeting in the absence of JS. The Chair opened the meeting welcoming members of the Board and those observing the meeting. The Chair reminded those observing the meeting that they were not invited to participate in discussions and that there will be an opportunity for governors to ask questions at the end of the meeting. Apologies were received from JS, JD and RH. There were no declarations of interest other than those already recorded on the register of interests.
35-25	**Draft minutes of the public meeting held on 8 May 2025** The Board **agreed** that the minutes of the public Board meeting held on 8 May 2025 are a true and accurate record of that meeting and **approved** them on that basis.
36 -25	**Matters arising and actions pending from previous meetings** The following updates were provided on pending actions: Action 1 (organisational culture) HE reported that work is continuing to embed the Trust's behaviour framework. There will be an ongoing assessment though a period of change via the Strategy and culture committee once established. Action 4 (compliance with governing documents) LM reported that the governing documents have been reviewed and updated to ensure that they are accessible to staff. These are being presented at today's meeting for approval. The contract management and procurement policies have been updated. A communication plan related to individual responsibilities for staff is underway and the development of the governance handbook will commence in quarter 2.

	Action 5 (cost improvement plan) SM reported that there are various updates included within the reports for the meeting. A more detailed report is being presented to the private Board meeting and the trajectories will feed in once available. This action will be closed. The Board **noted** the verbal and written updates for the actions.
37-25	**Patient story** The Board welcomed the patient who was in attendance at the meeting to share her experience of QVH with the Board. The patient described her experience as follows. The patient has had various surgical procedures at QVH and she has found the staff to be professional and kind. She was recently one of the first non-specific pathway patients for the East Grinstead community diagnostic centre (CDC) and she again found the staff to be helpful, specifically in following up with her GP about her care. The patient was awaiting results from a test she had five weeks ago and had recently discovered a diagnosis on her NHS app which she was not previously aware of. TE acknowledged two important learning points for the Trust. The first being to ensure that patients know how to use the app and that communication with patients is effective and the second being patients waiting a long time for test results which may be causing them to worry. TE thought that it should be possible for the Trust to resolve this more quickly for the patient. Discussion was had regarding the patient's experience of communication between QVH and her GP practice and AJ explained that an ambition of the ten year plan is to better connect hospitals to neighbourhood care. It is a priority for the Trust to connect with GP surgeries and work together to address issues for patients. The Board extended thanks to the patient for sharing her experience of the non-specific symptom pathway which is new to QVH. [the patient left the meeting]
38-25	**Chair's report** PDR presented the Chair's report to the Board. He highlighted: – Thanks to Chris Barham who has now stepped down as our lead governor – Janet Hall has taken up the role of lead governor and John Harold has taken up the role of deputy lead governor – Work has commenced to develop an option appraisal to consider strategic partnership options; this is a key priority for the Board – The NHS 10 year plan was published on 3 July and sets out the intention to remove the requirement for foundation trusts to have governors. Further guidance on this is expected in September 2025 The Board **noted** the contents of the report.
39-25	**Chief Executive's report** AJ presented the report to the Board, highlighting the following: - There continues to be significant challenges internally and externally and the teams are managing a great deal including with the estate and ward moves - Key risks include the Trust's financial position, delivery of performance targets and the risk to delivery of the QVH Strategy 2025-2030 given the national context and the need to align - The Trust has a material cost improvement plan of £7.5m. This is very high risk, however, the team has identified more cost reduction than ever before for QVH.

Months 1 and 2 have been delivered to plan. There is greater financial challenge ahead

- The NHS ten year plan has been published and indicates further change including with technology, being a good place to work and strengthening the patient voice. QVH had taken into account the 'three shifts' in the development of its five year strategy
- The new performance framework has been published and Trust's will report to NHSE. QVH has been placed into segment three as the Trust was in receipt of £1.5m of deficit funding from the ICB. AJ explained that she would expect the Trust to be in segment two otherwise. The Trust has been ranked 34 out of 134 for performance
- The Trust must collaborate in order for services to be sustainable. The Trust is developing an options appraisal and implementing an engagement plan. Clinical engagement has been good. Options for the future will be appropriately assessed
- QVH was rated better than expected in the CQC children and young people's survey 2024 which is testament to the hard work of all staff at QVH

The Board considered and discussed the updates as follows.

Discussion was had regarding the deficit funding received by the Trust and SM stated that most trusts have been in receipt of deficit funding this year. Trust's within Sussex are collectively managing positions as funding will be dependent on others performance. In response to a question, SM explained that this funding will likely not be available in future years and trusts will be expected to make sufficient savings.

In response to a question, AJ confirmed that the team are working through what the ten year plan means for QVH and its impact; usually this is driven through the national planning guidance. SM confirmed that there is limited clarity about how trusts will be funded, however it is expected that the move towards tariff will see the top up elements of contracts being withdrawn. The consequences of this should be understood by September 2025. The Board acknowledged the uncertainty related to funding as a strategic risk.

In response to a question from a Board member about the workforce plan controls, AJ confirmed that there are additional controls in place for temporary staffing and that the use of temporary staffing has reduced, however during month two this was impacted due to some logistical challenges with the site.

A Board member asked whether the Bognor Community Diagnostic Centre (CDC) is a risk for the Trust. In response, AJ confirmed that the team are progressing with the design of the CDC and looking to hand the project over to another organisation to manage once the building work starts.

Discussion was had regarding upcoming strike action for resident doctors. The Board acknowledged that this will have an operational impact for the Trust and its waiting lists. KT confirmed that there is a team in place who are focussed on how the Trust will deliver safe care for patients during this time.

Discussion was had regarding collaboration. In response to a question from a Board member, AJ confirmed that the Board must make a decision about its preferred partner in November 2025 and that this timeline is fixed. The Board acknowledged the challenges presented by the continued changing external landscape. AJ explained that there are strategic risks but also opportunities for which the Trust must remain agile to respond to.

The Board **noted** the contents of the report and **ratified** the strategic priorities for 2025/26 as set out within the report.

40-25	**Freedom to Speak Up Guardian report** [JDo joined the meeting] The Board welcomed JDo who had joined the meeting in person to present the report. She reported that there has been an increase in people who are speaking up being happy to have their cases escalated and that some people have been happy to share their name. She acknowledged that there is still work to do, however in general she thought that people are feeling safer to speak up. JDo suggested that managers are trained so that they are equipped when members of staff raise concerns with them, and to ensure that staff feel they are listened to and that action has been taken. A Board member asked whether speaking up training would be provided to managers and what is being done to target staff fears of speaking up. In response, AJ confirmed that a wider training package is being developed for managers and that consideration is being given to how this can be delivered, as it will be challenging to take managers away from their business as usual duties to undertake the training. She explained that a targeted approach is planned to those who need the training. Speaking up training is a priority and will be a subset of the wider training programme. A Board member asked what is done to understand and address barriers to reporting. HE explained that there have been targeted interventions to promote the freedom to speak up service and that speaking up numbers appear to have increased as a result. She acknowledged the importance of action being taken when someone speaks up, as feedback indicates that staff not feeling heard or not believing that action will be taken continues to be a barrier to speaking up. AJ outlined key actions that are being taken to ensure that people speak up, that leadership model the appropriate behaviours and that people are listened to and the appropriate action is taken. She explained that people are proactively encouraged to speak up at every opportunity, that support is in place to ensure that all staff including senior leaders understand how the Trust's behaviour framework is being implemented and their role in that and that training for managers will include guidance about what to do when a member of staff has raised a concern. A Board member asked how resolutions of concerns are tracked. In response, JDo explained that she keeps in touch with every person who has raised a concern until they are content with the outcome. She confirmed that staff are also asked if they have experienced any detriment for speaking up. This period, there has been no detriments report. The Board **noted** the contents of the report. [JDo left the meeting]
41-25	**Standing Orders, Scheme of Delegation and Reservation of Powers and Standing Financial Instructions** LM presented the report to the Board. She explained that there have been some challenges with compliance with the governing documents during 2024/25. One of the actions arising was to review these documents to ensure that they are clear and accessible to all staff. The Audit and risk committee have reviewed the changes to the documents and agreed to recommend them to the Board for approval. Significant amendments are suggested to the Scheme of delegation and reseration of powers. LM and SM described these as below: - The whole document has been reformatted to make it more accessible - Definitions have been updated to ensure that they are clear - A paragraph related to non-compliance and disciplinary action has been included - Extracts from committee terms of reference have been removed to ensure that there is no duplication - Additional guidance for business cases has been included

	- Financial have been updated to support the right decisions being by the right groups eith less escalation sirectly to the Board. The Finance and performance committee will approve contract awards of over £1m and the Board will approve contract awards of over £2m The Board acknowledged the previous challenges with compliance and the importance of understanding delegated limits. The Board **approved** the Standing Orders, Scheme of Delegation and Reservation of Powers and Standing Financial Instuctions as presented which would come into effect immediately.
42-25	**Strategy and culture committee** LM presented the report to the Board which proposed to combine key elements of the People committee and Strategic development committee to have one committee focussed on key current priorities. She explained that the draft terms of reference had been shared with Board members ahead of the meeting and that feedback received had been incorporated. RH had sent apologies to this meeting but has confirmed that he is happy with the proposal as prospective Chair of the committee. A Board member suggested that it would be helpful for the Board to be provided with a definition of what we mean by culture so that there is collective understanding. HE agreed to provide this. **ACTION HE** The Board highlighted the need to ensure clear definition between the terms of reference for the Strategy and culture committee and the Finance and performance committee. These would be reviewed. The Board **approved** the establishment of the Strategy and culture committee and its terms of reference as well as the disbanding of the People committee and Strategic development committee.
43-25	**Organisational risk register** LM presented the report to the Board as read, highlighting that: - The highest scoring risk is related to delivery of the Trust's cost improvement plan for 2025/26. Other high scoring risks are largely related to the Trust's ageing estate - There is a new high scoring risk to be added to the organisational risk register and this is related to the Trust's cash flow and reserves falling lower than the Trust would like - The current score for risk 16 (mental capacity act) has been reduced from a 16 to a 12 due to mitigating actions being put in place including the establishment of a task and finish group, appointments letters being updated and the forms and schedulers highlighting patients at risk - Since the discussion at the Finance and performance committee meeting, the risk owner has reviewed risk 153 (fire compartmentalisation) and reduced the score from 15 to 12 on basis that alarms would alert to fire and appropriate action would be taken to stop the spread of fire A Board member emphasised the need for risk owners to ensure that their risks are kept up to date. Discussion was had regarding target dates which had passed and LM explained that these risks had met their target scores. Discussion was had regarding risk 16 (mental capacity act) and SOL confirmed that the reduction in score had been discussed by the Quality and safety committee. Committee members thought that the reduction in score was reasonable given the mitigating actions which are already in place.

	The Board **noted** the contents of the report.
44-25	**Integrated quality and performance report** KT presented the report to the Board. She explained that the report has a new and improved format which she hoped is easier for readers to navigate. KT provided an update on operational performance. She raised concern about cancer performance, confirming that the Trust had not achieved the faster cancer diagnostic standard for month one and that there has been unprecedented increase in referrals for suspected skin cancer. This increase in urgent referrals will have an impact on 28 and 92 day wait lists for referral to treatment. ET provided an update on quality and safety. He reported that there are no concerns. There has been a marked improvement in ethnicity recording as part of the Trust's health inequalities work. SM provided an update on finance. For month three the Trust is currently meeting its financial plan, however this has been a challenge and the plan becomes more challenging as the year progresses. The Board acknowledged that the activity requirement increases during the year within the plan which will be a continued challenge. In response to a question, AJ confirmed that the review of the Trust's burns service has been received and that it is currently being reviewed by the executive team. The report will be shared with the Board. Discussion was had regarding consultant job plans and TE acknowledged that these have not previously been signed off in good time. Good progress is being made in this area and TE hoped to meet the August 2025 target set. The Board **noted** the contents of the report.
45-25	**Staff survey results 2024** HE presented the report to the Board. She reported that overall, the results are similar to the results of the previous survey. Compared to other acute specialist trusts, the Trust score average or above average for the seven people promise themes. Of the seven themes, QVH showed an improvement in zero, the same score on four and decreased scores for three. HE highlighted areas for required improvement which include the experience of staff who have a disability or a protected characteristic and staff feeling safe to speak up. The Workforce Race Equality Standard (WRES) and Workforce Disability Equality Standards (WDES) annual reports would be presented to the Board in September 2025. A Board member asked what will be the indicators that the organisational culture is improving. HE thought that the indicators will come from a number of mechanisms including these survey metrics and qualitative information which comes through the speaking up route. The Board noted the range of activities listed within the report and emphasised the need to focus on initiatives which will have the biggest impact. HE thought that the embedding of the behaviour framework will have the biggest impact and will become integral to everything that the Trust does. The Board requested that a staff survey action plan with progress updates is presented to the Strategy and culture committee. **ACTION HE** The Board **noted** the contents of the report.

46-25	**Annual review of learning from patient stories** ET presented the report to the Board, highlight the actions taken to date in response to patient stories to ensure that improvements are embedded. The Board took assurance from the report that patients are listened to and that the appropriate changes are made as a result. The Board **noted** the contents of the report.
47-25	**Audit and risk committee assurance incl. committee annual report** PDR presented the committee assurance report to the Board. In response to a question from a Board member, PDR confirmed that committee members are comfortable that actions being taken will have a positive impact in improving significant control issues identified in the Annual governance statement 2024/25. He confirmed that the committee has received assurance that there has been no instances of non-compliance during quarter four of 2024/25 and that the committee will continue to seek assurance on compliance and good governance. The Board **noted** the contents of the report.
48-25	**Quality and safety committee assurance incl. annual reports** SOL presented the committee assurance report to the Board. Discussion was had about the outcome of the recent food hygiene inspection. SOL stated that the committee were assured that in the short term, addressing the issues raised is a priority, however, the committee requires further evidence that new ways of working have and will be embedded in day to day practice. The committee will receive an update at the next meeting. The Board **noted** the contents of the report. The following quality and safety annual reports were presented to the Board by TE and ET, and the board acknowledged that these have been scrutinised by the Quality and safety committee at its meeting in June 2025: • Patient safety (duty of candour) • Learning from deaths • Safeguarding • Infection, prevention and control • Complaints • Research and innovation • Consultant revalidation The Board commended the Research and innovation work completed during 2024/25. The Board: - **Noted** the contents of the quality and safety annual reports presented - Reviewed the content of the consultant revalidation annual report including Annex A to the report and **ratified** the Trust's compliance with The Medical Profession (Responsible Officers) Regulations 2010 (as amended in 2013)
49-25	**Financial, workforce and operational performance assurance** POD presented the report to the Board. He commended the new IQPR report which the committee found to be more digestible. He reported that the committee continues to have

	oversight of the delivery of the financial and operational plans for 2025/26, acknowledging that delivery becomes more challenging as the year progresses. The committee has requested to see a trajectory and forward view. Discussion was had about the Trust's estate and POD explained that although a lot of work has been done to make improvements, there continues to be significant challenges with a smaller budget than before. The Board **noted** the contents of the report
50-25	**Any other business (by application to the Chair)** There was no further business and the meeting closed.
51-25	**Questions from members of the public** There were no questions received from members of public. The Chair invited the lead governor to ask questions regarding any of the items discussed during the meeting on behalf of the governors. The lead governor asked the following questions and the following responses were given. Question How are staff being informed of current challenges? Response AJ explained that once per month, a 'Team Talk' session is held which all staff are invited to. Around 150 members of staff attend each session and the team have used this forum to communicate news about the financial position and the partnership with escalation through to teams by managers. Staff have welcomed this approach. Question Why did the patient story report only look into 2024/25? Response ET agreed to see if there was a previous report.

Matters arising and actions pending from previous meetings of the Board of Directors - PUBLIC								
ITEM	**MEETING Month**	**REF.**	**TOPIC**	**AGREED ACTION**	**OWNER**	**DUE**	**UPDATE**	**STATUS**
1	January 2025	98-25	Culture	Assessment of the organisational culture to be completed to enable the Board to understand the gap between where it is now and where it needs to be in line with the values and behaviour framework previously agreed by the Board	**HE**	~~**8 May 2025**~~ ~~**July 2025**~~ **September 2025**	May 2025: There is work underway to trinagulate information from the staff survey, people pulse survey, FTSU/ raising concerns, employee relations cases, listening sessions and datix to understand the micro cultures at QVH and where it needs to be alligned with our values and behaviour framework. There is variation across different departments and directorates in terms of behaviours but this is underpinned by a commitment to patient care. We know there have been challenges relating to governance and compliance. There are areas where there is a resistance to change and legacy practices and behaviours where support is needed. A management essentials programme is in development proposed to start in June 2025, along with change management support and work to further embed our values and behaviour framework. July 2025: Continued work in progress alongside strategic partnership work and KSO3 (behaviour framework). Ongoing assessment through period of change via the Strategy and culture committee once established. September 2025: Assessment completed and will be presented to the Strategy and culture committee on 9 October ahead of Board on 13 November 2025.	**PENDING**
2	July 2025	42-25		Provide definition of what we mean by culture.			September 2025: This will be included in report to the Stratety and culture committee and Board as above.	
3	May 2025	7-25*	Company secretary's report	Provide ongoing updates about progress on actions to improve compliance with Governing documents to the Board for monitoring	**LM, AJ**	**September 2025***	July 2025: Governing documents have been reviewed and updated to ensure they are accessible to staff. These will be presented to the Board for approval at its meeting in July 2025. Material updates have been made to the Scheme of Delegation. Both the Contract management policy and Procurement policies have been updated. Communication plan related to individual responsibilities for staff is underway and development of the Governance handbook will commence in Q2. September 2025: Governing documents revised and approved by the Board at its meeting in July 2025. An internal audit has been completed on compliance which has received reasonable assurance with considerable progress in strengthening controls. The Governance handbook is in development.	**PENDING**

4	May 2025	10-25*	Annual business plan 2025/26	Provide the Board with an update on the trajectory and phasing of the cost improvement plan	**SM**	**July 2025***	July 2025: Key finance risks including cost improvement plans (CIP), income and cash flow are set out within the CEO's report and a paper to the Private Board meeting . The trajectory and phasing of our CIP is shown within our annual plan. Our actual progress and forecast against this trajectory will be presented monthly at F&P from Month 3. July 2025: Agreed at the public Board meeting that this action will be closed.	**CLOSED**
5	July 2025	45-25	Staff survey 2024	Staff survey action plan with propgress updates to be presented to the Strategy and culture committee	**HE**	**October 2025***	September 2025: This will be presented to the Strategy and culture committee at its meeting on 9 October 2025.	**CLOSED**

Report cover-page					
References					
Meeting title:	Board of Directors				
Meeting date:	11/09/2025	**Agenda reference:**	**62-25**		
Report title:	Chair's report				
Sponsor:	Jackie Smith, Trust Chair				
Author:	Jackie Smith, Trust Chair				
Appendices:	None				
Executive summary					
Purpose of report:	To update the Board of Directors on Chair, non-executive director and governor activities since the last meeting.				
Summary of key issues	• At the end of July 2025, Chris Parrish (Patient Experience Manager) stepped down from his role as a staff governor. Agreement will be sought from the Council of Governors to fill the remainder of the term (until the end of June 2026) • Paul Dillon-Robinson, one of our Non-executive directors and Chair of the Audit and risk committee, will complete his second and final term on 30 September 2025 after six years on the Board • Jagjit Dosanjh-Elton will join the Board as a Non-executive director and the Chair of the Audit and risk committee from 1 October 2025 • The first meeting of the Strategy and culture committee was held on 6 August 2025				
Recommendation:	The Board is asked to **note** the contents of the report.				
Action required	Approval	**Information**	Discussion	Assurance	Review
Link to key strategic objectives (KSOs):	**KSO1:**	**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:	NA				
	Date:		Decision:		
Next steps:	NA				

Report to:	Board Directors
Agenda item:	62-25
Date of meeting:	11 September 2025
Report from:	Jackie Smith, Trust Chair
Report author:	Jackie Smith, Trust Chair
Date of report:	2 September 2025
Appendices:	None

Chair's report

Council of Governors

I continue to meet regularly with our lead and deputy lead governor to discuss key issues.

At the end of July 2025, Chris Parrish (Patient Experience Manager) stepped down from his role as a staff governor. Agreement will be sought from the Council of Governors to fill the remainder of the term (until the end of June 2026). I would like to thank Chris for his contribution to the Council of Governors whilst in this role.

During September to date, governor working groups have been held with the Finance and Performance, Quality and safety committee and Audit and risk committee Chairs, executive leads and governors. We also held the first governor working group meeting for the new Strategy and culture committee. All governors were invited to this governor working group meeting where an update was provided on work completed to date on the option appraisal for strategic partnership opportunities.

Board of Directors

Work continues to develop an option appraisal to consider strategic partnership options and this is the Board's key priority. At a seminar in September, the Board will review the current position, the case for change, partnership objectives and the timetable governance and next steps.

The Board also remains focussed on the Trust's challenging financial position for this year and future years.

Paul Dillon-Robinson, one of our Non-executive directors and Chair of the Audit and risk committee, will complete his second and final term on 30 September 2025 after six years on the Board. I would like to extend my thanks to Paul for everything he has done for QVH during his time in the role.

Jagjit Dosanjh-Elton will join the Board as a Non-executive director and the Chair of the Audit and risk committee from 1 October 2025 and I am pleased to welcome Jag to the Board.

Other activities

Our Annual report and accounts 2024/25 have been published on our website. This document is testament to the hard work of everyone at QVH. Our Annual General Meeting (AGM) is being held at 6pm on 23 September 2025 and is open to all. At our AGM, there will be a review of what we achieved during 2024/25 and a presentation from our external auditor. There will also be an opportunity for members and stakeholders to hear about our future plans and from our Council of Governors about their work during the period.

I continue to meet regularly with the Chair of NHS Sussex and engage with NHSE as well as Chair's and Chief executive officers from other providers within and outside of the system to explore collaborative working opportunities.

Stephen Lightfoot will step down as Chair of NHS Sussex from September 2025. On 1 September 2025, it was announced that Ian Smith has been appointed as Chair across the Surrey and Sussex Integrated Care Boards (ICBs). I am looking forward to working with Ian in his new role.

Strategy and culture committee
The first meeting of the Strategy and culture committee was held on 6 August 2025 and it was Chaired by me. Going forwards this meeting will be Chaired by Russell Hobby.

Key agenda items

- Draft option appraisal
- Engagement plan

Alert

- The committee has emphasised the importance of the assessment of the organisation's culture as this is a critical component to considerations
- The committee acknowledged that the scale of work to be completed is significant with a challenging timeline
- The committee has emphasised the importance of the Board understanding what it will take for the Trust to breakeven in 2025/26 and in future years

Assure

- The committee were assured that extensive engagement has been undertaken and that engagement from potential partners has been good
- The committee was content that there is a robust process being developed to support the Board in assessing options

Advise

- The committee have requested that consideration be given to the minimum requirements to support Board decision making which must be supported by the case for change

Risks discussed and new risks identified
The key risks identified and discussed include organisational morale, external factors and input and the financial position.

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

Report cover-page					
References					
Meeting title:	Board of Directors				
Meeting date:	11/09/2025	**Agenda reference:**	**63-25**		
Report title:	Chief Executive Officer (CEO) report				
Sponsor:	Abigail Jago, Acting Chief Executive Officer and Chief Strategy Officer				
Author:	Kathy Brasier, Deputy Chief Strategy Officer Allison Hunter, Strategy Support Officer				
Appendices:	None				
Executive summary					
Purpose of report:	This report outlines the main developments to be brought to the Board's attention since the last public Board meeting.				
Summary of key issues	• The Trust continues to face a challenging financial outlook for the year ahead with the need to deliver significant savings to assure breakeven for 2025/26. There remains considerable uncertainty regarding the financial challenges for QVH given the wider system and national position. • The trust continues to carry material risks relating to its estate. Work continues to deliver infrastructure improvements within the limited capital resource available. This includes addressing issues with the roof within the main theatre complex. Recent water damage has been identified and is being managed whilst further investigations and remedial works are progressed. With current information available it is not expected to disrupt patient care. • As part of the revised national Cyber Assessment Framework there are a number of additional requirements for this year. Cyber security is a significant risk for all organisations. Action plans are in place to meet the requirements of the new framework. • Key risks for the organisation relate to the financial position, estates challenges and ongoing delivery of our performance standards.				
Recommendation:	The Board is asked to **note** the contents of the report.				
Action required	Approval	**Information**	Discussion	Assurance	Review
Link to key strategic objectives (KSOs):	**KSO1:**	**KSO2:**	**KSO3:**	**KSO4:**	**KSO5:**
	Outstanding patient experience	***World-class clinical services***	***Operational excellence***	***Financial sustainability***	***Organisational excellence***
Implications					
Board assurance framework:	All				
Organisational risk register:	None				
Regulation:	None				
Legal:	None				
Resources:	Resource impact as identified within the report.				
Assurance route					

Report to:	Board Directors
Agenda item:	63-25
Date of meeting:	11 September 2025
Report from:	Abigail Jago, Acting Chief Executive Officer/Chief Strategy Officer
Report author:	Jane Dickson, Interim Deputy Chief Executive Officer Kathy Brasier, Deputy Chief Strategy Officer Allison Hunter, Strategy Support Officer
Date of report:	02 September 2025
Appendices:	None

Acting Chief Executive Officer (CEO) report

Alert

- The Trust continues to face a challenging financial outlook for the year ahead with the need to deliver significant savings to assure breakeven for 2025/26. There remains considerable uncertainty regarding the financial challenges for QVH given the wider system and national position.
- The Trust continues to carry material risks relating to its estate. Work continues to deliver infrastructure improvements within the limited capital resource available. This includes addressing issues with the roof within the main theatre complex. Recent water damage has been identified and is being managed whilst further investigations and remedial works are progressed. With current information available it is not expected to disrupt patient care.
- As part of the revised national Cyber Assessment Framework there are a number of additional requirements for this year. Cyber security is a significant risk for all organisations. Action plans are in place to meet the requirements of the new framework.
- Key risks for the organisation relate to the financial position, estates challenges and ongoing delivery of our performance standards.

Assure

- An internal audit on compliance of governance arrangements including contract management, procurement processes and compliance with QVH governing documents concluded in August. This reported reasonable assurance and the auditors observed 'considerable progress and strengthening of controls' compared to when work was previously conducted in this area in 2024/25.
- Work continues in the development of an option appraisal to consider strategic partnership opportunities, working in collaboration with potential partners to ensure future sustainability for the organisation.
- The Environmental Health Officer (EHO) carried out an inspection of the Trust's food hygiene arrangements in June 2025. Two Hygiene Improvement Notices were issued and have now been removed due to significant progress.
- Preparations are well underway for commencement of the East Grinstead Community Diagnostic Centre (CDC) building works, contractor is appointed and several site surveys are underway.
- The Electronic Patient Record programme assurance confirms amber status due to complexity, but with organisational confidence in the agreed go live date of 4th November. A detailed critical path and cutover plan have been described including NHSE formal assurance review in September. It is recognised that November 4th is a key landmark in an ongoing digital transformation journey for QVH which will need to be followed up by an optimisation phase including replacement of the PAS (patient administration system) and introduction of Ordercomms (closed loop results system) when enabled by the Sussex Pathology Network transformation.

- Steady progress continues across all elements of the key strategic objective areas with monthly reporting within the Integrated Quality Performance Report (IQPR). The full delivery of our cost improvement programme for 2025/26 is the most significant risk.

Advise

- The implementation of the National Oversight Framework continues to be rolled out. This includes quarterly performance segments and league tables and a new requirement for a Provider Capability Assessment. In quarter 1 QVH has been confirmed as segment 3 (segment 1 highest and 4 lowest) and ranked 28 out if 134 providers.
- The Year 1 Key Strategic Objectives (KSO) for 2025/26 have been progressed for Q1, and monitored against the deliverables identified, with Q2 objectives beginning to progress.
- Negotiations continue with University of Chichester on Heads of Terms for the Bognor CDC programme. We continue to work with ICB and primary care partners to negotiate a long-term operating model for the Bognor site.

National and Local Updates

NHS Oversight Framework

The NHS Oversight Framework sets out a revised approach to assessing integrated care boards (ICBs), NHS Trusts and Foundation Trusts for 2025/26. This process is to enhance public accountability for performance and improve the identification of providers that require support to improve. The Q1 position for the 2025/26 NHS National Oversight Framework segment and league table position for QVH has now been validated using published data from the first quarter. The Queen Victoria Hospital NHS Foundation Trust has been placed in segment 3, within a framework of 4 segments, in an acute league table position of 28 of 134. Data will be refreshed quarterly.

There is a new national requirement for the trust to complete a Provider Capability Assessment on trust capability against a range of expectations including strategy, leadership and planning, quality of care, people and culture, access and delivery of services, productivity and value for money and financial performance and oversight. This will inform a view of the organisation's capability as part of the National Oversight Framework.

Planning Guidance 26/27

The NHS Planning Guidance for 2026/27 is now published. This document outlines a continued commitment to system-wide transformation, with a focus on improving access, operational efficiency and financial sustainability. Key national priorities are set out including reducing elective care backlogs, enhancing cancer and urgent care performance, and expanding access to community-based services. The guidance reinforces the role of Integrated Care Systems (ICSs) in delivering locally tailored solutions, underpinned by digital innovation and data-driven decision-making. There is a strong emphasis on addressing health inequalities and ensuring services are equitable and responsive to population needs, while maintaining financial discipline within allocated system envelopes.

As we move into our business planning phase for next year, this document will play a critical role into how we can plan accordingly to address the NHSE national priorities in line with ICB commissioning intentions.

Finance and Performance

For M4 the Trust reported a surplus of £327k, which reduced our YTD deficit position to £464k in line with our plan 2025/26. Whilst our position at Month 4 remains positive, there will need to be acceleration in both the delivery of our better value programme and elective activity

levels to assure the planned break-even position for 2025/26. To date £7.6m of better value schemes have been identified and are in progress, However,, our current risk adjusted forecast indicates confidence in the delivery of £5m with some further improvement expected in month 5. Actual delivery to month 4 was £2.1m. Work continues on identifying additional mitigations to the potential better value shortfall and specifically on driving further productivity and procurement opportunities.

Whilst the level of recurrent cost reduction is the highest the Trust has delivered to date, delivery of the full £7.5m remains challenging and given our relative economies of scale, partnership collaboration remains key to realising the long-term savings required.

While our focus is on delivering this year's plans, future financial pressures may arise due to the removal of top-up funding (extra support beyond standard budgets), a shift to a tariff-based system (fixed payments per treatment), and reductions in fair share allocations (funding based on population need). Planning work for 2026/27 will be undertaken over the next four months in line with the national timetable.

The Trust met its planned performance against the 2025/26 operational targets for Referral to Treatment (RTT) but did not meet the internal forecast for the 52-week's percentage standard due to the overall waiting list size decreasing following the NHSE Sprint Validation programme.

Cancer performance was achieved for Faster Diagnosis (FDS) and 62 Day standards. The increased skin demand continues to challenge our 31-day performance, with recovery action plans in place. Month 4 performance was achieved against Referral to Treatment and Cancer, but focus continues on the 65-week.

Quality and Safety

Adult Inpatient Survey

The Trust has received the embargoed results of the Adult Inpatient Survey 2024, which will be published nationally on 9 September. We are expecting a positive response to the survey.

Food Hygiene Inspection Update

In June 2025, the Environmental Health Office (EHO) carried out an inspection of the Trust's food hygiene arrangements. Two Hygiene Improvement Notices were issued, requiring corrective action by August 2025. In response, immediate steps were taken with executive led oversight.

The EHO revisited the Trust in early August 2025 and confirmed that substantial progress had been made. As a result, the Improvement Notices have now been lifted. The EHO noted that the Trust had undertaken a significant amount of work in a short period and only highlighted minor issues, which were addressed immediately.

A further inspection is scheduled for September 2025 to reassess the Trust's food hygiene rating. While this represents a positive outcome and important milestone, it is essential that the Trust continues to maintain the strengthened standards, embed training compliance and ensure robust oversight to avoid recurrence of the issues identified earlier in the year.

Strategic Partnership Development
Work continues to develop the future collaborative strategic partnerships for QVH. Since the last board meeting engagement has continued with potential partners, staff and key external stakeholders including NHS England and the Sussex Integrated Care Board as host commissioner. There is a programme plan in place and QVH actions are on track.

The option appraisal process has commenced and approach shared with newly formed the Strategy and Culture Committee. This includes the development of outline criteria that is being agreed with NHSE and Sussex ICB and will be considered within the appraisal.

An engagement plan has been developed and is also on track. This includes a 12 hour 'walk in' workshop and virtual workshop that have taken place. In total 185 staff attended the events, from 52 teams and this contributed to over 900 pieces of feedback which is being utilised to inform the thinking. Two further workshops will be held in September with wider stakeholders. An internal Stakeholder Assurance Group has been established and will test the principles of the approach.

Celebrating our QVH Team
Recognising the impact of diagnostics
On 18 August 2025, the Department of Health and Social Care (DHSC) and the Health and Social Care Secretary, Wes Streeting MP, published an update on the vital role Community Diagnostic Centres (CDCs) play in providing diagnostic tests and scans out of hours in the community. Queen Victoria Hospital was cited as an example of best practice as we have been able to deliver five times more respiratory patient interactions per clinic session, with 92% of patients avoiding hospital outpatient appointments entirely.

The winners of the HSJ Awards 2025 will be announced in November.

Values in Practice (VIP) award winners
In January 2025, we launched our Values in Practice (VIP) award programme, aligned to our Trust Behaviour Framework, which recognises colleagues who demonstrate our Trust values. Each month we receive nominations from across our organisation showing how colleagues have embraced and are living our values in their everyday work.

Our winner in June 2025 was Amanda Bobby, Health Records, Electronic Document Management and Community Services Manager, who was nominated for our value 'listening to improve'. Amanda's nomination recognised her involvement in setting-up the new electronic triage process for our Sleep service and how she went above and beyond to overcome challenges with the electronic referral system. Her in-depth systems knowledge was invaluable along with the support she gave colleagues.

Our July 2025 winner was Ben Davis, IT Service Desk Engineer, who was nominated for 'being caring and inclusive (over all else)'. Ben was recognised for being helpful and friendly, understanding the frustration of users not being able to carry out their work due to an IT issue, whilst never making colleagues feel a nuisance if the problem turns out to be user error. He was also thanked for following up on queries.

We continue to recognise everyone who was nominated and winners at our monthly Team Talk session open to all colleagues.

Recommendation

The Board is asked to:

- **NOTE** the contents of the report.

Appendix one- Implementing the *QVH Strategy 2025 – 2030*

Year 1 of the implementation of the *QVH Strategy 2025-2030* is set out in the 2025/26 Key Strategic Objectives.

Progress has been achieved across all domains in Quarter 1 and is summarised as set out below:

	2025-26	Q1 progress
Key Strategic Objective 1: To deliver outstanding care	Development of children's model phase 1	**Children's model** initial assessment completed and in draft for review with key internal stakeholders. Scoping of next phase in progress.
	Quality Priority /Health Inequalities: Meet the individual needs of patients including communication and data	**Health Inequalities** objectives agreed for 2025/26. Ethnicity recording improved in Q1 from 79.6% to 85.5% in July 2025, using a Continuous Improvement approach. 2025/26 first manual review and analysis conducted of variation in long-waiters by age, deprivation, and ethnicity.
	NHSE Burns Service review recommendations	**Burns network review** recommendations received, action plan drafted, and timelines agreed. Data collection in progress.
	Deliver Access Targets - RTT, Cancer, Urgent Emergency Care	As per IQPR reporting
Key Strategic Objective 2: To innovate and improve	Embed Continuous Improvement	**Continuous Improvement (CI) programme** on track – departmental face-to-face and virtual huddles in operational areas across the Trust. Improvement projects underway through staff-initiated projects and yellow and green belt trained staff concentrating upon strategic project delivery in line with Trust Key Strategic Objectives (KSO). CI is now having demonstrable impact on wider areas of focus including the recent Environmental Health Office (EHO) improvements.
	Quality Priority: Evidence through measurable Outcome Measures	**Audit plan** progressing as expected with good activity on all aspects of the action plan. All national 'must do' audits identified and in agreed directorate action plans. Clinical audit report available as a living document to all directorates with increased narrative on key messages and any agreed outcomes. Governance engagement established to inform the clinical audit programme for 2026/27.
	Research & Innovation: Governance, Collaborative Framework & Research Centre	Refreshed **research** structure and governance defined. National Institute for Health Research (NIHR) funded post for General Practitioner (GP) research partnership appointed with other NIHR grant applications pending. Mid-year evaluation of progress against strategy shared. Proposal for research, innovation and education hub submitted to Charity Committee.
Key Strategic Objective 3: To be an excellent employer	Deliver Equality Diversity and Inclusion Priorities	**Equality Diversity and Inclusion (EDI) champions** continue to promote inclusion across the Trust and support celebration of success. Launching a resource document for managers to support staff with disabilities. Work is continuing to roll out a development programme for line managers, with a strong focus on building inclusive cultures within teams.
	Embed Values / Behavioural Framework	**Behavioural framework** workshops in place for all staff to provide an understanding of how to apply and embed the framework through areas of responsibility, including 1:1s, appraisals, and employee relations cases. The behaviour framework is being used to develop team charters to support improved team behaviours as part of staff survey action plans.
		Monthly resilience workshops are in place from September – December with in-house and NHS Elect sessions. Change management workshops are starting in September 2025. Coaching continues on an ad hoc basis, as requests are received.
Key Strategic Objective 4: To deliver sustainable services	Financial sustainability	On plan at M4 in terms of income and expenditure. Ongoing risk in delivering the £7.5m best value schemes.
	Electronic Patient Record (EPR)	The **Electronic Patient Record** is progressing as planned.
Key Strategy Objective 5:	Development of strategic partnerships to deliver corporate sustainability	Partnership collaboration engagement in progress and QVH activities on track. Work progressing in regard to engagement plan and development of option appraisal. Timeline for governance sign off in progress.

To collaborate with others	QVH Local - Community Diagnostic Centres (CDC)	Preparations underway for the commencement of the **Community Diagnostic Centre (CDC)** building works on the East Grinstead site. CDC activity remains a key focus as well as negotiations with University of Chichester on Heads of Terms for the Bognor programme. Working with the ICB and primary care partners to negotiate a long-term operating model.
	Contribution to Sussex Major Service Review	For the **contribution to the Sussex Major Services** review - QVH is participating in the newly established Integrated Frailty and Complex Needs Sussex Delivery Group.

Report cover-page			
References			
Meeting title:	Board of Directors		
Meeting date:	11/09/2025	**Agenda reference:**	64-25
Report title:	Integrated Quality and Performance Report Month 3		
Sponsor:	Kirsten Timmins, Chief Operating Officer		
Author:	Allison Hunter, Strategy and Partnership Project Support Officer		
Appendices:	Appendix – Integrated Quality and Performance Report (IQ&PR) M3 slide pack		
Executive summary			
Purpose of report:	To discuss the Month 3 Integrated Quality and Performance Report 2025/26		
Summary of key issues	**KSO1** - The Trust delivered against plan for activity and achieved the planned performance for RTT (first appointment, 18 week performance) and Cancer Faster Diagnosis Standard. The Trust did not achieve its monthly trajectories for urgent and emergency care (missed plan by 3.6%), Cancer 62 day standard (marginally missed plan by 0.4%) and the percentage of patients waiting in excess of 52 weeks (marginally missed plan by 0.07%). The Trust continues to be part of 'Project Sprint' in Q2, which aims to reduce the overall size of the waiting list through focussed validation efforts. The reduced waiting list size poses a risk to delivery of the 52 week wait percentage target, in M4 and this has been communicated externally. Looking forward, the Trust is on track to deliver performance against the cancer trajectories in M4, and urgent and emergency care performance is likely to improve by M5 when staff are fully trained. One reportable patient safety incident occurred and is being comprehensively reviewed and declared as required. We've improved data capture for patient ethnicity, advancing our commitment to reducing health inequalities. CDC activity was below plan at 81.4%. Underperformance is within ophthalmology, Dexa scans, and phlebotomy. Estates, equipment and staffing issues within ophthalmology are challenging the delivery of planned activity levels, despite additional weekend clinics being booked. Additionally, referral demand for cardiology diagnostics is hoped to increase with the new Heart Failure pathway. M4 activity delivered against plan. The children's model task and finish group ToR has been agreed. Baseline assessment is completed in draft form for consultation. The London and South-East Burns Network Review conclusion was received in June. An action plan is in draft form pending further discussion **KSO 2** – Research team structure defined. NIHR bid for CDC research not shortlisted. NIHR funded post for GP research partnership appointed to The audit plan for 2025/26 evolving as a living document with governance intelligence on outcomes from this. Progress informing strategy for 2025/26 CI programme on track. Face to face and virtual huddles in operation across the Trust, Executive Masterclass programme continues, Successful 'Celebration event' showcasing successful improvement projects completed and the graduation of nine further yellow belts **KSO 3** – Temporary staffing levels continued to decline in Month 3, supported by targeted efforts from Heads of Nursing and the Temporary Staffing Reduction Oversight Group. Behavioural framework workshops are ongoing through September, aimed at embedding values across leadership and operational practices, including 1:1s, appraisals, and employee relations. EDI Champions remain active in promoting inclusion, with monthly features in the 'Stay Well' update to raise awareness of their roles. Staff wellbeing is further supported		

	through resilience workshops, change management initiatives, and coaching, helping teams navigate ongoing NHS-wide transformation **KSO 4** – The Trust reported an Income and Expenditure position in line with the planned deficit of £0.8m and had a cash balance of £5.0m at Month 3. Whilst on plan and our position therefore remains positive, there will still need to be a significant improvement in contribution to deliver the planned breakeven position for 2025/26, with the main risk area being the full delivery of best value schemes of £7.5m (6%) for the year The Electronic Patient Record programme and Sussex Pathology Network programmes remain on track Freedom of Information requests responded to within 20 days has improved in M3 to 63%. This continues to be an area of focus for the Information Governance / Digital Steering Groups, with follow ups with managers planned to ensure responses are returned for sign off and sent back to the requestor in a timely manner. **KSO 5** – Preparations underway for the commencement of building works on the East Grinstead site. CDC activity remains a key focus as well as negotiations with University of Chichester on Heads of Terms for the Bognor programme. QVH is participating in the newly established integrated Frailty and Complex Needs Sussex Delivery Group. The group's objective is to define minimum standards that will underpin a core service offer for identified population cohorts across neighbourhoods. **Major Projects** **Community Diagnostic Centre** – Preparations being made for commencement of building works on East Grinstead site. Engagement continues with University of Chichester regarding next steps for the Bognor site **Sussex Pathology Network Programme** – Due to complexity of programme, over status remains Amber, however on track for delivery. NHSE funding confirmed for pathology digital projects and histopathology modernisation. **Electronic Patient Records Programme** – Due to complexity of programme, overall status remains Amber. On track to deliver for November go live				
Recommendation:	The Board is asked to note the Month 3 IQ&PR position				
Action required	Approval	Information	Discussion	**Assurance**	Review
Link to key strategic objectives (KSOs):	KSO1: ***Outstanding patient experience***	KSO2: ***World-class clinical services***	KSO3: ***Operational excellence***	KSO4: ***Financial sustainability***	KSO5: ***Organisational excellence***
Implications					
Board assurance framework:	BAF 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:	Executive committee for quality and risk, Finance and performance committee and Quality and safety committee				
	Date:	August and September 2025	Decision:		

Queen Victoria Hospital
NHS Foundation Trust

Queen Victoria Hospital

Integrated Quality and Performance Report

Month 3: July 2025

BALANCED SCORECARD

Queen Victoria Hospital
NHS Foundation Trust

Priority Metrics	M12 target	Latest month	Planned trajectory in month	Actual performance in month	Previous Month	Summary	Confidence in delivery (RAG)
Breakeven YTD	£0.0m	June-25	-£0.1m	-£0.1m	£0.3m	The Trust's Income and Expenditure position was in line with the planned in month deficit.	
RTT> 52 weeks as a proportion of waiting list	1%	Jun-25	2.10%	2.17%	2.19%	Marginally missed the M3 target (by 0.06%). Common cause variation - no significant change.	
Cancer 62 days	75%	May-25	70.8%	71.0%	75.8%	Achieving target. Common cause variation - no significant change.	
% Overall FFT Recommendation Rate	90%	Jun-25	90%	95.5%	95.0%	Achieving target. Common cause variation - no significant change.	
Trust vacancy rate (excluding bank and agency)	8%	Jun-25	7%	5.94%	6.50%	Improved position in month. Special Cause - improving variation.	

Major Project	This Month	Overall Status	Last Month	Summary
To deliver the Community Diagnostic Centre programme at East Grinstead and Bognor (respectively)		On track (East Grinstead) Off track (Bognor)		Preparations being made for commencement of building works on East Grinstead site. Engagement continues with University of Chichester regarding next steps for the Bognor site.
To deliver the Sussex Pathology Network Programme		On track	.	Due to complexity of programme, overall status remains Amber however on track for delivery. NHSE funding confirmed for pathology digital projects and histopathology modernisation.
To implement year one of the Electronic Records Programme		On track		Due to complexity of programme, overall status remains Amber. On track to deliver for November go live

CEO SUMMARY

Queen Victoria Hospital
NHS Foundation Trust

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

Alert

- The Trust has a challenging financial outlook for 2025/26 with a significant savings programme required to deliver breakeven and requirement for reduction in corporate costs. Focussed work is directed towards achieving the savings programme, yet there remains risk in achieving the savings required.
- Work has commenced on a strategic partnership options appraisal to secure long-term sustainability, for Board approval in November 2025.
- Operational challenges and increased service demand led to a reduction in performance across Cancer and Urgent & Emergency Care. Significant increased skin cancer referrals, and consultant capacity at spoke sites risk impacting the trust's cancer performance in the second quarter of the year and achievement of 52ww % performance.
- The Trust achieved its plan for income from activity, however did not meet Community Diagnostic Centre (CDC) activity in all modalities, achieving 81% of plan in month 3. Under-performance was due to demand, estates and equipment challenges, and trajectories for improvement are in development.
- Key risks relate to the financial position, estate challenges, increased skin urgent suspected cancer referrals impacting on cancer and long waiter performance.

Assure

- The trust achieved the planned performance metrics for RTT first appointment, RTT 18 week performance and Cancer Faster Diagnosis standard.
- The trust remains on plan for the Electronic Patient Record programme implementation from November 2025.

Advise

- The Trust's Income and Expenditure YTD position was in line with the planned deficit of £0.8m and had a cash balance of £5.0m. The main risk remains the delivery of best value schemes of £7.5m (6%) for the year.
- Organisational culture continues to be a key priory for the Trust. A wellbeing & inclusion survey was launched in May to better understand the experience of our staff and change management support is in place to support colleagues through the ongoing change across the NHS.
- Preparations are being made trust continues to progress for the commencement of building works on the Community Diagnostic Centres programmes at East Grinstead and Bognor CDC site. Work continues to optimise current CDC activity in East Grinstead and negotiation with University of Chichester on Heads of Terms for the Bognor programme.

Abigail Jago
Acting Chief Executive Officer

KEY STRATEGIC OBJECTIVES – SUMMARY

Queen Victoria Hospital
NHS Foundation Trust

KSO1

- The Trust delivered against plan for activity and achieved the planned performance metrics for RTT (first appointment, 18 week performance) and Cancer Faster Diagnosis Standard. The Trust did not achieve its monthly planned trajectories for urgent and emergency care, Cancer 62 day standard and the percentage of patients waiting in excess of 52 weeks. For M4, the Trust is on track to meet both the planned trajectory and the national cancer standards. For UEC, staffing challenges are likely to continue to impact in M4, with recovery in M5. The Trust will also continue to be part of 'Project Sprint' in Q2, which aims to reduce the overall size of the waiting list through focussed validation efforts. The reduced waiting list size poses a risk to delivery of the 52 week wait percentage target, and this has been communicated externally. .
- The children's model task and finish group ToR has been agreed. Baseline assessment is completed in draft form for consultation
- The London and South-East Burns Network Review conclusion was received in June. An action plan is in draft form pending further discussion

KSO2

- Research team structure defined. NIHR bid for CDC research not shortlisted. NIHR funded post for GP research partnership appointed to
- The audit plan for 2025/26 evolving as a living document with governance intelligence on outcomes from this. Progress informing strategy for 2025/26
- CI programme on track. Mixture of face to face and virtual huddles in operation across the Trust, Executive Masterclass programme continues, Successful 'Celebration event' showcasing successful improvement projects completed and the graduation of nine further yellow belts

KSO3

- Temporary staffing reduced further in M3 – ongoing focus through Heads of Nursing and Temporary Staffing Reduction Oversight group
- Behavioural framework/toolkit workshops continue to September to provide an understanding of how to apply and embed the framework throughout areas of responsibility. Further work is underway to promote and use the behaviour framework in 1:1s, appraisals, and employee relations cases to embed our values and behaviours further
- Our EDI champions continue to promote inclusion across the Trust. In the monthly 'Stay Well' update we are introducing an EDI champion each month to promote them / their role
- Resilience workshops / change management support / coaching continues to support our staff through the ongoing change across the NHS.

KSO4

- At the close of June 2025, the Trust reported an Income and Expenditure position in line with planned deficit of £0.8m and had a cash balance of £5.0m.Whilst an on plan position for the YTD remains positive, there will need to be a significant improvement in Trust contribution to deliver the planned breakeven position for 2025/26, with the main risk area being delivery of best value schemes of £7.5m (6%) for the year
- The Electronic Patient Record programme and Sussex Pathology Network programmes remain on track
- Freedom of Information requests responded to within 20 days has improved in M3 to 63%. This continues to be an area of focus through the Information Governance Group and Digital Steering Group and a follow up with managers for responses to be returned for sign off and sent back to the requestor in a timely manner.

KSO5

- Preparations underway for the commencement of building works on the East Grinstead site. CDC activity remains a key focus as well as negotiations with University of Chichester on Heads of Terms for the Bognor programme
- QVH is participating in the newly established Integrated Frailty and Complex Needs Sussex Delivery Group. The group's objective is to define minimum standards that will underpin a core service offer for identified population cohorts across neighbourhoods.

Queen Victoria Hospital
NHS Foundation Trust

KSO1

To deliver outstanding care

Ambition

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

Board Assurance Framework

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

2025/26 Annual Objectives

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

2025/26 Annual goals

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

KSO1 EXECUTIVE SUMMARY

The Friends and Family Test recommendation rate remains high for the Trust in M3. The Trust has contributed to the London and South East Burns Review and has received the final report and implementation plan for review via the Burns review task and finish group. The Trust is committed to reducing health inequalities, with focussed work on improving data capture of patient ethnicity which has seen an improvement in month.

There has been one reportable patient safety incident, full review and stratification of patients underway, working alongside third parties as part of the review, declared to CQC, GP and ICB links. Eleven medical emergency calls noted in month, higher than previous months, no themes noted or areas of concern.

The children's model task and finish group has defined terms of reference and performed a baseline assessment against required standards and a 'case for change' document which are in draft form pending review and consultation.

The MCA risk has been reviewed and a risk level of 12 provisionally accepted on the basis of work done to date mitigating risks around GP referrals, appointment letters, booking / scheduling and clinical story-telling in governance forums. There is further work to do around outpatient support logistics and the skin pathway in particular.

The Trust reported a reduction in Cancer 62 day performance in M2; this was driven by capacity challenges, and a significant increase in skin cancer referrals on an urgent suspected cancer pathway, driven by May Melanoma awareness month and the hot weather. The Trust improved performance against the Faster Diagnosis standard and met the FDS trajectory for M2. The significant increase in cancer urgent suspected referrals risks impacting RTT performance and the long waiting position.

The Trust continued to meet the Referral to Treatment (RTT) first appointment and 18 week performance trajectories in M3 and continued to participate in NHSE's 'Project Sprint' initiative which has been extended into Q2, with focussed RTT waiting list validation efforts to reduce the overall waiting list size. The Trust marginally missed achieving the RTT 52week wait trajectory, achieving 2.17% against a plan of 2.1%. Looking forward to M4, the RTT 52ww % target is unlikely to be achieved given the reduced waiting list because of 'Project Sprint' and this has been communicated to the ICB and NHSE.

The Trust continues to deliver urgent and emergency care performance in excess of the 95% standard, yet saw a 1% decrease in performance in M3 due to staffing constraints in MIU. The trust DM01 performance was impacted by the loss of equipment (the Cone Beam CT scanner) and constraints in inpatient sleep studies. The new Cone Beam CT scanner was operational from M3 and the Trust is working through the backlog of routine referrals. Within the outpatients programme in M3, transformation work focussed on sleep services, and the review of clinic templates.

Income from activity was above plan for M3; however, the Trust did not meet Community Diagnostic Centre (CDC) activity in all modalities, achieving 81% of plan in M3. Under-performance was due to demand, estates and equipment challenges. This activity is being reviewed weekly at the operational performance meeting and trajectories for improvement are in development.

Kirsten Timmins
Chief Operating Officer

Edmund Tabay
Chief Nursing Officer

KSO1 BALANCED SCORECARDS

Queen Victoria Hospital
NHS Foundation Trust

QUALITY & SAFETY METRICS

Metric	Latest Month	Target	Variation	Assurance	Actual	Actual Previous Month	Mean	LCL	UCL	Summary
Ethnicity recording	Jun-25	95%	H	F	83.75%	80.99%	79.38%	76.26%	82.50%	Special Cause - improving variation
Smoking Status	Jun-25	95%		P	99.10%	99.52%	99.01%	97.75%	100.28%	Common cause - no signficant change
Falls per 1,000 Occupied Bed Days	Jun-25	7		?	5.0	5.9	4.14	-4.09	12.38	Common cause - no signficant change
Hospital Aquired PU Per 1,000 Occupied Bed Days	Jun-25	0		?	2.5	0.0	0.80	-2.13	3.72	Common cause - no signficant change
% Complaints Responded On Time	Jun-25	70%		P	87.50%	100.00%	95.14%	73.61%	116.67%	Common cause - no signficant change
Safer Staffing Compliance	Jun-25	90%		P	99.77%	99.89%	99.63%	98.51%	100.76%	Common cause - no signficant change
% Overall FFT Recommendation Rate	Jun-25	90%		P	95.51%	95.00%	95.46%	94.51%	96.41%	Common cause - no signficant change
Overall FFT Response Rate	Jun-25	25%		F	20.30%	20.55%	20.70%	17.08%	24.33%	Common cause - no signficant change
FFT Recommendation Rate - Inpatients	Jun-25	90%		P	99.30%	100.00%	99.70%	98.13%	101.27%	Common cause - no signficant change
FFT Response Rate - Inpatients	Jun-25	25%		?	42.14%	34.18%	40.53%	20.53%	60.54%	Common cause - no signficant change
FFT Recommendation Rate - Inpatients Children	Jun-25	90%	H	P	100.00%	100.00%	99.52%	97.83%	101.20%	Special Cause - improving variation
FFT Response Rate - Inpatients Children	Jun-25	25%	H	?	51.21%	30.65%	23.56%	-0.88%	48.01%	Special Cause - improving variation
FFT Recommendation Rate - MIU	Jun-25	90%		?	88.11%	93.48%	92.79%	87.82%	97.75%	Common cause - no signficant change
FFT Response Rate - MIU	Jun-25	25%		?	16.97%	17.34%	19.04%	12.69%	25.38%	Common cause - no signficant change
FFT Recommendation Rate - Outpatients	Jun-25	90%		P	95.35%	94.04%	95.14%	93.98%	96.30%	Common cause - no signficant change
FFT Response Rate - Outpatients	Jun-25	25%		F	17.18%	16.87%	17.49%	15.02%	19.97%	Common cause - no signficant change
Readmissions< 30 Days	Jun-25	2%		?	1.87%	2.19%	2.19%	0.74%	3.65%	Common cause - no signficant change
VTE Risk Assessment	Jun-25	95%		?	97.38%	97.94%	97.61%	94.44%	100.78%	Common cause - no signficant change

KSO1 BALANCED SCORECARDS

Queen Victoria Hospital
NHS Foundation Trust

QUALITY & SAFETY METRICS

Metric	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25
Number of Complaints	3	9	3	5	7	4	5	8	7	4	6	7	6
Number of Open CAS Alerts	2	3	2	2	1	0	1	0	0	0	0	0	0
Number of Patient Falls Incidents	0	4	6	6	4	1	1	5	2	4	1	5	4
Number of QVH Acquired Pressure Ulcers Cat. 2 and above	0	0	0	1	0	2	0	0	0	4	2	0	2
Never Events declared	0	0	0	0	0	0	0	0	0	1	0	1	0
Medication Incidents (No and low harm)	0	16	19	27	33	18	7	4	8	12	9	6	10
Medication Incidents (Moderate harm or above)	0	0	0	0	0	0	0	0	0	0	0	0	0
Internal Investigation declared	1	1	0	0	0	0	0	0	1	0	0	0	0
Patient safety incident investigations declared	0	0	0	0	0	0	0	0	0	0	0	0	1
Mortalities	0	0	0	0	0	0	0	1	0	1	1	0	0
Hospital Acquired CDI, MRSA, E.Coli, MSSA	0	0	0	0	1	1	2	0	1	1	0	1	0
Occupied Bed Days	836	899	797	828	908	939	755	803	893	991	781	848	800
Oliver McGowan Training Compliance	90.5%	91.9%	92.5%	92.8%	92.2%	92.1%	92.2%	92.4%	92.3%	91.8%	91.9%	91.5%	91.8%

KSO1 BALANCED SCORECARDS

Queen Victoria Hospital
NHS Foundation Trust

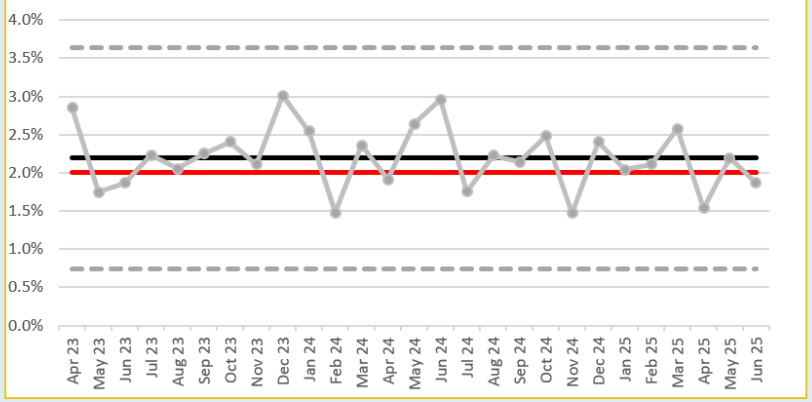
OPERATIONAL PERFORMANCE METRICS

Metric	Latest Month	Target	Variation	Assurance	Actual	Actual Previous Month	Mean	LCL	UCL	Summary
RTT 18 week wait performance - first appointment	Jun-25	75.32%	H	?	75.80%	74.74%	71.52%	67.32%	75.73%	Special Cause - improving variation
RTT 18 Week Wait Performance	Jun-25	62.35%		?	62.36%	60.92%	59.71%	56.93%	62.49%	Common cause - no signficant change
RTT Waiting List	Jun-25	-			17,869	17,624	18137.11	17472.93	18801.29	Common cause - no signficant change
RTT >52 Weeks	Jun-25	-			388	386	416.41	339.57	493.24	Common cause - no signficant change
RTT >52 Weeks as a proportion of Waiting List	Jun-25	1.00%		F	2.17%	2.19%	2.29%	1.93%	2.66%	Common cause - no signficant change
CDC activity vs plan	Jun-25	100.00%		?	81.17%	107.99%	100.70%	58.45%	142.95%	Common cause - no signficant change
% Income Vs Plan	Jun-25	100.00%		?	101.72%	104.06%	99.84%	89.06%	110.63%	Common cause - no signficant change
Cancer 28 Day FDS	May-25	80.00%		?	84.34%	76.38%	82.56%	70.11%	95.00%	Common cause - no signficant change
Cancer 62 Days	May-25	75.00%		?	71.01%	75.78%	77.56%	65.16%	89.96%	Common cause - no signficant change
Outpatient Productivity - Patient Initiated Follow Ups (PIFU)	Jun-25	2.00%	H	?	2.20%	2.38%	1.81%	1.20%	2.43%	Special Cause - improving variation
Outpatient Productivity - Missed Appointment Rate	Jun-25	4.00%	L	F	4.80%	5.21%	5.31%	4.81%	5.82%	Special Cause - improving variation
Diagnostics 6 Week Wait Performance	Jun-25	95.00%	L	F	73.39%	79.28%	86.60%	79.00%	94.19%	Special Cause - concerning variation
UEC 4 Hour Performance	Jun-25	98.00%	L	P	96.44%	97.86%	99.26%	98.04%	100.47%	Special Cause - concerning variation
Theatre Productivity - % of Cancellations on the Day	Jun-25	5.00%		F	4.05%	5.05%	104.59%	25.61%	183.57%	Common cause - no signficant change
Theatre Elective Utilisation - QVH Site (Capped)	Jun-25	85.00%		?	84.83%	84.96%	82.84%	78.01%	87.67%	Common cause - no signficant change
NHS App appointments available	Jun-25	70.00%		P	84.37%	86.02%	80.23%	75.14%	85.31%	Common cause - no signficant change

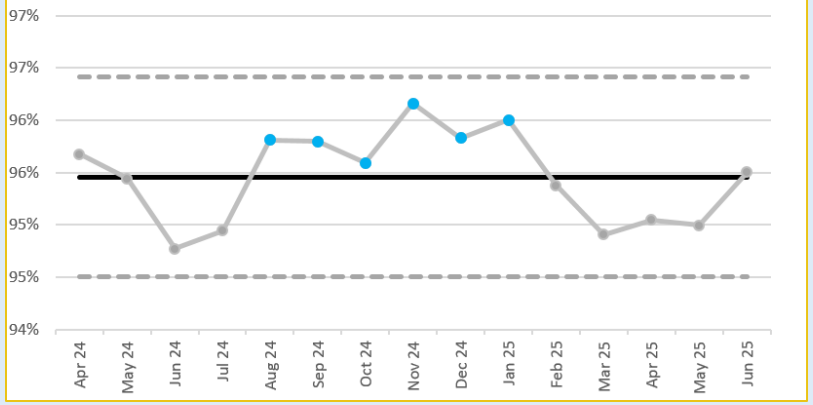
QUALITY & SAFETY METRICS

Queen Victoria Hospital
NHS Foundation Trust

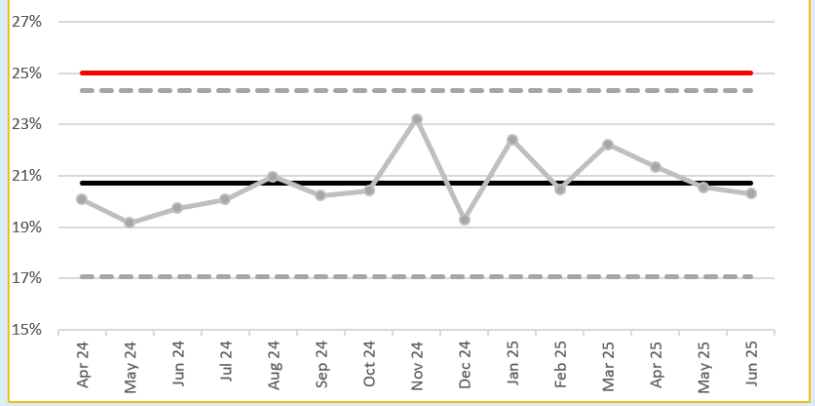
Readmissions< 30 Days



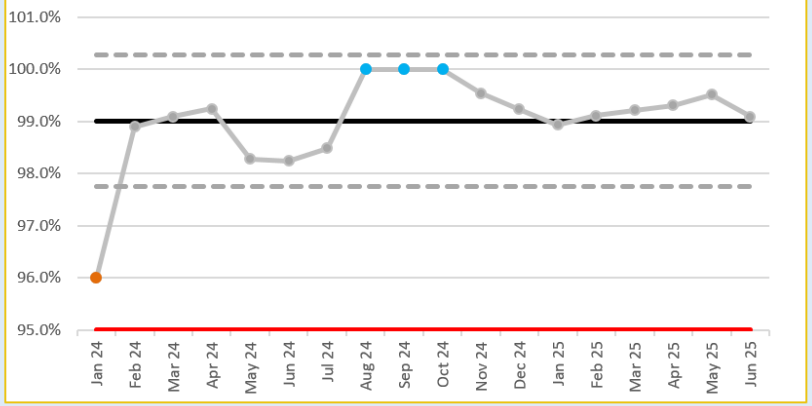
% Overall FFT Recommendation Rate



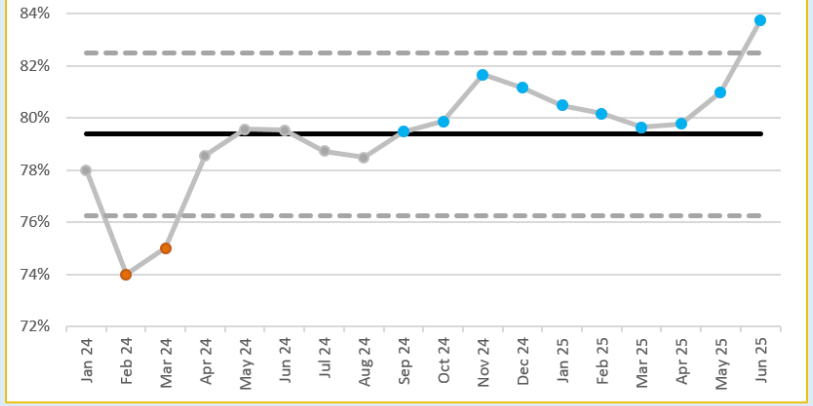
Overall FFT Response Rate



Smoking Status



Ethnicity Recording



Safer Staffing Compliance - Trust

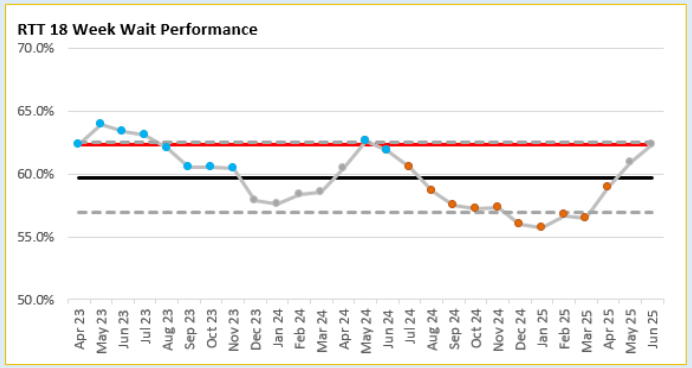
	Planned staff			Actual staff			June 2025
DAY	RN	NA	HCA	RN	NA	HCA	
	4,145.75	115.00	1,546.75	4,145.75	115.00	1,535.25	*Total Hrs Planned and Actual*
				100.0%	100.0%	99.3%	*% Planned Hrs Met*
			5,807.50			5,796.00	*Total Hrs Planned & Actual - Combined reg & support*
						99.80%	*% Planned Hrs Met - Combined reg & support*
NIGHT	Planned staff			Actual staff			
	RN	NA	HCA	RN	NA	HCA	
	3,461.50	103.50	782.00	3,450.00	103.50	782.00	*Total Hrs Planned and Actual*
				99.7%	100.0%	100.0%	*% Planned Hrs Met*
			4,347.00			4,335.50	*Total Hrs Planned & Actual - Combined reg & support*
						99.74%	*% Planned Hrs Met - Combined reg & support*
Combined	Planned staff			Actual staff			
	RN	NA	HCA	RN	NA	HCA	
	7,607.25	218.50	2,328.75	7,595.75	218.50	2,317.25	*Total Hrs Planned and Actual*
				99.8%	100.0%	99.5%	*% Planned Hrs Met*
			10,154.50			10,131.50	*Total Hrs Planned & Actual - Combined reg & support*
						99.77%	*% Planned Hrs Met - Combined reg & support*

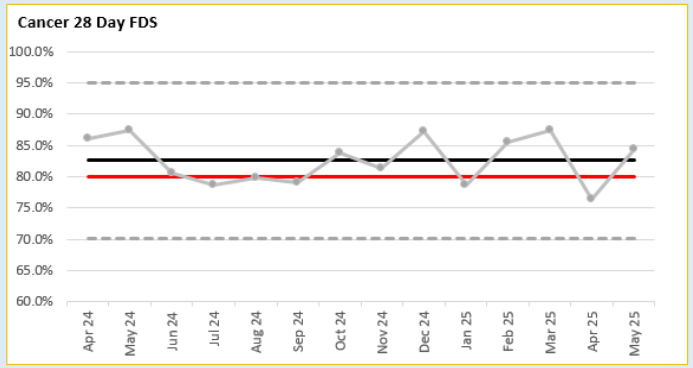
SPC Chart Key:

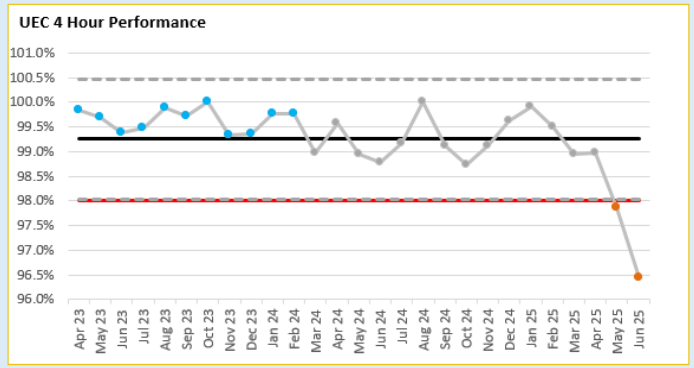
- Mean
- Target
- Process limits
- Special cause - concern
- Special cause - improvement

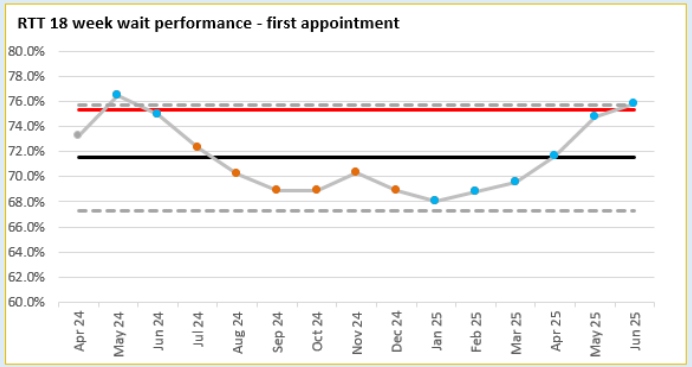
OPERATIONAL PERFORMANCE METRICS

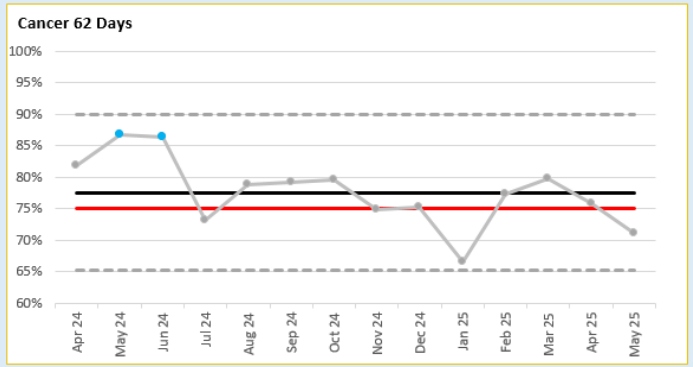
Queen Victoria Hospital
NHS Foundation Trust

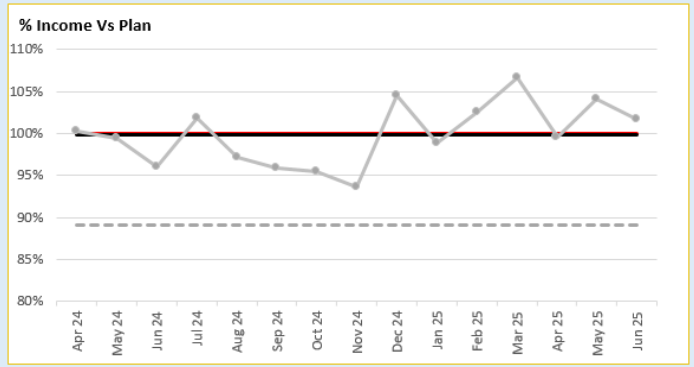


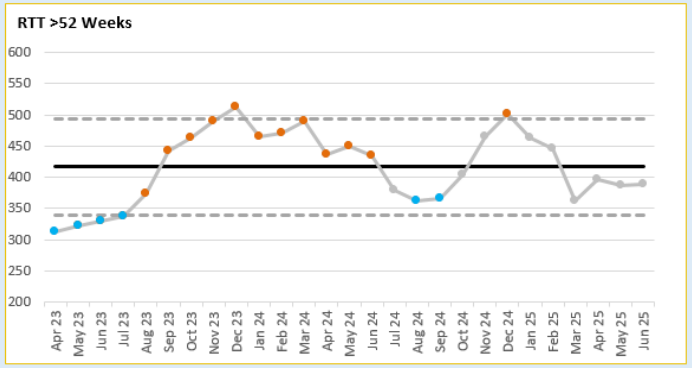


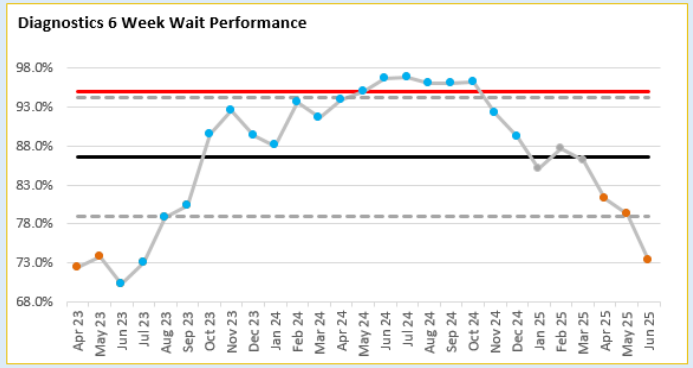


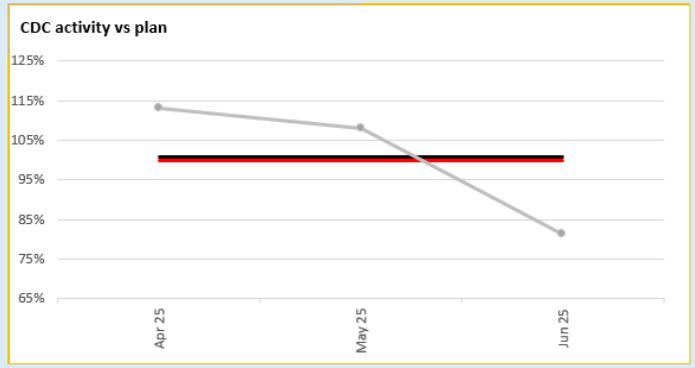












KSO1 AREAS OF FOCUS

Queen Victoria Hospital
NHS Foundation Trust

Area	Summary, impact and actions
Ethnicity Recording	The trust delivered an improvement in ethnicity recording to 83.7%.
Smoking Status	Remains at 99% compliance.
Falls	A total of four falls within the Trust. Three inpatients falls; two unwitnessed and reported by patients, no harm. One witnessed fall due to a fainting episode. One further fall reported by patient in the car park with no harm. All investigations complete.
Pressure ulcers	Two reported pressure ulcers, both low harm and investigations completed.
% Complaints Responded On Time	87% complaints responded to within time frame. One compliant response was delayed due to further investigation into the issue raised.
Safer Staffing Compliance	Safe staffing levels noted throughout the inpatient areas.
Patient Safety Incident Investigations (Internal)	Two open internal investigations (both subject to inquests).
Patient Safety Incident Investigations (External)	One externally reported patient safety incident with CCCS directorate, currently being investigated.
% Overall FFT Recommendation Rate	Remains high at 95%.
VTE Risk Assessment	Meeting target VTE compliance at 97.3%.

KSO1 AREAS OF FOCUS

Queen Victoria Hospital
NHS Foundation Trust

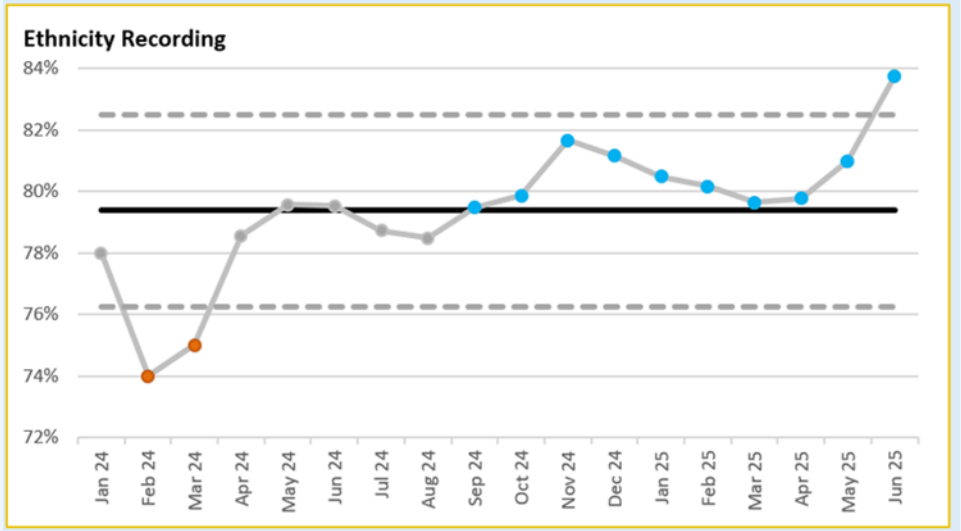
Area	Summary, impact and actions
RTT> 65 weeks	The Trust reported 45 patients waiting over 65 weeks in M3, which was an improved position against the internal forecast of 58 patients. There will continue to be a small number of 65 week wait patients over the coming months – particularly within DIEP and Mohs services. The Trust has progressed both recruitment and insourcing mitigation actions to provide more capacity in future months to reduce the long waiting position, yet this will remain a challenge for Q2.
RTT >52 Weeks %	M3 performance (2.17%) narrowly missed the 2.1% planned trajectory, despite QVH remaining on plan for the number of patients waiting over 52 weeks. The Trust's current trajectory is based on the overall M3 waiting list which was predicted to be 20,685 patients (in comparison to 17,869 currently); therefore, the Trust will need to revisit the trajectory at the end of Q2 when the validation sprint concludes, and the waiting list size can be better predicted.
RTT - 18 week wait - first appointment	The Trust achieved the planned trajectory for M3 and predicts to remain on plan in M4.
RTT 18 Week Wait Performance	The Trust achieved the planned trajectory for M3 and predicts to remain on plan in M4.
RTT Waiting List	The RTT Waiting List increased by 245 patients overall (from 17,624 to 17,869). This was driven by an increase in the registration of Sleep patients due to the new electronic referral process. NHSE's 'Validation Sprint' continued to improve internal 12 week-validation performance and ensured inactive pathways were removed from the waiting list. Project Sprint will continue until the end of Q2.
Cancer 28 Day FDS	The Trust reported a 7.7% improvement in performance to achieve both the national standard and internal trajectory, despite an 8.0% increase in referrals year to date. Diagnostic delays, first & follow-up outpatient capacity, late referrals, and patient choice continue to impact on performance. However, the Trust expect the achieve the trajectory and national standard in M3.
Cancer 62 Days	The Trust reported a reduction in 62 day performance and did not meet the internal trajectory. The Trust is challenged particularly in skin services where referrals have seen a significant increase. Comparing 2023/24 to 2024/25, skin reported a 22% increase in the number of cancer treatments. Additional Skin clinics and theatre lists continued in M3. The trust is working with the Sussex system to review the pathway and opportunities to transform.
Diagnostics 6 Week Wait Performance	DM01 performance reduced in M3, primarily driven by Cone Beam CT capacity (due to equipment failure in M1). CT performance deteriorated by 13.6%. The new CBCT machine has been installed and became operational in M3, with a forecasted improvement in CT diagnostics during M4. Inpatient Sleep diagnostic capacity constraints (given the fixed number of overnight beds) also led to wait times in excess of six weeks. The Sleep service have commenced mitigation actions, including: review of the patient wait list to consider alternative diagnostics and increased capacity for home studies. Until these actions are fully integrated, the trust is likely to see DM01 performance challenged, and an improvement plan is in development.
MIU 4 Hour Performance	Trust performance (96.4%) missed the 98.0% internal target due to staff shortages and skill mix; this led to triage delays. As reported in M2, MIU is likely to face some challenges in meeting the internal trust target until M5, when new staff will be fully trained. However, it is forecast that the national target (95%) will continue to be achieved going forward.
% Income Vs Plan	The Trust achieved the planned trajectory for M3.
% CDC activity vs plan	The Trust achieved 81.2% overall activity vs plan. Estates, equipment and staffing issues within ophthalmology are challenging the delivery of planned activity levels, despite additional weekend clinics being booked. Additionally, referral demand for cardiology diagnostics is hoped to increase with the new Heart Failure pathway. Trajectories are being developed for modalities not delivering to plan.
Outpatient productivity- missed appointment rate	Missed appointment rates in M3 improved to 4.8%, reflected the best performance recorded over the past year.

HEALTH INEQUALITIES PRIORITY PROGRESS

Queen Victoria Hospital
NHS Foundation Trust

Area	Summary and actions
Data Improvement	The Trust ethnicity data collection for June is 83.7%, an increase from last month. A new 12-week task and finish group will commence in July to focus on priority areas to: • Improve visibility and accessibility of data • Improve visibility of missing data in Patient Centre system • Initial data shows an additional 767 collections in Plastics from Q1 baseline Each Directorate has improving ethnicity recording as an annual goal for 2025/26.

Ethnicity data collection



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

Queen Victoria Hospital
NHS Foundation Trust

KSO2

To innovate and improve

Ambition

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

Board Assurance Framework

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

2025/26 Annual Objectives

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

2025/26 Annual goals

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

KSO2 EXECUTIVE SUMMARY

Research & Innovation:
The team structure for the research & innovation is now defined and established. NIHR funded research partnership role to facilitate collaborative work with GPs appointed to. Application for charitable funds to support refurbishment of a research, innovation and improvement hub at the heart of the QVH estate and pump priming of proof-of-concept local investigator-initiated research agreed by ELT to go to Charity Committee in August. Offer of support from Health Innovation Network to steer innovation development received. NIHR bid for funding to support CDC research not shortlisted. Training programme in data mapping for staff initiating research to start in Sept 25

Quality priority: Evidence through measurable outcomes
The audit plan for 25/26 has been developed with directorates as a living document with accountability for workstreams and is informing development of the 3-year audit strategy. Set up of RedCAP database is constrained by other IT priorities including EPR and therefore other solutions for digital survey are being developed including Lime Survey and PKB.

Embed continuous improvement (CI):
The CI programme remains on track, Improvement huddles continue across 15 areas with mixture of physical and virtual huddles with plans in place to refresh three ward areas once ward moves complete. Huddle Board Leads Community of Practice continues to embed and oversee this Trust wide. One new virtual improvement huddle area has been trained and now launched in Therapies. Executive Masterclasses are in progress with some refinement made of the next session to support current priorities and strategy deployment. Next Celebration event set for September for final in-house Yellow Belt cohort graduation. Discussion ongoing regarding a sustainable CI training programme. CI mandatory training video draft complete, feedback awaited.

Medical Education:
The BMA ballot of Resident doctors has given a 6-month mandate for strike action from July 25. Medical Education will monitor impacts on teaching & training. A programme of CPD events for supervisors (consultants and SAS) is being planned that will be delivered by Doctors Training. The BMA will be supporting us with a programme of events for resident doctors. Our VRiMS virtual reality kit is now on site, incorporating six Pico 4 Ultra headsets with preloaded access to relevant training apps. The GMC survey of doctors in training results are due in July and will be evaluated with services.

Tamara Everington
Chief Medical Officer

Queen Victoria Hospital
NHS Foundation Trust

KSO3

To be an excellent employer

Ambition

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

Board Assurance Framework

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

2025/26 Annual Objectives

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

2025/26 Annual goals

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

KSO3 EXECUTIVE SUMMARY

Temporary staffing use continued to decrease in M3 and is under plan for Q1 25-26. To maintain grip and control focus is through the temporary staffing reduction oversight group and dedicated management by the Heads of Nursing, with substantive roles being filled and turnover decreasing.

There was a single grievance raised in M3.

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

Stability is being achieved for overall sickness absence, however it is noted that there is an increase in Long Term Sickness absence and a reduction in short term absence. Support continues to be provided to managers and staff and the Trust are also linked with system partners on sharing best practice.

Time to hire has increased in M3 due to complex occupational health references being required and visa application delays.

The organisational development team are working with managers to support their staff survey action plans. Focussed work is ongoing for specific areas of mandatory and statutory training compliance, with the learning and development team following up with managers where their compliance rates are lower than required.

The trust is delivering behavioural framework/toolkit workshops from June to September to provide and understanding of how to apply and embed the framework throughout areas of responsibility. Further engagement will be undertaken to promote the workshops, along with embedding the behaviour framework in 1:1 conversations, appraisals and team development sessions.

Helen Edmunds
Chief People Officer

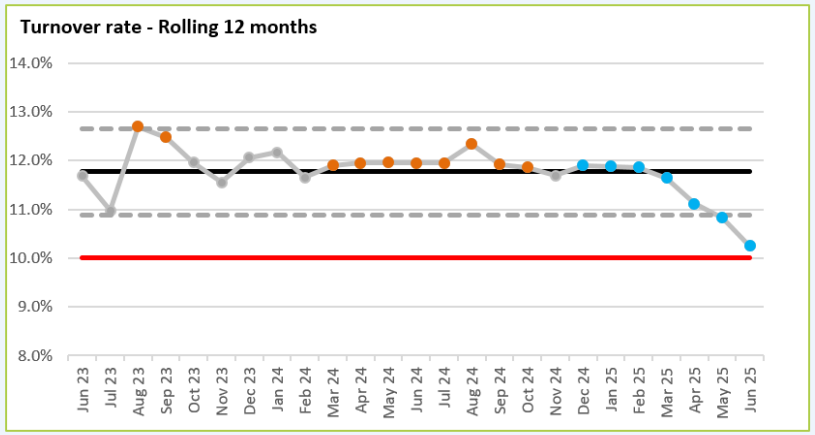
KSO3 BALANCED SCORECARD

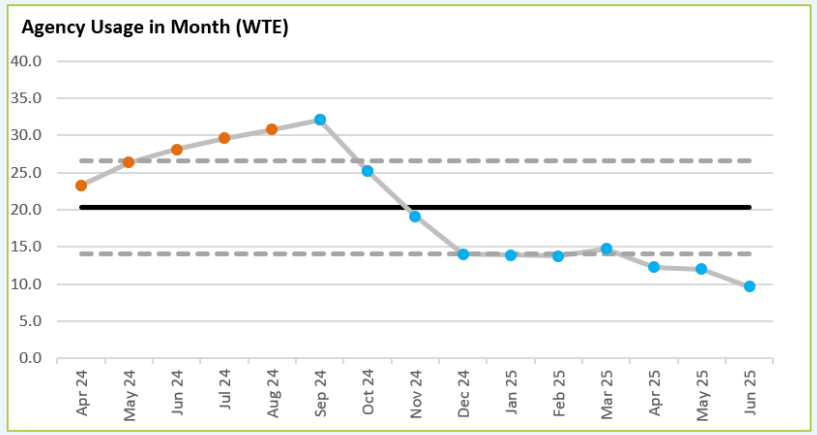
Queen Victoria Hospital
NHS Foundation Trust

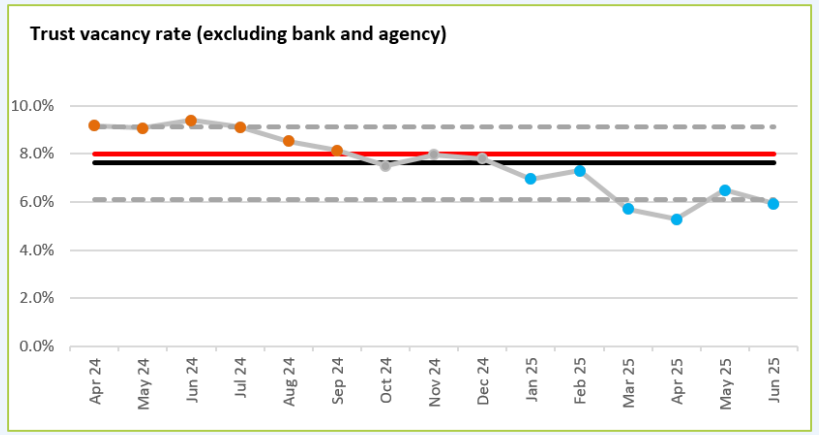
Metric	Latest Month	Target	Variation	Assurance	Actual	Actual Previous Month	Mean	LCL	UCL	Summary
Trust vacancy rate (excluding bank and agency)	Jun-25	8%			5.9%	6.5%	7.6%	6.1%	9.1%	Special Cause - improving variation
Vacancies - Incl Bank & Agency	Jun-25	8%			2.2%	1.0%	1.9%	-0.5%	4.3%	Common cause - no signficant change
Average Time to Hire - Days	Jun-25	53			87.9	66.2	63.24	24.93	101.56	Special Cause - concerning variation
Turnover rate - Rolling 12 months	Jun-25	10%			10.3%	10.8%	11.8%	10.9%	12.6%	Special Cause - improving variation
Sickness absence rate - Rolling 12 months	Jun-25	3%			3.9%	3.9%	3.7%	3.6%	3.9%	Special Cause - concerning variation
Appraisal Rate	Jun-25	90%			83.3%	82.9%	84.3%	81.9%	86.7%	Common cause - no signficant change
Statutory & Mandatory Training Compliance	Jun-25	90%			91.1%	90.8%	92.0%	90.8%	93.1%	Special Cause - concerning variation
Agency Usage in Month (WTE)	Jun-25	-			9.6	12.0	20.31	14.01	26.62	Special Cause - improving variation
Bank Usage in Month (WTE)	Jun-25	-			65.7	72.4	82.18	64.36	100.00	Common cause - no signficant change
Annual Leave Taken	Jun-25	-			23.9%	19.5%	19.2%	6.4%	32.0%	Common cause - no signficant change

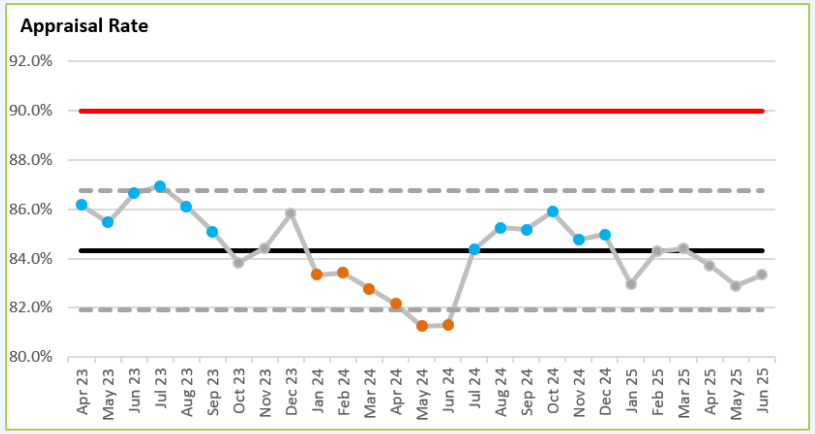
EXCELLENT EMPLOYER KEY METRICS

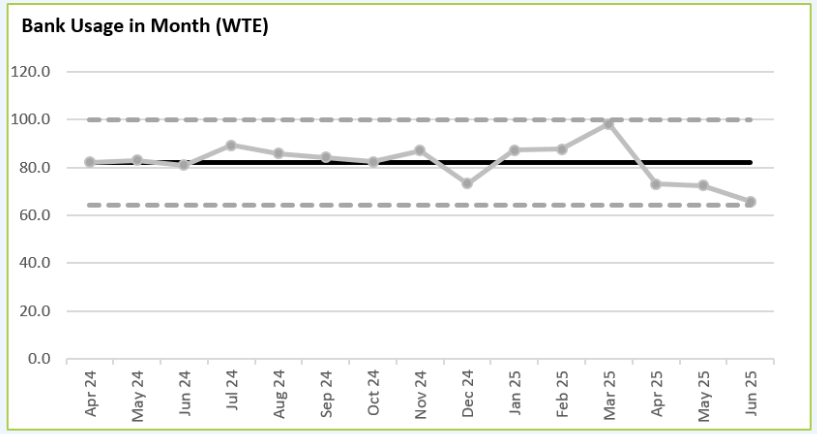
Queen Victoria Hospital
NHS Foundation Trust

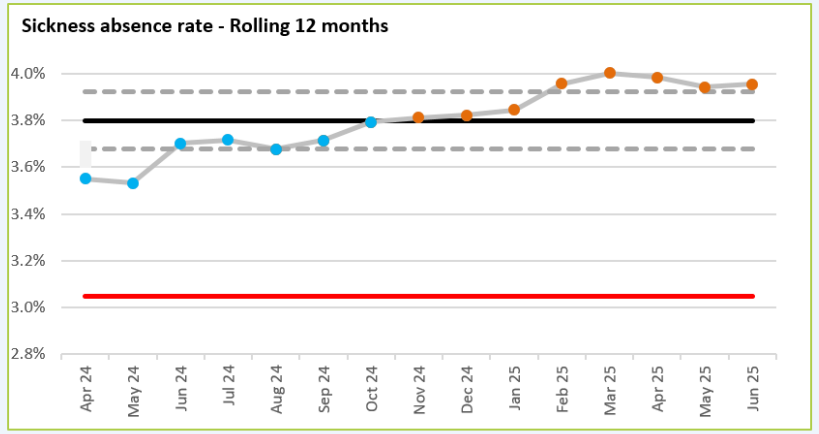












KSO3 AREAS OF FOCUS

Queen Victoria Hospital
NHS Foundation Trust

Area	Summary, impact and actions
Trust vacancy rate (excluding bank and agency)	M3 shows headcount of 1254 (1075.52 whole time equivalent (WTE). This is the same headcount as M2 (1254) but a slight increase in WTE (1074.21 WTE) of 0 HC / 1.31 WTE. Trust vacancy rate has reduced to 5.9% in M3 from 6.5% in M2
Average Time to Hire - Days	Increase from 66.2 days in M2 to 87.9 in M3. The longest delays were in CDC, CCU, Radiography and Maxillofacial due to more complex Occupational Health (OH), references and visa applications. Both the OH and reference delays were due to more complex issues that required manager clearance. Visa delays were due to the time taken for visa approval.
Sickness Absence Rate - Rolling 12 Months	This measure shows 'concerning variation' as performance has been above the mean for 6 months and has remained the same since last month. This measure remains under 4% (which is the system target in the national operational planning guidance), and it remains an ambition for QVH to reduce sickness absence to 3% or less which we are striving to achieve. Long term sickness absence has seen an increasing variation of 0.50% over the year and has increased above 2% with most working days lost due to oncology. Short term sickness absence has seen the usual downward trend over the last quarter and is below 2%. We anticipate a continuing improving picture as we move through the summer months. Absences due to cold, cough, flu remain the highest reason.
Agency Usage In Month (WTE)	Reduction in agency usage from 12.3 in M2 to 9.6 in M3. Highest agency usage for M3 was Nursing at 3.30 WTE followed by Allied Health Professional Staff Group at 2.02 WTE (a decrease from M2). The highest use areas are Peri-op at 5.22 WTE with the Theatres team accounting for 3.78 WTE. Ongoing work is underway with Heads of Nursing staff for final sign off and approval for any agency requests within Nursing. Agency cascade commenced in June bringing more scrutiny, with roll out to Nursing initially.
Bank Usage In Month (WTE)	Bank has decreased for M3 from 72.4 WTE in M2 to 65.7 WTE in M3. Highest staff group was Nursing which has decreased from 30.08 WTE in M2 to 20.88 WTE in M3. Peri-op had the highest use at 25.87 WTE of which 9.44WTE is accounted for in Theatres.
Grievances raised	1 grievance raised in M3.
% Job plans complete	84% of job plans are currently complete, with focussed work underway and a stretch target of August 2025 to achieve 95%.
Turnover rate	Turnover has reduced further to 10.25% in M3 from 10.8% in M2 and 11% in M1. Whilst this is above the 10% target, this has been a reducing rate for Q1 and has continued since 24-25. Exit interviews continue to be undertaken. There are no significant patterns / areas of focus, however it is accepted that turnover through natural attrition is likely to be lower through 25/26 due to there being less vacancies for staff to move around.
Statutory and mandatory training	This measure still shows 'concerning variation' although there has been a slight increase in compliance over the past two months. MAST compliance has shown an improvement and has increased from 90.8% in M2 to 91.1% in M3. Resus Adults and Paeds L2 training were highlighted as a focus for improvement.
Appraisal rate	We continue to strive to meet the 90% completion rate, with a continued focus with managers and highlighting areas that are outstanding via the Trusts' senior managers. M3 shows a 0.47% increase in compliance.

Queen Victoria Hospital
NHS Foundation Trust

KSO4

To deliver sustainable services

Ambition

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

Board Assurance Framework

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

2025/26 Annual Objectives

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

2025/26 Annual goals

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

KSO4 EXECUTIVE SUMMARY

At the close of June 2025, the Trust reported an Income and Expenditure position in line with planned deficit of £0.8m and had a cash balance of £5.0m. Whilst an on plan position for the YTD remains positive, there will need to be a significant improvement in Trust contribution to deliver the planned break even position for 2025/26, with the main risk area being delivery of best value schemes of £7.5m (6%) for the year.

Elective activity value was slightly ahead of plan in M3 and is above plan YTD. This is offset by some underperformance in CDC income in both M3 and YTD. ERF income is currently estimated based on last year's target baselines and payment arrangements until 2025/26 contract baselines and reconciliation process is agreed.

Pay was c£0.1m adverse to plan for YTD mainly due to non-delivery of best value schemes (£0.2m). Worked WTE was in line with M2 and agency spend was broadly on trend of recent months and within the 2% target of overall. Non-pay was underspent for the YTD (£0.3m) and in M3 there was an improved position in part due to reduced bad debt provisions due to collection of historic debt (£0.1m).

At the end of M3, the Trust reported a YTD delivery of £1.5m efficiencies against a plan of £1.5m. Whilst many schemes are making progress, there are a small number of large schemes which remain high-risk and significant work is required to ensure the annual £7.5m best value plan is delivered.

The Trust's capital plan for the year was £26.4m of which £18.0m relates to the CDC. Spend was low in M3 against plan but is expected to catch up in later months.

The Electronic Patient Record programme and Sussex Pathology Network programmes remain on track.

Freedom of Information requests responded to within 20 days has improved in M3 to 63%. This continues to be an area of focus through the Information Governance Group and Digital Steering Group and a follow up with managers for responses to be returned for sign off and sent back to the requestor in a timely manner.

Simon Marshall
Interim Chief Financial 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	Jun-25	-£0.80m			-£0.80m	-£0.70m	-0.64	-1.15	-0.13	Common cause - no signficant change
Cash at Bank YTD	Jun-25				£5.00m	£5.10m	6.33	-2.23	14.88	Common cause - no signficant change
Capital Spend YTD	Jun-25	£6.6m			£0.90m	£0.20m	3.76	-7.65	15.16	Common cause - no signficant change
Efficiencies YTD	Jun-25	£1.50m			£1.50m	£0.90m	3.48	-0.60	7.56	Common cause - no signficant change
BPPC (NHS & Non NHS) - volume	Jun-25	95%			91.4%	89.0%	0.90	0.87	0.94	Common cause - no signficant change
BPPC (NHS & Non NHS) - value	Jun-25	95%			90.6%	89.0%	90.0%	84.9%	95.1%	Common cause - no signficant change
Agency spend <2% total pay bill	Jun-25	£0.39m			£0.31m	£0.22m	0.22	-0.04	0.47	Common cause - no signficant change
Agency spend 40% less than 24/25 forecast	Jun-25	£0.37m			£0.31m	£0.22m	0.22	-0.04	0.47	Common cause - no signficant change
Bank spend reduction of 10% of Total Pay Bill	Jun-25	£1.12m			£0.93m	£0.63m	0.64	-0.12	1.40	Common cause - no signficant change
Subject Access Requests - Total Received	Jun-25				78	81	76.11	32.32	119.90	Special Cause - concerning variation
Subject Access Requests - % Closed within 30 calendar days	May-25	100%			100.0%	100.0%	93.2%	72.3%	114.1%	Special Cause - concerning variation
Freedom of Information requests – Total Received	Jun-25				57	58	49.81	15.85	83.78	Common cause - no signficant change
Freedom of Information requests – % Closed within 20 working days	May-25	80%			63.2%	38.7%	64.1%	40.9%	87.3%	Common cause - no signficant change

KSO4 EXECUTIVE SUMMARY

Queen Victoria Hospital
NHS Foundation Trust

Capital

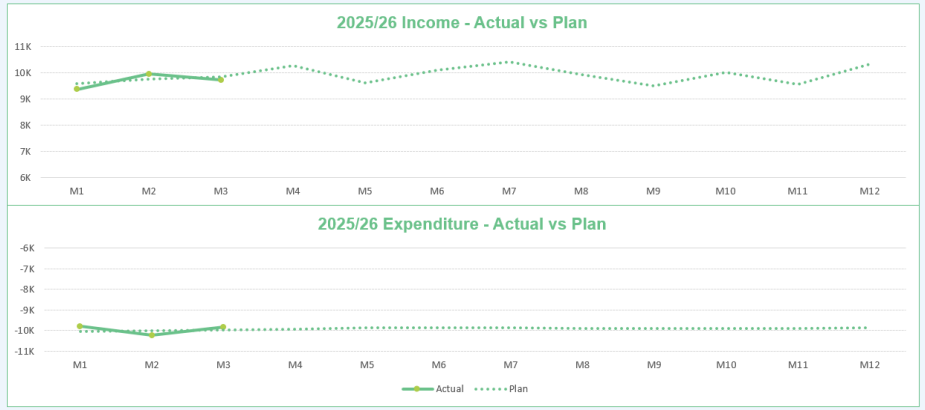
	In Month £'000			Year to Date £'000			Forecast Outturn £'000s		
	Plan	Actual	Variance	Plan	Actual	Variance	Plan	Actual	Variance
IT	0	2	2	131	13	(118)	131	131	0
Medical Equipment	83	0	(83)	249	0	(249)	1,000	1,000	0
Estates Maintainance	193	178	(15)	193	191	(2)	1,907	1,907	0
Estates Other	0	0	0	750	0	(750)	750	-	(750)
EPR	248	379	131	744	495	(249)	2,983	2,983	0
CDC	1,495	167	(1,328)	4485	204	(4,281)	17,949	17,949	0
Other Capital	24	0	(24)	24	0	(24)	1,640	1,640	0
Total	2,043	726	(1,317)	6576	903	(5,673)	26,360	25,610	(750)

Income and Expenditure

	In Month £'000			Year to Date £'000			Forecast Outturn £'000s		
	Plan	Actual	Variance	Plan	Actual	Variance	Plan	Actual	Variance
Income									
Patient Activity Income	9,498	9,358	(140)	28,144	27,982	(162)	114,691	114,691	0
Other Operating Income	350	367	17	1,051	1,085	34	4,226	4,226	0
Total Income	9,848	9,725	(123)	29,195	29,067	(128)	118,917	118,917	0
Pay									
Substantive	(5,861)	(6,004)	(143)	(17,683)	(18,092)	(409)	(69,910)	(69,910)	0
Bank	(381)	(305)	76	(1,145)	(933)	212	(4,228)	(4,228)	0
Agency	(134)	(87)	47	(402)	(306)	96	(1,599)	(1,599)	0
Total Pay	(6,376)	(6,396)	(20)	(19,230)	(19,331)	(101)	(75,737)	(75,737)	0
Total Non-Pay	(2,902)	(2,717)	185	(8,717)	(8,458)	259	(34,943)	(34,943)	0
Total Non Operational Expenditure	(709)	(737)	(28)	(2,128)	(2,137)	(9)	(8,511)	(8,511)	0
Total Expenditure	(9,987)	(9,850)	137	(30,075)	(29,926)	149	(119,191)	(119,191)	0
Surplus/(Deficit)	(139)	(125)	14	(880)	(859)	21	(274)	(274)	0
Technical Adjustments	23	23	0	69	69	0	274	274	0
Adjusted Surplus / (Deficit)	(116)	(102)	14	(811)	(790)	21	0	0	0

Efficiency

	In Month £'000			Year to Date £'000			Forecast Outturn £'000s		
	Plan	Actual	Variance	Plan	Actual	Variance	Plan	Actual	Variance
Pay - Establishment Reviews	61	100	39	183	310	127	922	1,037	115
Pay - Corporate Service and Digital Transformation	175	28	(147)	425	84	(341)	2,000	1,576	(424)
Pay - Clincal Service Redesign	53	56	3	159	168	9	1,310	1,264	(46)
Pay - Agency	39	55	16	117	166	49	463	512	49
Non-Pay - Procurement	58	57	(1)	114	210	96	641	737	96
Non-Pay - Other	-	197	197	-	197	197	-	197	197
Non-Pay Corporate Service and Digital Transformation	137	52	(85)	341	149	(192)	1,584	1,392	(192)
Non-Pay Clinical Service Redesign	13	56	43	39	168	129	153	282	129
Income - Non-patient care	31	6	(25)	93	22	(71)	376	455	79
Income - Other	1	-	(1)	3	-	(3)	11	8	(3)
Total	568	608	40	1,474	1,474	0	7,460	7,460	0

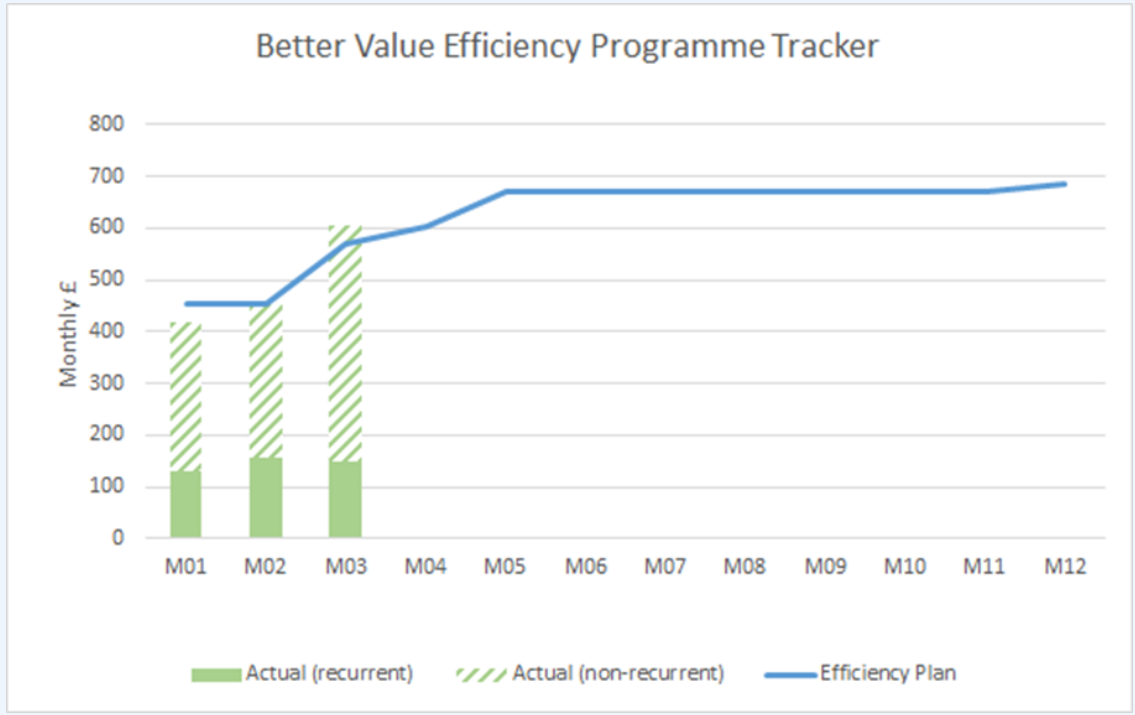


	Annual Target	Forecast Outturn
Income & Expenditure	£0.0m	£0.0m
Cash at bank	£1.9m	£1.9m
Capital Spend	£26.4m	£25.6m
Efficiencies	£7.46m	£7.46m
BPPC (NHS & Non-NHS)		
Volume	95.0%	91.9%
Value	95.0%	93.6%

Trust Best Value Efficiency Programme

Queen Victoria Hospital
NHS Foundation Trust

% Confidence	Financial Risk Rating	£000	%	Risk Adj. £000
100%	Blue	2,289	30%	2,531
80%	Green	582	8%	508
60%	Amber/Green	1,011	13%	748
40%	Amber	765	10%	306
20%	Amber/Red	718	9%	144
10%	Red	2,241	29%	224
Total		**7,606**	**100%**	**4,462**



KSO4 AREAS OF FOCUS

Queen Victoria Hospital
NHS Foundation Trust

Area	Summary, impact and actions
Breakeven YTD	Position was on plan of £0.8m deficit for M3. Patient activity value was £0.1m favourable to plan in month and £0.2m YTD. This is offset by CDC underperformance of -£78k in month and -£170k YTD. ERF Income is currently estimated using 24/25 target values until 2025/26 contract baselines and reconciliation processes are agreed.
Cash at Bank YTD	Cash at M3 was £5.0m, below the planned £5.8m, mainly due to the delayed receipt of the first tranche of CDC capital support expected in June. Cash levels remain supported by the slow start in capital spending
Capital Spend YTD	The Capital Plan for M3 included £4.7m for CDC and £0.8m for boiler lease (which was contracted in 2024/25). Excluding these items planned spend was £0.9m in M3 with an underspend in M3 of £0.8m due mainly to delays in spending for EPR & Estate Safety Fund programmes.
Efficiencies (Cost Improvement Plans) YTD	Delivery of £1.475m vs plan of £1,474m. Includes element of non-recurrent vacancy. Significant level of high-risk schemes remain and work is being undertaken to ensure the annual £7.5m CIP plan is delivered.
BPPC (NHS & Non-NHS) Volumes	BPPC is slightly below target at 91.4% due to delays in processing requisitions.
BPPC (NHS & Non-NHS) Values	BPPC is slightly below target at 90.6% due to delays in processing requisitions.
Agency spend 40% less than 24/25 forecast	On plan.
Agency Spend Less than 2% of Total Pay Bill	On plan.
Bank spend reduction of 10% of Total Pay Bill	On plan.
Pay Spend	Position improved slightly due to recent trend in M3 mainly due to reduced bank spend in medical pay. Pay is overspent YTD (£0.1m) mainly due to slippage in best value schemes.
Non-Pay Spend	£0.3m underspent for the YTD. Improvement in bad debt provision in M3 (£0.1m) due to collection of historic debt. It will be essential to maintain and reduce the non-pay spend to deliver the plan in future months.

KSO4 PROJECT REPORT

Queen Victoria Hospital
NHS Foundation Trust

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

LIMS - This project remains red until a CCN on a revised project plan is agreed. However key milestones dates have been agreed, and the project's activities continue against these. The project technical enablement work and UAT phase 1 execution continues to track slower than required to meet the UAT phase 2 gateway, which will not be met. Exception report raised and options appraisal underway
Digital Histopathology (DHP) - Work continues on the development of a 2D barcode solution for slide labels which is key to identification of digital images. There have been a number of emerging technical issues which has slowed progress on this task. A series of meetings has been established to discuss integration of DHP with WInPath Enterprise in preparation for the deployment and go-live at QVH
Order Comms (ICE) - Configuration stage continues with design and build of the platform, aiming for completion mid Sept. to enable testing alongside LIMS UAT P3. Additional resources are required to prepare for testing, procurement underway. Comms/engagement workstream to be re-established in July to communicate with wider stakeholder group and seek volunteers for testing in multiple care settings.
Digital Infrastructure - Slippage due to dependencies on third parties, not expected to impact critical path, but may result in conflicting resource requirements in Jan/Feb 26. Expectation to align with the LIMS UAT Phase 3 to enable full end-to-end testing. IT Operational process review has agreed principles and commenced review of SLA/ BCPs etc, challenging resource availability may result in further slippage
Managed Service Contract (MSC) - SPN Board agreed to delay Round 2 evaluation and moderation to enable a review of options going forward following an external legal review to assess risk of legal challenges. A summary report has now been sent to all SPN organisations for review and approval by mid-August. Further development is paused until this point.
Network Formation - The project team has approved the development of an enhanced version of the Memorandum of Understanding (MOU) to allow network working to continue with the OBC is being drafted. This MOU was approved and formally signed off by all organisations. Collation of information for the Outline Business Case continues with a target to put through governance in September.
Laboratory Operating Model (LOM) - The LOM Outline Business Case (OBC) continues to be drafted with focus through July on reviewing estates information, development of the finance and economic case sections and conducting OBC review meetings in preparation for target completion in September.
Quality – No further developments this month. The project is currently paused and handed over to a reference group for ongoing monitoring. Monthly NHSE PQAD submissions are still being completed and DHP reporting metrics are now included. UKAS ISO 15189:2022 assessments are underway at various laboratories within SPN (QVH ISO15189 Clinical Assessment 9th May 2025).

Milestone	Start Date	Expected Completion Date	Commentary
LIMS complete validation for Cell Path and Blood Transfusion	End Feb 2025	TBC	Current progress and supplier issues risks go-live targets Options appraisal underway
Completion of Network Formation MOU OBC for approval	Sept 2025	Sept 2025	Collation of OBC content to be completed by August.
MSC summary report approval to all SPN Trust Execs	July 2025	August 25	Approval required for progression of Phase 3
Technical completion of 2D barcoding solution for DHP.	April 2025	September 2025	Lack off Winpath V5 connectivity/functionality has required an alternative data collection approach to be engineered.

Date Raised	Risk Description	Mitigating Actions
April 2025	Capacity of Trust resourcing insufficient to meet programme timelines.	Collaborative working across SPN, agree priority projects, secure additional external resources.
April 2025	Varying internal governance scheduling delays programme timelines.	Assign Trust and Network SROs to manage issues, project boards and steering groups in place, early socialisation of business cases via SROs.

KSO4 PROJECT REPORT

Queen Victoria Hospital
NHS Foundation Trust

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

Given the complex nature of the programme, the EPR programme board agreed that the programme status is Amber with November go live on track. PAS planned to go live in Q3/4 2026.

A significant amount of work has already been progressed to get the Trust ready for an EPR, including mobilising a team with experience of delivering EPRs, engagement, testing, training strategies and plans approved. Electronic documents have been configured, clinically validated and tested for inpatient documents. Work underway for documents in MIU, Outpatients and Surgical Care. Catalogue build is now completed for EPMA and is now 100% validated. Integration progressing well with links to Safer Sleep, MIU and ICE still outstanding, but planned.

Governance has been strengthened as the programme has progressed. This now includes a monthly EPR Finance Subgroup. Within the overall milestone plan, there are activity and milestone trackers around key workstreams including business change, configuration, testing and integration.

We will undertake a hybrid 4.0/4.5 approach, which is moderate in terms of assurance by NHS England. This approach was presented at the July 2nd EPR Programme Board. Follow up meetings/interviews are scheduled for July-September. Additional go live sign off will also be required by ICB and this has been reviewed. Sign offs for both are expected in September.

Programme finances clarified and included within 2025/26 business planning. Benefits being reviewed for further opportunities with time and motion studies being planned for June-August 2025.

Some challenges exist regarding finalising transition to BAU and subsequent BAU model being in place to support go live and post go live, outpatient scope, accessing Archie at spoke sites and report writing skills.

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

Date Raised	Risk Description	Mitigating Actions
Oct-24	Risk of lack of clinical engagement.	Medical CAG now established on fortnightly basis. Additional medical resource has been provided for surgical pathway to support CCIO. SRO is Trust Chief Medical Officer who will also support clinical transformation.

Queen Victoria Hospital
NHS Foundation Trust

KSO5

To collaborate with others

Ambition

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

Board Assurance Framework

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

2025/26 Annual Objectives

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

2025/26 Annual goals

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

KSO5 EXECUTIVE SUMMARY

Local Offer
Progress to continue to work at pace for this project has been reduced in July due to recent changes in the resource capacity available. However, work continues to advance on operational initiatives related to the QVH's community rehabilitation services and is now further supported by the senior operational delivery team.

QVH is participating in the newly established Integrated Frailty and Complex Needs Sussex Delivery Group. The group's objective is to define minimum standards that will underpin a core service offer for identified population cohorts across neighbourhoods. This will be informed by risk stratification and will support the development of the Integrated Neighbourhood Teams model for local delivery, with a view to ensuring readiness for winter 2025/26.

A strategic meeting has taken place with the ICB to discuss QVH's role within the Sussex-wide urgent and emergency care framework. The ICB will review relevant data to inform recommendations on future service provision in East Grinstead and will provide feedback in due course.

Major Service Review (MSR)
Outputs from the Sussex-wide Rehabilitation and Intermediate Care workshops held in May and June have been developed and shared. These have now been cascaded to frontline teams within QVH to gather feedback and ensure alignment with proposed practice. A final draft will now be submitted to the Committee in Common and the NHS Sussex Board in September.

We continue to await further information from the Urgent and Emergency Care Review.

CDC – East Grinstead and Bognor
Preparations underway for the commencement of building works on the East Grinstead CDC site. CDC activity in East Grinstead remains a key focus as well as negotiations with University of Chichester on Heads of Terms for the Bognor programme

Kathy Brasier
Deputy Chief Strategy Officer

KSO5 PROJECT REPORT

Queen Victoria Hospital
NHS Foundation Trust

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

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

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

1. Building contractor chosen and works starting on site in near future.
2. Engagement continues with University of Chichester regarding next steps for the Bognor site
3. Activity against plan for East Grinstead was at 92% for May 2025.
4. Contract for current activity in Bognor being run by UHSX elapses in Feb 2026. Arrangements post this time need to be agreed

Key areas for focus over the next period are starting the construction of the new CDC building on the East Grinstead site, continuing to optimise current CDC activity in East Grinstead, negotiation with University of Chichester on Heads of Terms for the Bognor project and considering arrangements for the current activity in Bognor post Feb 2026.

Milestone	Start Date		Expected Completion Date	Commentary
Agreement on Heads of Terms.	30/4/25		30/7/25	Discussions with University of Chichester on new site for Bognor. Delays in obtaining a draft Heads of Terms from the University.
Construction commences on East Grinstead site	01/09/25		01/09/25	Pre-ommencement works underway.
Full reporting of CDC activity and plan.	30/4/25		30/5/25	Reporting template and CDC modality inputs developed and being used to monitor activity. Milestone completed.

Date Raised	Risk Description	Mitigating Actions
01/01/2025	NHS Funding long-term availability.	Trust engaging with ICB and NHSE regarding funding requirements.
01/06/25	Continuity of activity at Bognor.	Trust engaging with UHSX about future arrangements post Feb 2026.
04/04/25	Actual CDC activity vs plan.	Urgent remedial actions being taken to bring back to plan.

Trajectories- Operational performance

Queen Victoria Hospital
NHS Foundation Trust

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

Cancer (reported a month in arrears)	M1	M2	M3	M4	M5	M6	M7	M8	M9	M10	M11	M12
FDS	79.4%	79.9%	80.0%	80.4%	80.8%	80.8%	81.0%	80.4%	81.0%	80.0%	80.4%	80.8%
62 days	70.8%	71.4%	71.0%	72.2%	72.9%	73.2%	75.3%	75.7%	71.8%	71%	75.7%	75.7%

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

Key

Performance achieved trajectory

Performance did not achieve trajectory

Interpretation of Summary Icons for Statistical Process Charts

Queen Victoria Hospital
NHS Foundation Trust

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

SPC Chart Key:

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

GLOSSARY

Queen Victoria Hospital
NHS Foundation Trust

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

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

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

Report cover-page					
References					
Meeting title:	Board of Directors				
Meeting date:	11/09/2025		**Agenda reference:**	**64-25.2**	
Report title:	Estates update				
Sponsor:	Simon Marshall, interim Chief finance officer				
Author:	Simon Marshall, interim Chief finance officer				
Appendices:	None				
Executive summary					
Purpose of report:	To provide the Board with an overview of the Trust's estate including how risks are being overseen and mitigated.				
Summary of key issues	There are a number of emerging issues for which mitigating actions are being developed and implemented. These include: - Water ingress in theatres and smoke dampers - Equipment replacements leading to estate improvement requirements - End of life buildings which are uneconomic to maintain - Capacity within the estates team and vacancies incl. authorising engineer - Capital and revenue funding constraints The PAM is required to be submitted to NHSE before the end of September each year. This year's submission demonstrates that the Trust has improved substantially from a position of only 33% of responses being "good" or "requiring minimal improvement" in 2024 to 74% in 2025. Consequently, those requiring "moderate improvement" or rated "inadequate" have reduced from 66% in 2024 to 22% in 2025. Despite improvements made, there remain substantial issues to be addressed. Further prioritised actions will therefore be required to improve our PAM scores and our assurance further.				
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:	BAF3- there is a risk that the Trust's physical infrastructure is not fit for purpose				
Organisational risk register:	There are various estates risks on the corporate risk register- the highest scoring risks relate to fire dampers, heating and hot water, the boiler, electrical fire and water ingress on the theatre roof				
Regulation:	Premises Assurance Model				
Legal:	Various legal requirements				
Resources:	Limited capital resource available in 2025/26. Funding is being sought from elsewhere where possible				
Assurance route					
Previously considered by:	Finance and performance committee				
	Date:	September 2025	Decision:		

Report to:	Board Directors
Agenda item:	64-25.2
Date of meeting:	11 September 2025
Report from:	Simon Marshall, interim Chief finance officer
Report author:	Simon Marshall, interim Chief finance officer
Date of report:	4 September 2025
Appendices:	None

Estates update

Introduction

This report provides the Board with an update on the Trust's estate including how risks are being overseen and mitigated.

Executive summary

The Trust is carrying substantial risk in relation to its aging estate and internally generated capital resources are insufficient to address the backlogs of work.

Risks related to the Trusts estate continue to emerge.

Processes to identify and assess estates related risks include:

- The Premises Assurance Model (PAM) which supports Boards, Directors of Finance, estates teams and clinical leaders to make informed decisions about the development of their estates and facilities services. It provides partial assurance that the estate is safe, efficient, effective and of high quality
- Triangulation with third party assurance such as PLACE inspection outcomes, Healthwatch reports, Fire safety inspections and reports from the Local Security Management Service (LSMS)
- Testing and surveillance regimes.

Emerging issues

There are a number of emerging issues for which mitigating actions are being developed and implemented. These include:

- Water ingress in theatres and smoke dampers
- Equipment replacement programmes which trigger estate improvement requirements
- End of life buildings which are uneconomic to maintain
- Limited capacity within the estates team and vacancies incl. authorising engineer
- Capital and revenue funding constraints.

Premises Assurance Model (PAM)

PAM is a requirement from NHS England. It was first published in 2013 and was made mandatory for Trusts to complete in July 2022 for 2021 – 2022. The model supports boards, directors of finance and estates and clinical leaders to make more informed decisions about the development of their estates and facilities services. It provides assurance that the estate is safe, efficient, effective and of high quality. This is often one of the key documents the CQC will review before carrying out an inspection as it highlights areas for further improvement and action.

PAM now contains 491 Self-Assessment Questions (SAQs) that cover 50 subject sections over 5 domains. It requires the co-operation and involvement of many different areas across the Trust, subject matter experts in their fields from Estates and Facilities, Health and Safety, Chief Nurse, Infection Prevention and Control (IPC) and Safety & Patient Experience. The domains cover:

- Safety: Hard & Soft Facilities Management
- Patient Experience
- Efficiency
- Effectiveness
- Governance
- FM Standard Maturity Framework

Individual questions, sections, and summary scores are all categorised as follows:

- **Outstanding:** compliant with no action required, plus evidence of high quality services and innovation.
- **Good:** compliant, no action required.
- **Requires minimal improvement:** the impact on people who use services, visitors or staff is low.
- **Requires moderate improvement:** the impact on people who use services, visitors or staff is medium.
- **Inadequate:** action is required quickly – and the impact on people who use services, visitors or staff is high.

The PAM is required to be submitted to NHSE before the end of September each year. This year's submission demonstrates that the Trust has improved substantially from a position of only 33% of responses being "good" or "requiring minimal improvement" in 2024 to 74% in 2025. Consequently, those requiring "moderate improvement" or rated "inadequate" have reduced from 66% in 2024 to 22% in 2025.

Despite improvements made, there remain substantial issues. Further prioritised actions are therefore required to improve our PAM scores and our assurance further.

2025 overall summary scores

Sections	Outstanding	Good	Minimal Improvement	Moderate Improvement	Inadequate	Not Applicable	Total
Safety Hard	0	43	33	24	25	4	129
Safety Soft	0	39	20	3	1	3	66
Patient Experience	0	13	7	1	1	0	22
Efficiency	0	11	11	0	1	3	26
Effectiveness	0	8	6	5	2	1	22
Governance	0	11	9	3	0	0	23
Total	0	125	86	36	30	11	288
	0%	44%	30%	12%	10%	4%	100%

Improvements since 2024

	2024	2024 %	2025	2025 %	Movement year on year
Outstanding	0	0%	0	0%	No change
Good	34	12%	125	44%	+91, +32%
Minimal Improvement	59	21%	86	30%	+27, +9%
Moderate Improvement	86	30%	36	12%	-50, -18%
Inadequate	104	36%	30	10%	--74, -26%
Not applicable	3	1%	11	4%	+8, +3%
Total	**286**	**100%**	**288**	**100%**	**-**

Third party assurance

PLACE

The Trusts 2024 PLACE inspection results show improvement across all domains compared to 2023, with six out of eight scoring at or above the national average with areas of challenge demonstrating progress. The 2025 PLACE review will commence shortly.

Healthwatch

The last visit found a high standard of care and cleanliness, with some specific environmental issues and safety concerns (e.g. sharps and parking) that were acted on and are being monitored.

Environmental Health Office (EHO)

Following the issue of two Improvement Notices in June 2025 for failures in Hazard Analysis and Critical Control Point (HACCP) monitoring and inadequate training, the Trust implemented immediate corrective measures. These included restricting food handling until staff were fully trained, introducing daily ward audits, implementing role cards and Executive oversight. The EHO's revisit in August 2025 confirmed substantial progress, leading to the lifting of the two notices. A further inspection is expected in September 2025 which will review our last food hygiene rating.

Fire safety inspections and re-inspections

Following previous fire inspections and positive re-inspections, safety improvements are progressing, with new fire panels commissioned in May 2025 and all fire dampers inspected and tested by March 2025. Work continues towards L1 compliance. There is a need to undertake some evacuation exercises and the annual fire risk assessments. A fully functional alarm system is in place providing assurance of operational safety.

Local Security Management Service (LSMS)

The security management service programme continues with the development of a prioritised action plan required.

Testing, surveillance and compliance regimes

Areas	Testing, surveillance and compliance regimes
Fire safety (risks around age and infrastructure)	Fire alarm and evacuation testing and planning. Currently in year two of three year action plan
Ventilation (risks around building limitations and infrastructure)	Preventative maintenance and testing incl. air sampling. There have been no infection, prevention and control incidents reported and no fungal or bacterial growth
Asbestos (risks around deterioration and safe removal)	A comprehensive survey was completed. Actions have been completed in relation to high risk areas but concerns remain over end of life roofing
Medical air	Preventative maintenance works are in place and providing assurance
Gas safety	Preventative maintenance works are in place and providing assurance
Infection control (risks around sinks, water)	Hand hygiene measures and water compliance checks are in place to prevent infection, prevention and control issues
End of life buildings incl. outpatients, physio	The build of the East Grinstead CDC is on track. The new build RAAC works are in design stage. Backlog maintenance is increasing for other parts of the site given capital constraints

Oversight (estates governance arrangements)
Internal governance is in place to ensure appropriate oversight of estates issues, however there are some gaps in additional specialist oversight meetings to be addressed. Currently these areas are reporting directly to the Executive sub-committee for Estates and facilities. The governance structure for estates is set out below.

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

Report cover-page					
References					
Meeting title:	Board of Directors				
Meeting date:	11 September 2025	**Agenda reference:**	**64-25.2**		
Report title:	Research & Innovation Update - Bi-Annual Report				
Sponsor:	Tamara Everington, Chief medical officer				
Author:	Mary Mason, Associate Director of Research, Innovation and Improvement				
Appendices:	None				
Executive summary					
Purpose of report:	The bi-annual report is presented as a summary of activity during the first period of 2025 to September 2025.				
Summary of key issues	The report covers progress against the Research and Innovation Strategy to September 2025 and updates on the operational delivery and development of Research and Innovation at QVH. Headlines during this period include: • Preparation and consultation on a bid through ELT to Charity Committee with subsequent approval in principle for investment in a Research, Education and Innovation Hub through refurbishment of a central portion of the QVH estate. • Updates against the operational delivery plan now in place and on track including 2025/26 priorities. • Two studies have closed during this period leaving an active portfolio of six studies currently open to recruitment. Four further studies are progressing through set up, two of which are expected to open shortly. • Collaborations remain a priority and there is ongoing work with prospective partners including University of Sussex, Health innovation KSS and the Sussex CRDC, all of which are progressing with funding opportunities being explored to ensure we remain at the forefront of research and innovation. • Successful grant applications resulting in new in-year funding for our cross-boundary project in partnership with our PCN colleagues as a proof of concept for driving and delivering research opportunities within both primary and secondary care to the benefit of our mutual patients. • Other successful in-year grant applications now enabling recruitment to development posts to be to further support clinical areas to set up research studies and contribute to achievement of the NHSE commercial research set up targets with a Continuous Improvement component further reflecting the QVH commitment to these two key areas				
Recommendation:	The Board is asked to note the activity of first 6 months of 2025/6 within Research & Innovation 2025/6				
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:	N/A				
Legal:	None				

Resources:	None			
Assurance route				
Previously considered by:	Executive Leadership Team, Quality and safety committee			
	Date:	September 2025	Decision:	
Next steps:				

Report to: Board Directors
Agenda item: 64-25.2
Date of meeting: 11 September 2025
Report from: Tamara Everington, Chief medical officer
Report author: Mary Mason, Associate Director of Research, Innovation and Improvement
Date of report: September 2025
Appendices: None

Research and Innovation update

Executive Summary

The report covers progress against the new Research and Innovation Strategy to September 2025 and an update on the operational delivery and development of Research and Innovation at QVH. As the next Research & Innovation Committee meeting is scheduled in early September, data from the latest performance report presented at the end of July is noted in this report. The key highlight for this period has been gaining approval in principle, for a Charity Committee bid to invest in a Research, Education and Innovation Hub.

Work towards delivery of the Research Strategy continues with an operational delivery plan now in place and on track with 2025/26 priorities. Two studies have closed during this period leaving our active portfolio of six studies currently open to recruitment. Four further studies are progressing through set up, two of which are expected to open shortly. Further collaborations remain a priority and ongoing work with prospective partners is progressing with funding opportunities being explored to ensure we remain at the forefront of research and innovation.

Successful grant applications made by the team have enabled us to commence our cross-boundary project in partnership with our Primary Care Network colleagues. Further in year recruitment is in progress for this project as a proof of concept for driving and delivering research opportunities within both primary and secondary care to the benefit of our mutual patients. Other successful in-year grant applications will enable development posts to be used to further support clinical areas to set up research studies and contribute to achievement of the NHSE commercial research set up targets setting the scene for the coming years to deliver the highest quality outcomes and opportunities for our patients.

Background

Following development of the Research and Innovation Strategy, the new *'*Operational Delivery Plan' has now been developed to ensure that the ambitions and objectives required to support the QVH Strategy, aligning with the Sussex Health and Care System strategy *'Improving lives together'* with collaboration at its heart. This

strategy cannot be owned and delivered by the R&I Team alone, therefore some key foundations for its delivery and significant work on exploration of partnerships and key collaborations have been set within the first months of this year.

Revisions in our governance framework and the frequency of our R&I meetings has been implemented to ensure that we can move forward with our key stakeholders at pace with our ambitious but exciting plans.

This first bi-annual report will seek to provide assurance to the Board of our current portfolio as a baseline for our ongoing development, and the activity undertaken since April. This includes exploration of some significant innovative collaborations and partnerships both internally and externally, which together will contribute to successful and highest quality outcomes for the patients that we see.

Current Portfolio of Research Studies
In April 2025, QVH supported 10 open studies. As of August 2025, the active portfolio has reduced to 6 studies open to recruitment and 2 studies in follow-up following closure:

Maxillofacial Surgery

- **PETNECK-2** (PI: Mr Stergios Doumas)
  A randomised controlled trial evaluating PET-CT guided, patient-initiated surveillance versus standard clinic follow-up in head and neck cancer recurrence. Recruitment is challenging as eligible patients need to be recruited at the correct time. One participant enrolled to date with a new "focussed screening" approach being taken to improve recruitment.

- **RAPTOR** (PI: Mr Jag Dhanda)
  A trial testing the repurposed drug combination Pentoxifylline, Tocopherol and Clodronate (PENTOCLO) in managing osteoradionecrosis of the mandible, a complication of head and neck radiotherapy. Eligibility criteria are complex and dependent on identification by a consultant. Two patients have been recruited.

Corneoplastics

- **NAMinG** (PI: Mr Gokulan Ratnarajan)
  A randomised controlled trial investigating whether nicotinamide (vitamin B3) can slow visual field loss in glaucoma. The team have had support from the RRDN Agile team which has enabled steady recruitment and enablement of the extended follow-up visits required over 27 months. Discussions are ongoing to ensure that testing capacity is available in clinics as each patient requires multiple tests.
- **Star V** (PI: Mr Gokulan Ratnarajan)
  A commercial trial evaluating the safety and effectiveness of the MINIject implant in glaucoma. Terminated early by sponsor due to financial issues – all activity closed except to follow up.

Plastics

- **GRACE** (PI: Mr Adam Blackburn)
  A randomised controlled trial testing whether compression stockings are required alongside pharmacological thrombo-prophylaxis for venous thromboembolism prevention after breast reconstruction. Recruitment opened in March 2025, with 22 patients consented to date. Recruitment is on

trajectory with a significant increase in July situating QVH as the 6th highest recruiter from 33 sites.

- **Molecular Basis of Chronic Inflammatory and Degenerative Diseases (Dupuytren Study) (PI: Asit Khandwala)**
  Basic science study, no formal target – open and ongoing.
- **Flare** (PI: Rachael Harrison)
  A randomised trial comparing flexor digitorum profundus (FDP) repair versus both FDP and flexor digitorum superficialis (FDS) repair for treatment of complete zone 2 flexor tendon injuries – terminated early due to the low recruitment rate nationally.
- **Silver-I** (PI: Mr Baljit Dheansa)
  A commercial post-market surveillance study to confirm the safety and performance of Silver I Hydro-Alginate in infected burn wounds. Study closed in line with the study timeline.
- **SIMBAR** (PI: Simon Mackey)
  A feasibility trial of intra-operative Laser Speckle Imaging of tissue blood flow to avoid post-operative complications following breast reconstruction after mastectomy for breast cancer. Exceeded the initial site target of 24 and recruited 42. Study closed to recruitment and now in follow-up.

Anaesthetics

- **PQIP (Perioperative Quality Improvement Programme)** (PI: Dr Ida Forro)
  A national observational cohort study collecting perioperative care data and patient outcomes. No fixed local ceiling for recruitment – consistent accrual from plastics and maxillofacial pathways.

Pipeline of New Studies

We are actively engaging around several new studies that align with QVH's specialist patient population and wider NHS priorities:

Corneoplastics

- **ELIOS-Sterling**: In feasibililty / C&C stage - Two-arm randomised controlled trial comparing Excimer laser trabeculostomy (ELIOS) with iStent inject W in patients with open-angle glaucoma undergoing cataract surgery. Both procedures are already in routine use at QVH; this study will generate evidence to guide which approach provides better patient outcomes. Patients benefit from improved clinical decision-making.

Maxillofacial

- **CVLP – Cancer Vaccine Launchpad**: Referral platform for a Phase II clinical trial of a therapeutic cancer vaccine in recurrent HPV-positive oropharyngeal cancer. Patients may benefit from early access to cutting-edge immunotherapies where otherwise treatment options can be limited in some cases.

Oral & Dental

- **EXIST**: Survey and qualitative study exploring experiences of oral health-related stigma. Benefits include informing more patient-centred care and tackling health inequalities. Target 30 by Dec 2025; in set-up, recruitment due Aug 2025.

Plastics

- **D-MAPP:** A randomised controlled trial testing an app-based self-management tool for patients with chronic hand and wrist pain. Patients could gain access to

an innovative, low-cost self-management tool to improve daily function and quality of life.

Staffing Updates

Research Delivery Workforce:
In Quarter 2, we successfully appointed a Band 7 Senior Clinical Research Nurse to lead the development of our cross-setting research delivery programme with local Primary Care Networks (PCNs). The post was created because of our successful bid for in-year (non-recurrent) NIHR funding and was filled by an experienced member of the existing research delivery team, bringing valuable continuity and knowledge into the role. We are now in the process of backfilling their previous post to ensure wider R&I activities continue without disruption. In the meantime, short-term capacity is being supported by colleagues from the RDN Agile Workforce team, helping us maintain delivery across our active portfolio during this transitional period.

Leadership and Development:
A key milestone this year has been the successful accreditation of one of our research delivery team members as a Clinical Research Practitioner (CRP). This demonstrates that the individual meets defined professional standards in knowledge, skills, and conduct, and is formally recognised on a national register of accredited research professionals.

Our Lead Research Nurse in the Delivery Team has also become PPIE (Patient and Public Involvement and Engagement) Lead, utilising a small grant awarded to attend regular system wide meetings to develop our approach to involvement and engagement.

Progress against Research Strategy & Operational Action Plan

Research and Innovation KPI Dashboard / Reporting
A dashboard has been developed and will be improved to report monthly against Key Performance Indicators covering each of the Pillars from the Research and Innovation Strategy and Operational Delivery Plan. These will be reported at subsequent Monthly R&I meetings and future Bi-annual R&I Board reports.

The R&I Team are reporting regularly via the R&I Committee against the Operational Action plan developed to support the R&I Strategy. Key areas for the Board to note are as follows:

Pillar 1 – Leadership & Culture

- **R&I Steering Group:** This new meeting starts in September to provide oversight and strategic direction for research and innovation in collaboration with key stakeholders across Trust.
- **Regular communications via Connect:** Agreement has been reached to use the Trust's *Connect* platform for research updates. Regular Monthly updates will alert QVH staff to recent Research activity and successes following each R&I Committee. A new ***R&I intranet page*** has been created and is awaiting Go-live. The new ***Clinical Learning Forum*** has been in place from the start of Q1 with Research and Innovation featuring as part of the regular agenda
- **R&I Committee is now monthly and chaired by Clinical Director of R&I**

Pillar 2 – Workforce, Infrastructure & Governance

- **Research Quality Management System: Governance SOPs are under review to strengthen oversight and ensure compliance with best practice alongside process reviews to ensure that sign-off of all financial and non-financial contracts are approved according to the Standard Financial Instructions and Standing Orders.**
- **Study Approval & Sign-Off: A standardised checklist has been introduced for all C&C and study sign-off processes to provide full oversight and assurance of compliance prior to contract signature.**
- **Clinical Research Facility proposal / Bid :** As noted previously in the report, an area has been identified and full working has been undertaken for a paper submitted to ELT and subsequently presented with a bid for funding to the August Charity Committee. An agreement in principle to progress was obtained subject to further detailed costings.
- **Deployment of key research digital platforms: R studio (stats package) has been developed and is ready to start in autumn 2025. REDCap funding bid has been agreed in principle (as above) as it was not possible to resource work to set up the platform within existing IT resource.**
- **Fraud Policy and Commercial Income Re-distribution Policy re-written and submitted to R&I Committee – awaiting sign off at ECQR September/October.**

Pillar 3 – Sustainable Growth

- **New project triage process:** A structured triage system has been introduced to assess the suitability of new research proposals. All projects are now reviewed through this process and formally considered by the R&I Committee to ensure alignment with Trust priorities, capacity, and governance requirements.
- **Study performance monitoring:** RAG ratings for study recruitment progress are now reviewed monthly at the R&I Committee. A standard reporting template has been developed and is in active use, incorporating both RAG status and PRES responses, to support continuous improvement and reflective learning.
- **Two successful in-year funding bids submitted to NIHR –** First Clinical Support Bid developed to provide an in-year Band 4 Research Assistant post to support clinical areas set up interventional research studies. Second bid developed for the NHS Accelerator programme for meeting the NSHE 150 day set up target for Commercial research. Award letter received for the Clinical Support bid, with unofficial confirmation of NHS accelerator bid also. – Circa £25-30K in-year non-recurrent funding.

Pillar 4 – Partnerships & Collaboration

- **East Grinstead PCN partnership:** Following successful bid for in-year funding of £88k, a formal research delivery partnership has been established with the PCN to support dedicated staffing. A Band 7 Senior Research Nurse has been appointed, and recruitment to a Band 6 post is underway. One portfolio study is in the pipeline for cross-boundary delivery, marking the start of integrated research activity across QVH and primary care
- **SHCRP engagement:** QVH is strengthening its involvement with the ***Sussex Health and Care Research Partnership (SHCRP).*** The team will attend the

SHCRP Annual Conference on 16 October 2025 to identify opportunities to benefit from the network and increase QVH's representation.

- **Sussex University –**Meetings taken place with Academics from the engineering and robotic faculty at the University of Sussex / on site at QVH and at their site. Technology has been developed to fuse blood vessels using lasers and we are asked to be a clinical partner in the development of this technology. There isne further potential study to explore digitally measuring components of handgrip in hand therapy following trauma. The charity bid provides 30K in matched funds to undertake pilot work comparing standard surgical suturing with laser fusing in a laboratory setting. An initial 3-month project will lead to an ESPRC project grant bid with QVH as the clinical partner.
- **Bath University Integrated academic accelerator programme** – scoping underway for potential project to deliver chemotherapy drugs directly into skin cancers using cold atmospheric plasma. Prof Toby Jenkins has met with our Clinical Academic, Baljit Dheansa and Skin cancer surgeons at QVH with a view to undertaking work to develop proof of concept in the current research lab - potential ethics application in October 2025 to collect tissue for study with a potential ***Medical Research Council (MRC)*** bid to be submitted in March 2026.
- **Innovation -** Innovation with a view to realising our ambition for an Innovation Hub. Negotiations have led to the offer of an academic from ***Health Innovation Network Kent, Surrey &*** **Sussex** to work with us on site part time over a few months from late September to model this and develop AI opportunities within this space.
- Possible bid to ***Great Ormond Street Children's Hospital*** for a paediatric project is in development by Rania Ward.

Further strategic collaborations and Research under development
Other strategic partnerships have continued to develop during this period, including recent meetings with Professor Martin Llewellyn at the Sussex Commercial Research Delivery Centre to explore opportunities for QVH within Commercial Research. Closer working relationships also continue to develop with Sussex RRDN to again explore commercial portfolio opportunities. QVH has also supported the Modality Partnership with a bid to develop commercial research.

The following potential studies are being scoped by our Clinical Academic alongside QVH clinical colleagues:

Patient reported outcomes in breast surgery.
QVH breast surgeons perform anywhere between 6 and 12 breast reconstructions a week. At 12 months we do not know if the patients feel that the surgery they had is worthwhile. The breast team have proposed a longitudinal qualitative research study to understand patient outcomes as part of their standard care. A feasibility study using REDCap (an electronic data capture tool) is planned for Q3/Q4 2025

Sleep - CPAP user compliance
CPAP machines are the standard treatment for sleep apnoea, however, they are extremely uncomfortable. As a result patients may not use them regularly. QVH is responsible for over 20,000 machines. Each CPAP machine contains a sim card, which transmits data to a central server held by the manufacturer. We are exploring ways in which we can access this data in bulk to analyse CPAP usage.
Furthermore, we know that whilst CPAP gives relief of sleep apnoea symptoms, it

does not improve cardiac function. A further study to explore this is in early discussion.

Sleep - Daylight melatonin
Daylight Melatonin onset is responsible for controlling circadian rhythms and sleep. Whilst Melatonin is a known factor, no UK diagnostic lab can test it. Research tests for Melatonin are available - the sleep team would like to run a small-scale study to look at utility of melatonin assays in diagnosis. Funding needs are being sourced for ELISA analysis in the research lab.

Sleep – Narcolepsy - University of Kent / QVH
Our sleep neurologist, who is also senior lecturer at university of Kent medical school is applying for IAA funding to develop a sniff test to diagnose Narcolepsy. Bid due in October 2025.

Radiology
Bruce Smith (Consultant Radiologist) believes we can measure bone density in regular abdominal CT scans which can be passed back to GPs to confirm whether treatment is need for osteoporosis as an incidental finding. QVH undertakes around 40 abdominal CT scans for the local community a week. A prospective proof of concept study is planned. If successful we will engage with partners at the University of Sussex or through **Health innovation Network KSS** to build an artificial intelligence application that can automatically calculate bone density. This work will lead to an INNOVATE UK or MRC/ESPRC application

Plastics
NICE has recently announced that targeted muscle Re-innervation (TMR), post amputation has no benefit to patients. Clinicians at QVH have been undertaking TMR for over 10 years and do not agree with this recommendation, therefore our dataset of outcomes in this group of patients will be analysed within our ongoing systematic review. An application to NIHR RFPB funding stream will be made with Rehabilitation colleagues in Sussex Community trust to look at the efficacy of TMR in lower leg amputations.

Scar study
The ongoing analysis of the scar study will be completed at QVH in our laboratory.

Burns
Burns itch **-** during the first 12 months after healing, burns can cause severe itch. We know there are some fabrics that are coated by a special polymer that mimic the skin's water barrier, and we have hypothesised that using these garments in the later stage of wound healing may reduce itch. We have proposed this study to the Scar Free Foundation, and they have indicated they would be interested in funding a study of this nature (funding sought - £350k over 3 years)

European Collaboration with University of Bath and University of Regensburg.
Early discussion with collaborators in Bath and Regensburg, Germany around a European project on antimicrobials in wounds and surgery funded by EU. Call not announced yet.

Veterans' Health
Group convened to develop a bid about this for submission prior to April 26.

Research Governance
Following the restructure of the R&I leadership function, increased Board-level and senior leadership engagement is now reflected in bi-annual reporting to Board.

A review has been undertaken of the pre-feasibility and capacity and capability (C&C) for new studies to ensure that due diligence is undertaken at the right level and our governance processes for contract sign-off is aligned with the new SFI's and Standing orders. Discussions and review of these processes are underway with the support of the Company Secretary and Trust Governance Lead, the framework for which once confirmed, will be reflected in future reporting and meeting agendas. Safety reporting and Incidental findings / protocol deviations for all research work continue to be monitored and reported via governance routes and according to SOPs.

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

Report cover-page					
References					
Meeting title:	Board of Directors				
Meeting date:	11 September 2025		**Agenda reference:**	**64-25.4**	
Report title:	Annual assessment of addressing Health Inequalities (Quarterly Update)				
Sponsor:	Edmund Tabay, Chief Nursing Officer				
Author:	Ellie Winter, Programme Manager-Strategy and Victoria Worrell, Head of Access and Performance and Health Inequalities Lead				
Appendices:	N/A				
Executive summary					
Purpose of report:	The purpose of this report is to update the Board on the progress, priorities and patient impact of QVH's Health Inequalities Programme for 2025/26				
Summary of key issues	•Ethnicity data capture improved from 79.6% to 85.5% since April 2025, enabling better identification of disparities and more targeted interventions to enhance patient experience. •2025/26 Health inequalities programme of priorities include reducing variation in long waiters, improving paediatric attendance, addressing late-stage head and neck cancer presentation, embedding health inequalities awareness among staff, and enhancing compliance with the Accessible Information Standard. •Areas not progressed this year include tobacco cessation and data collection for other protected characteristics (e.g., LGBTQ+, learning disabilities, dementia) remain paused due to funding and system limitations, limiting targeted interventions in these areas. • Key risks to delivery include resource constraints, system limitations, and external factors such as funding changes, which may impact the pace and scope of implementation. These will be mitigated through cross-directorate ownership and oversight from the Health Inequalities Steering Group • Progress is monitored through the Health Inequalities Steering Group, with escalation to the Executive Committee for Quality and Risk.				
Recommendation:	The Board is asked to **note** the content of this 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:	Yes there is an impact on Business Intelligence Unit (BIU) resources due to required data to analysis – liaising with BIU colleagues				

Assurance route				
Previously considered by:	ECQR, ELT, Quality and safety committee			
	Date:	August and September 2025	Decision:	
Next steps:				

Report to: Board of Directors
Agenda item: 64-25.4
Date of meeting: 11 September 2025
Report from: Edmund Tabay, Chief Nursing Officer
Report author: Ellie Winter, Programme Manager-Strategy and Victoria Worrell, Head of Access and Performance and Health Inequalities Lead
Date of report: 22 August 2025
Appendices: N/A

Annual assessment of addressing Health Inequalities (Quarterly Update)

Executive summary

The Trust continues to advance its commitment to reducing health inequalities, as set out in the QVH Health Inequalities Enabling Strategy 2025–2030. Since April 2025, ethnicity data completeness has improved from 79.6% to 85.5% in July, with Plastics showing the most significant month-on-month gain. This improvement enables more accurate monitoring of service access and outcomes, which can support targeted interventions and enhancing patient experience.

The 2025/26 programme of priorities builds on this progress and reflects national guidance and local system needs. The programme includes work to reduce inequities in waiting times, improve attendance at appointments, address late-stage cancer presentation, embed health inequalities awareness across the workforce, and strengthen compliance with the Accessible Information Standard. Ownership is distributed across Directorates to ensure deliverability within existing resources.

However, some areas are not being progressed this year, including tobacco cessation (due to Integrated Care Board (ICB) funding withdrawal) and wider data collection for other protected characteristics such as LGBTQ+, learning disabilities and dementia remains constrained by limitations in the Trust's digital systems. These gaps limit the ability to address inequities in these groups in short term.

There are also risks to delivering this year's priorities, particularly capacity constraints, system limitations and external policy or funding changes. These will be mitigated through cross-directorate ownership and oversight from the Health Inequalities Steering Group.

Situation

QVH remains committed to a long-term strategy to reduce health inequalities, aligned with the NHS Long Term Plan, Core20PLUS5, and the Sussex Integrated Care Strategy. The Trust recognises the importance of meaningful local action and system-wide collaboration, and continues to engage with the ICB and other NHS providers to share learning and approaches.

For 2025/26, the Trust is progressing a targeted and manageable set of priorities that

are underpinned by robust data and reflect both national expectations and local population needs. These priorities are designed to deliver tangible improvements for patients and staff, while remaining achievable within current resource constraints. Delivery is supported by a cross-directorate approach and monitored through the Health Inequalities Steering Group (HSIG) and escalation to the Executive Committee for Quality and Risk.

Background

The QVH Health Inequalities Enabling Strategy 2025–2030 is structured around four institutional roles, which guide the Trust's action:

- QVH as a System Partner working collaboratively across Sussex to reduce unwarranted variation and address the wider determinants of health.
- QVH as a Provider of Services embedding equity in access, experience and outcomes.
- QVH as an Anchor Institution influencing the broader social and economic factors affecting health, through local employment, procurement and sustainability.
- QVH as a Health-Promoting Hospital, embedding prevention and health literacy in clinical care and staff engagement.

Each role provides a lens for action, and our 2025/26 delivery priorities have been mapped accordingly.

Assessment

Progress and next steps include:

Ethnicity Data Collection

Ethnicity data completeness has steadily improved from 79.6% in March 2025 to 85.5% in July 2025, with Plastics showing the most significant gains. This improvement enables more accurate identification of disparities in access and outcomes, supporting targeted interventions and enhancing patient experience.

Progress has been driven by a coordinated set of actions, including:

- Visibility enhancements in Patient Administration System (PAS)and patient lists
- Staff-facing materials such as posters, one-pagers, and Connect updates
- Adjustments to appointment letters and kiosk prompts
- Spot checks and process reviews in high-volume areas
- Directorate-level ownership and dashboard monitoring

These actions were tracked through a central Task and Finish Group action log, with closed-loop feedback and system changes implemented across services.

Delivery Priorities for 2025/26

In addition to ethnicity data, the following areas will be progressed across the organisation, these will be discussed at the 6 weekly Health Inequalities Steering Group, which will act as the point of escalation where plans are unable to meet agreed KPIs or where plans require support in delivery. The August Steering Group will be the first meeting where these new priorities and the progress made so far will be discussed.

Priority Area	Why Are We Doing It?	Impact	Delivery Timelines
Variation in long-waiters (by age, deprivation, and ethnicity)	Aligned to Core20PLUS5 and national access standards. Evidence suggests patients from more deprived or marginalised groups experience longer waits and poorer outcomes.	Enables identification of inequities in access and supports waitlist prioritisation and targeted intervention.	Dashboard in development to enable regular identification of inequities in access, enabling targeted actions for prioritisation and interventions. **Q1** age & Index of Multiple Deprivation (IMD).
DNA, cancellations, and WNBs (paediatrics)	King's Fund and NHSE guidance recommend using operational data to identify access barriers. DNAs are often higher among deprived or digitally excluded populations.	Insight can support redesign of outpatient models (e.g. reminder systems, flexible appointment options) and improve equity in access.	Regular analysis of data to understand barriers to attendance; tailor support to reduce missed appointments and improve outcomes e.g. spoke, virtual, phone etc. **Q4.**
Cancer staging and late presentation (Head and Neck services)	National priority under the NHS Long Term Plan and Core20PLUS5. People from underserved groups are more likely to present late due to factors such as low health literacy and limited access.	Enables earlier identification, targeted health promotion, and supports primary care to raise awareness.	Agreed sharing of head and neck cancer staging data with primary care to improve referral pathways and reduce late stage presentation related to inequalities. **Q2**.
Making Health Inequalities Everyone's Business	Supported by NHSE guidance and King's Fund. Cultural shift is needed to embed equity across all roles.	Builds awareness, accountability and skills across the workforce, making equity a core part of daily practice.	Identify health inequalities champions across the organisation to support a knowledgeable workforce. **Q2.**
Accessible Information Standard compliance	Statutory requirement and critical to patient safety. Disproportionately affects people with learning disabilities, sensory impairments, or language barriers.	Improves patient experience, supports shared decision-making, and reduces risk of harm.	Improve patient experience, communication, and engagement leading to better health outcomes. Ongoing.

Recent external analysis has highlighted that at QVH there is an 8.1% gap in waiting times between the most and least deprived patient groups. This reflects both the specialist nature of our services as some patients are referred to us after already exceeding the 18-week threshold and the complexity and volume of pathways in some of our specialties, for example skin.

Our current focus has been on monitoring health inequalities in patients waiting over 52 weeks and above, and work is underway to expand this to 18 weeks, ensuring earlier identification of disparities. This will support improvements in both current services and the design of future pathways.

Risks to delivery include:

- Resource constraints: Limited BIU capacity, a small Health Inequalities team, stretched staff availability across services, and ongoing corporate cost reduction pressures all present challenges to sustaining and scaling delivery. These constraints may affect data analysis, implementation of actions and the ability to respond to emerging needs.
    - Mitigation: Annual plan has been developed with available resource in mind. Health Inequalities (HI) data dashboard to be developed as automated to reduce manual reporting requirements. Identifying HI champions across key services to increase potential resource and will also support with continuous improvement. Any delays to projects or plans will be escalated to the HISG.
- System dependencies: Limitations in PAS functionality, system capabilities, and integration with other platforms may restrict data capture and automation, slowing progress in key areas.
    - Mitigation: Linking in with key stakeholders, including EPR project team and clinical systems team to ensure consideration to HI in system developments. BIU engaged to maximise existing data for actionable insights.
- External factors: Changes in ICB funding, referral processes, and national policy may impact the scope and pace of delivery, particularly in areas previously supported by external investment.
    - Mitigation: Key internal stakeholders are regularly involved in strategic ICB HI meetings and linked in with key ICB colleagues. Funding applications made for HI projects to the ICB and other charitable organisations for additional desirable projects, including tobacco cessation and burns asylum seekers patients.

Recommendation

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

Report cover-page					
References					
Meeting title:	Board of Directors				
Meeting date:	11 September 2025	**Agenda reference:**	**65-25**		
Report title:	Trust Winter Plan 2025/26				
Sponsor:	Kirsten Timmins, Chief Operating Officer				
Author:	Kirsten Timmins, Chief Operating Officer				
Appendices:	Trust winter plan 2025-26				
Executive summary					
Purpose of report:	To share with Board for discussion and approval.				
Summary of key issues	It is an expectation that all Trusts have a Winter Plan outlining how they will maintain services through the winter period. The attachment is the draft Winter plan which has been collated from teams across the Trust. It is presented to Board for approval before being shared with the ICB. For 2025/26 winter planning, the CEO and Chair of all NHS trusts are required to sign a Board Assurance Statement to ensure the Trust's Board has oversight that all key considerations have been met. The key considerations to be addressed in the winter plan are included on slide 13 of the winter plan.				
Recommendation:	Trust Board is asked to approve the Trust Winter Plan				
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:	Supports the Board Assurance Framework regarding patient services				
Corporate risk register:	Supports the Corporate Risk Register				
Regulation:	ICB, NHS England and Care Quality Commission (CQC)				
Legal:	None				
Resources:	None				
Assurance route					
Previously considered by:					
	Date:		Decision:	N/A	
Next steps:	For approval to share with the ICS				

Delivering Operational Resilience Winter 2025-26

Queen Victoria Hospital NHS Foundation Trust

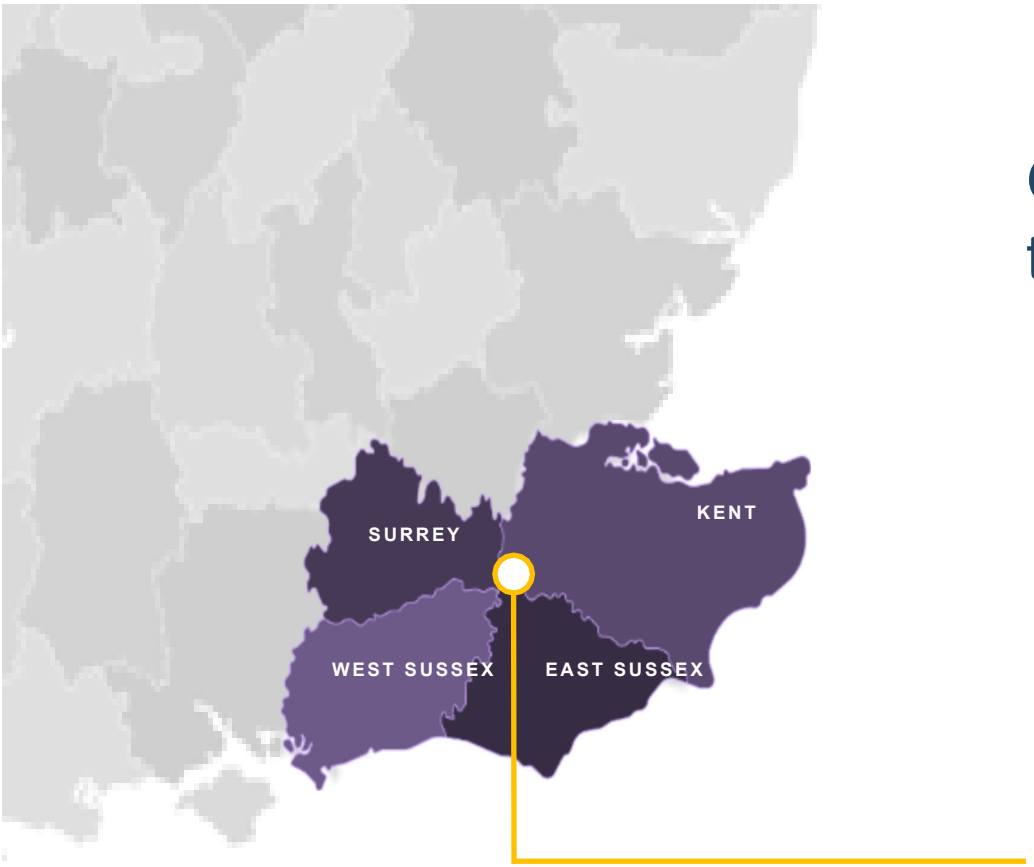
September 2025

Contents

Background

The Winter Plan is developed to

- Focus as a whole system on achieving improvements that will have the biggest impact on urgent and emergency care services this winter.
- increase services provided outside hospital compared to last winter, particularly through the development of CDC pathways.
- maintain elective and cancer services during winter, and support the wider Sussex system where possible.
- QVH will be part of a live exercise in September run through the EPRR network, to stress test the plans for this coming winter.
- The Winter Plan is underpinned by:
  - Applied learning from winter 2024/25
  - Delivery of the latest national guidance ‘Urgent and Emergency Care Plan 2025/26’ and Emergency Preparedness, Resilience and Response (EPRR) guidance.



Our winter plan has considered the needs of the **populations we serve**:

Our specialist and regional services across **Kent, Surrey & Sussex** and beyond

Our services for our l**ocal population** and **Sussex**

Elective Care

QVH and System Support

- Due to the specialist nature of the services provided at QVH, the trust is not anticipating any impact on the elective plan from non-elective attendances.
- Theatre capacity over Christmas and New Year naturally demonstrates a slight reduction in activity and this is accounted for in the agreed activity plans. The trust experiences a higher proportion of patients declining surgery during this period. Where appropriate, activity will be switched to a Day Case capacity, to maximise attendance.
- The trust continues to develop and expand its Community Diagnostic Centre pathways, to ensure patients can be seen closer to home and to take pressure away from large acute trusts with UEC pressures.
- QVH is supporting the system with the continued transfer of patients from UHSx to reduce long waits across the system, and will continue to offer mutual aid wherever it has capacity.

Bed capacity

- The trust operates a largely day case model, which ensures flow through the hospital of elective care patients. Bed capacity data taken at midnight is not reflective of bed occupancy during daytime hours.
- Bed occupancy data has been reviewed, demonstrating the opportunity to reconfigure services to meet demand, deliver activity and trauma services and deliver efficiencies. This has resulted in a reduced bed footprint of 10-12 beds. This capacity is intended to support ambulatory care models and contributes to the trust efficiency target. Ensuring patient safety remains the trust priority, and this will provide the trust escalation beds which can be re-opened should this be required over winter.
- Staffing for Critical Care Unit and burns unit remain the same during the winter period. Flexibility through bank and agency to support further capacity in CCU (up to a maximum of 5 beds) if required.
- Staffing levels are driven by the activity plan and the requirement to respond to trauma and are maintained through the year. Staffing for inpatient and outpatient areas will be at template establishment (based on planned activity levels) in the two weeks over Christmas and New Year, taking in to account the bank holidays.

Community Services

We are proud to offer a wide range of services to our community:

- Our Minor Injuries Unit sees over 18,000 patients every year. It is open 7 days per week throughout winter including Christmas and New Year. 4 hour UEC performance remains consistently above 95%.
- Our Community Diagnostic Centre offers diagnostics to the local community and innovative new pathways. This reduces the demand for diagnostics in larger acute trusts over the winter period. We will continue to offer mutual aid to other trusts challenged in delivering diagnostic tests in a timely way.
- We offer surgical capacity for High Volume Low Complexity procedures to the local community.
- Our therapies teams provide services to the adults in our local community and during winter will continue to support people with orthopaedic, neurological and deteriorating conditions and falls.

People

Staffing Levels and Rostering

- Minimum safe staffing levels are in place across all clinical areas to ensure patient safety
- All rosters produced at least 6 weeks in advance, electronically utilising Health roster to ensure proactive management of gaps.
- Continued substantive recruitment into hard to fill roles, as well as areas of high vacancy.
- Directorates to monitor known surges in staff absence (half term breaks, Christmas and New Year) to ensure appropriate cover arrangements in place

Annual Leave

- Trust Policy requires clinical staff to give 8 weeks notice of leave where possible. Annual Leave reports are shared with Directorate leadership teams monthly.
- Each Directorate to ensure services are appropriately staffed and ensure that any known absence is planned with suitable cover arrangements.

Temporary Staffing

- Weekly workforce controls meeting to review Bank and Agency requests, with Exec oversight.
- Trust uses only framework agencies for supply of temporary staff to ensure quality of candidates and compliance
- QVH an active part of SE Temporary Staffing Collaborative

Sickness Management & Staff Wellbeing

- Employee Assistance Programme in place with enhanced staff support including access to a GP
- Wellbeing and Inclusion team to actively promote wellbeing resources
- Financial Wellbeing resources available for staff via wagestream
- Trust managers encouraged to have regular wellbeing conversations with their staff, and identify any additional areas of support.
- Trust Occupational Health service provided by Cordell Health with onsite OHP clinic presence 3 days a week
- Additional support for staff available through psychological therapies service and access to work.
- QVH operates a 24/7 Speak Up Guardian service for all staff
- Staff sickness absence managed in line with Trust's Managing Attendance at Work Policy.

Vacancy Rates

- The trust has reduced vacancy rates to 5.9% (from 9% this time last year). Work continues to focus on building resilience amongst our substantive workforce and reducing the requirement for temporary staffing options

Vaccination Programme

- The trust is focussed on improving vaccination rates by 5% or greater this year in comparison to last year.
- Flu campaign will commence in October 2025, offering three clinics per week through our Occupational Health provider on site.
- The trust is increasing the number of roaming vaccinators to provide support for vaccinations for clinical staff. Roaming vaccinators will have allocated times in departments to encourage more staff to take up the vaccine.
- Vaccinators have been identified to vaccinate the 65 years and over cohort of staffing.
- ‘Opt out’ forms are available on the intranet for those staff that do not wish to be vaccinated.
- Data is being gathered via our internal incident response email and is uploaded via NIVS.
- The trust will continue to submit data to Immform at the required frequency.
- Covid vaccine is provided through Alliance for Better Care, clinics operating on site in the run up to winter.
- Staff are encouraged to take up flu and covid vaccinations if offered by their primary care provider.
- Weekly updates on times on clinics are available in our internal communications via Connect.

Infection Prevention and Control

Respiratory infections outbreak prevention and management Robust Management of Respiratory Illness policy in place and available on QNET, staff supported with action required if they are unwell (via Covid-19 SOP and infection control advice – stay off work until symptoms have resolved) or if patient begins to display respiratory symptoms (as per policy). Covid positive PCR results monitored daily as per Micro report, Incident control central e mail account monitored by management and reports of Covid or other respiratory infection potential clusters flagged to Infection Prevention Control Team (IPACT). Staff absence spreadsheet monitored for periods of increased incidence within any one staff group. If required, interventions can be implemented including increased social distancing, mask wearing for 1 – 2 week period minimum with regular review for new cases.

Covid testing Covid testing not routinely provided for staff or patients pre admission. Patients should undergo testing if they are displaying respiratory symptoms. Both Lateral Flow Device (LFD) and PCR testing continues to be available for patients that require it. Covid SOP in place and requirement also covered in the Respirator infections policy.

Norovirus/D&V Guidance in place for staff to remain off work until 48 hours clear of Diarrhoea and/or vomiting. Any patient exhibiting symptoms of Diarrhoea and/or vomiting should be isolated within 2 hours onset as per policy and remain isolated until 72 hours clear of symptoms, with ensuite/dedicated toilet facilities/dedicated commode. Wards contact IPACT when advice required or if increased incidence within any clinical area. Microbiologists communicate any positive micro result, including C Diff positive. IPACT conduct daily checks of C Diff positive spreadsheet for reassurance. Switchboard message asks patients not to attend site if they have had D and V.

Antimicrobial stewardship IPACT form part of the antimicrobial steering group which meets quarterly. Pharmacy leading on auditing antimicrobial prescriptions/raising the profile of antimicrobial awareness week (including screensavers, training opportunities for staff). IPACT provide training to staff during Induction, Junior Dr, Consultant training and Mandatory clinical update about importance of using antibiotics when clinically indicated by patient condition/symptoms and reviewing antibiotics regularly as well as prescribing them correctly and only administering them if prescription complete. IPACT regularly advise on case by case basis if antibiotics should be reviewed, stopped or may be required. Micro will discuss antibiotics as required.

IPC guidance All guidance can be found within policies or SOPs on QNET. All year around but particularly during the winter, the IPACT emphasis is on good hand hygiene and good respiratory hygiene, including staff not attending work if symptomatic of illness including respiratory/D and V. IPACT role model exemplary uniform/hand hygiene/scrub compliance as per policies and continue to challenge non-compliance.

Patient cohorting The need to Cohort patient will be decided by the IPACT based on numbers of infections, type of infection presenting and available beds. Organism specific policies in place to guide decision making. Outbreak policy in place for use when an increase in the same type of infection is seen.

Environmental cleaning Continues as per policy with enhanced cleaning where indicated due to high risk area (e.g Burns) or high risk patient (e.g suspected/known infection). Cleaning checklists and charts in place to prompt staff with process required and ensure record maintained. Routine cleaning charts in use in all clinical areas for day to day/weekly cleaning. IPACT champion cleaning as a cornerstone of Infection Control to prevent any transmission.

FIT Testing FIT testing is required for all clinical staff annually with 24 FIT testers in place across multiple clinical departments. Individuals FIT testing compliance is recorded on their individual ESR. Staff compliance is monitored individually by managers through the appraisal process and Trust wide through the IPACT quarterly reporting.
The Goods Inwards team monitor stock levels of all PPE to ensure adequate supplies are held. An emergency PPE store cupboard is available for emergency use.

Estates and Facilities

Proactive Maintenance
- In October 2024 the trust installed a new temporary boiler and distribution system due to ongoing issues and failure of the existing heating systems. Maintenance contract in place with further works to strengthen the heating and domestic hot water systems across our site.
- Lighting has been upgraded during winter 2024/25 with more improvements planned.
- Gritting service will commence from October with automatic visits depending on weather forecast (Met Office)

Standby Systems
- Additional electrical heaters are available for the winter period.
- The installation of the new generator provides additional resilience over the winter period.

Arrangements for cover, out of hours and on-call
- The out of hours provision is managed via the in-house team, with additional support provided via contracting partners to ensure consistent cover over the Winter.

Soft Facilities Service - Catering
- Current supplier contracts and SLAs are in the processed of being reviewed as part of the contracting work that is ongoing.
- All Business Continuity Plans are available on QNET should any service encounter any disruption.
- Should the Trust encounter a disruption to our fresh food provision QVH are able to continue with catering services for 3-4 days dependent on patient capacity, as frozen stock provision could be utilised.
- Vending machines are available on site, which are fully stocked and able to provide snacks, tea & coffee.

Soft Services – Domestic and Linen
- The Trust holds a minimum of 3 days supply for cleaning and linen provisions and should there be any disruption to services clinical areas would be prioritised.
- Any disruption to the domestic and linen supplies would be monitored by the Goods Inwards department, with escalations to the senior estates team as required.

External arrangements i.e. public network road gritting
- The estates team manages the external contacts and can liaise with relevant parties for support as and when required.

Communications strategy

Internal Communications

- Weekly communications to staff and volunteers throughout the Winter highlighting key messages.
- Promotion through all communication channels of flu vaccination for staff and volunteers, including through onsite vaccination clinics.
- Asking staff who do not want a flu vaccination to tell us why to help us better understand how we can support colleagues.
- If appropriate and based on government guidance, promotion of Covid vaccination to staff and volunteers, including through onsite vaccination clinics if available.
- Providing adverse weather information and what staff should do/know, as required.
- Supporting the promotion of staff wellbeing messages through internal communications channels.
- Providing communications support to the executive leadership team as required.

External communications

- Working with NHS Sussex to promote and amplify key messages throughout the winter, including on QVH social media.
- Highlighting the role the QVH MIU has to play in supporting the system as part of encouraging the public to use services wisely. Proactively supporting media opportunities to amplify this message and the role of an MIU vs UTC vs A&E.
- Promoting what the QVH MIU can and cannot see, as part of using the most appropriate services. Also open hours – 365 days a year 8am-8pm, including Christmas Day and Boxing Day.
- Pubic thanks to colleagues who are supporting our services and patients throughout the Christmas period in particular.
- Supporting partners in the amplification of their winter messages as part of a joint system approach.

NHSE checklist of criteria to be addressed in the plan

Queen Victoria Hospital NHS Foundation Trust

NHSE Checklist
Prevention
There is a plan in place to achieve at least a 5 percentage point improvement on last year's flu vaccination rate for frontline staff by the start of flu season.
Capacity
The profile of likely winter-related patient demand is modelled and understood, and plans are in place to respond to base, moderate, and extreme surges in demand.
Rotas have been reviewed to ensure there is maximum decision-making capacity at times of peak pressure, including weekends.
Seven-day discharge profiles have been reviewed, and, where relevant, standards set and agreed with local authorities for the number of P0, P1, P2 and P3 discharges.
Elective and cancer delivery plans create sufficient headroom in Quarters 2 and 3 to mitigate the impacts of likely winter demand – including on diagnostic services.
Infection Prevention and Control (IPC)
IPC colleagues have been engaged in the development of the plan and are confident in the planned actions.
Fit testing has taken place for all relevant staff groups with the outcome recorded on ESR, and all relevant PPE stock and flow is in place for periods of high demand.
A patient cohorting plan including risk-based escalation is in place and understood by site management teams, ready to be activated as needed.
Leadership
On-call arrangements are in place, including medical and nurse leaders, and have been tested.
Plans are in place to monitor and report real-time pressures utilising the OPEL framework.

Report cover-page					
References					
Meeting title:	Board of Directors				
Meeting date:	11/09/2025	**Agenda reference:**	**-25**		
Report title:	Organisational risk register				
Sponsor:	Executive risk leads				
Author:	Leonora May, Company secretary				
Appendices:	Appendix one- Organisational risk register				
Executive summary					
Purpose of report:	The organisational risk register as at 22 August 2025 is presented to the Board for review.				
Summary of key issues	• Currently the highest scoring open risk is risk 148 (delivery of the cost improvement plan (CIP)) which has a current score of 20. Other high scoring risks (current score of 15 or above) include risks related to fire dampers, heating and hot water, the Trust's boiler, electrical fire, the delivery of the QVH Strategy 2025-2030 and cash flow • There have been no changes to current risk scores during the period • Risk 161 has been added to the register during the period and is in relation to the Trust's cash balance falling below zero or lower than the Trust would like. It has a current score of 16 with mitigations • Risk 176 has been added to the register during the period and is in relation to the temperature of medicines. It has a current score of 12 with mitigations • The BAF risks are currently being updated in line with the new Key Strategic Objectives, QVH Strategy 2025-2030 and the current context within which the Trust is operating. The new strategic risks have been drafted and shared with the Board for feedback. The key risk themes are long term finance, sustainability, the Trust's estate being fit for the future, quality of care, well led, leadership capacity, access, workforce and digital.				
Recommendation:	The Board is asked to **note** the contents of the report.				
Action required	Approval	Information	Discussion	Assurance	**Review**
Link to key strategic objectives (KSOs):	**KSO1:** ***To deliver outstanding care***	**KSO2:** ***To innovate and improve***	**KSO3:** ***To be an excellent employer***	**KSO4:** ***To deliver sustainable services***	**KSO5:** ***To collaborate with others***
Implications					
Board assurance framework:	Organisational risks to be linked to the BAF				
Organisational risk register:	Appendix one				
Regulation:	CQC well led Risk management framework				
Legal:	None				
Resources:	None				
Assurance route					
Previously considered by:	Finance and performance committee, Quality and safety committee				
	Date:	September 2025	Decision:		
Next steps:	NA				

Report to:	Board of Directors
Agenda item:	-25
Date of meeting:	11 September 2025
Report from:	Executive risk leads
Report author:	Leonora May, Company secretary
Date of report:	22 August 2025
Appendices:	Appendix one- Organisational risk register

Organisational risk register

Introduction and background

The organisational risk register as at 22 August 2025 is presented for review.

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

Executive summary

- There are currently 26 open risks on the organisational risk register
- Currently the highest scoring open risk is risk 148 (delivery of the cost improvement plan (CIP)) which has a current score of 20. Other high scoring risks (current score of 15 or above) include risks related to fire dampers, heating and hot water, the Trust's boiler, electrical fire, the delivery of the QVH Strategy 2025-2030 and cash flow
- There is a new risk coming onto the risk register related to water ingress on the Trust theatre roof and water leaking into the theatre complex due to defective roof membrane which may result in the theatre environment becoming compromised. This risk has a current score of 15. Actions taken to date include investigations to conclude a permanent solution supported by a structural engineer and pebbles and insulation blocks being removed from the roof to inspect the area. Estates are inspecting the roof daily and water pumps are in place to ensure no build up of rain water
- There have been no changes to current risk scores during the period
- Risk 161 has been added to the register during the period and is in relation to the Trust's cash balance falling below zero or lower than the Trust would like. It has a current score of 16 with mitigations
- Risk 176 has been added to the register during the period and is in relation to the temperature of medicines. It has a current score of 12 with mitigations
- Risk 115 was closed from the organisational risk register and is in relation to the Trust failing to deliver a breakeven position for 2024/25. This has been closed due to the Trust's final audited position being a small surplus
- Risk 147 was closed from the organisational risk register and is in relation to the critical failure of CBCT equipment. This has been closed due to the new equipment being installed, however it should be noted that this has had an impact on the waiting list

Heat map

Likelihood	*Consequence*				
	Negligible	**Minor**	**Moderate**	**Major**	**Catastrophic**
Almost certain					
Likely			**125** **16**	**161** **176**	**148**
Possible			**73** **48**	**47** **144** **149** **17** **38** **117** **121** **88** **153**	**49** **53** **54** **132** **139**
Unlikely			**77** **133**	**11** **14**	**138**
Rare					

Board Assurance Framework (BAF)
The BAF risks are currently being updated in line with the new Key Strategic Objectives, QVH Strategy 2025-2030 and the current context within which the Trust is operating.

The new strategic risks have been drafted and shared with the Board for feedback. The key risk themes are long term finance, sustainability, the Trust's estate being fit for the future, quality of care, well led, leadership capacity, access, workforce and digital.

The updated BAF will be reviewed by the Board at its seminar at the end of October 2025 and will be presented to the Board at its public meeting in November 2025.

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

Risk Register Organisational

DATE DOWNLOADED 22/08/2025| TIME DOWNLOADED 11.48

NHS
Queen Victoria Hospital
NHS Foundation Trust

Risk ID	Risk Stage	Risk Description - Cause	Risk Description - Risk	Risk Description - Effect	Risk Register Type	Initial Consequence	Initial Likelihood	Initial Rating	Current Consequence	Current Likelihood	Current Rating	Target Consequence	Target Likelihood	Target Rating	Target Date	Owner	Handler	Child Controls	Actions	Actions completed	Actions Outstanding	Latest Update Comments	Risk type	Risk Substype
Risk 00000011	Open	Due to ineffective communication or a breakdown in trust	There is a risk that there may be a breakdown in the effective working relationship between the Board and the Council of Governors	Which may result in further formal regulatory action impacting on the reputation and sustainability of the Trust	Organisational	5	3	15	4	2	8	4	2	8	31/03/2025	Leonora May	Leonora May	Code of conduct for governors Code of governance for NHS provider trusts Development of Trust strategy People Relationship building between Board and Council of Governors				This risk has met its target score. It is proposed that it remains on the risk register throughout the development of strategic sustainability options for monitoring. Score reduced from 12 to 8 given results of most recent Council of Governors effectiveness review and feedback on relationships. Risk to remain on risk register for continued monitoring	Regulatory and Compliance	External regulatory standards
Risk 00000014	Open	Due to a culture of non-compliance with processes and procedures	There is a risk of a non-compliant event involving SFIs or scheme of delegation and reservation of powers	Which may result in regulatory action including fines, adverse publicity or impact to reputation	Organisational	4	3	12	4	2	8	4	2	8	31/07/2025	Leonora May	Leonora May	Audit and risk committee Scheme of delegation and reservation of powers Standing financial instructions	Board level review of Scheme of delegation and reservation of powers Longer term actions to address wider cultural issues	0	2	The target score for this risk has been met Score reduced from 12 to 8 given work completed on contracts data base, new procurement and contract management policies and updated SoD RoP and SFIs which are being disseminated across the organisation Score reduced from 16 to 12 given work completed to address weaknesses in value for money arrangements including work to minimise single tender waivers, the development of a reliable contracts database and additional process and oversight by governance and finance teams	Regulatory and Compliance	External regulatory standards
Risk 00000016	Open	Due to the structure and timeframes of the patient pathway	There is a risk that mental capacity assessments are not being routinely undertaken when required	This may result in either absence of valid consent for procedures that are undertaken or proceedures being declined without patient having capacity to do so, which may result in patients being unable to continue with treatment or procedure being completed without full compliance with the MCA	Organisational	4	5	20	3	4	12	3	1	3	28/11/2025	Edmund Tabay	Ian Cruickshank	Awareness training MCA compliance audit MCA lead MCA training for consultants	Repeat the Audit of compliance Set up task and finish group to review processes nd patient pathways to identify opportunities MCA training	0	3	Primary / secondary GP interface group discussions May / June asking them to flag. Risk regularly discussed at governance meetings with storytelling. Training compliance >90% MCA T&F group working through issues. Appointment letter changed, Evolve form being adapted, schedulers highlighting patients at risk. Date for completion altered to reflect Board discussion and 6 month time frame for task and finish group Risk reviewed. No change with the scores. Task and finish group meeting scheduled in April 2025 to support addressing the issue. Reviewed Risk and residual score after mitigations. Reduced to 16. Policy updated and changes to training. Audit data presented to clinical teams. MCA policy approved, awaiting new MCA document sign off.	Patient safety, outcomes and experience	Clinical safety/quality of care
Risk 00000017	Open	Due to the potential for individuals not feeling safe to speak up	There is a risk that staff may not speak up with concerns	Which may result in concerns not being addressed leading to patient safety issues, staff safety issues, reputational damage	Organisational	4	4	16	4	3	12	4	1	4	18/12/2025	Edmund Tabay	Edmund Tabay	Cultural transformation steering group External FTSU Guardian FTSU engagement FTSU policy Monitoring of FTSU referrals	Implement FTSU engagement plan Board engagement plan Organisational culture assessment	0	3	Freedom to speak annual report was presented to the Board. There has been an increase in the number of concerns raised with the independent Freedom to speak guardian compared to the previous model when the service model was managed in-house. The rating score remains unchanged as there is always a risk associated with this. Risk reviewed and the scores remain the same Risk reviewed. Scores remain the same currently. Controls have been implemented and there is a regular update of FTSU that goes to the Executive Leadership Team and the Trust Board. Controls have been implemented but will require information to determine if these are working. The external service has only been implemented for about 12 months.	Regulatory and Compliance	External regulatory standards
Risk 00000038	Open	Due to insufficient and inadequate space on Peanut ward to meet the individual care needs of both children who are inpatients and those who need to be seen in an outpatient setting for surgical assessment.	There is a risk that the environment on Peanut ward is not appropriate for children or their families, particularly those with additional needs. There is a further risk that due to limitations in Peanut space that children are alternatively cared for in areas which are not adequately set up for paediatric care and do not have sufficient staff clinically skilled to support the holistic care of children.	Which may result in children's care being compromised by limitations in the physical estate available to support them. This may lead to limitations in access to appropriately trained paediatric staff in an outpatient setting which may compromise individualised care and privacy for children and their families and, potentially impact on safeguarding processes.	Organisational	4	4	16	4	3	12	3	2	6	16/10/2025	Tamara Everington	Rosie Lindley	Monitoring throughput within ward Process for paediatric admission, stay and discharge Risks to paeditatric	Review provision for Paediatrics across QVH (strategic priority for year one)	0	1	Task & Finish group established to address the children's model for care chaired by the CMO. Group developing the clinical service model estate requirements led by the Dep CNO Reviewed by Jane Dickson and Tamara Everington. Included risks from Peanut Ward care for inpatients as well as the outpatient risk. Owner changed to TE. Discussed risk and is a cross-directorate risk, therefore more appropriate to add to Organisational Risk Register for organisational oversight. Scheduled for approval at next ECQR on 18/11/24	Estates infrastructure and environment	Property maintenance and management
Risk 00000047	Open	Due to the age and construction of existing electrical cabelling and infrastructure on site	There is a risk of multiple failures of the site electrical systems	Which may result in loss of electrics, increased costs for repairs, potential injury to staff due to wiring faults	Organisational	4	4	16	4	3	12	3	2	6	31/12/2025	Claire Lowe	Claire Lowe	47 Fixed wire	Specification for works to be written	0	1	The estates team have engaged with specialist contractors and consultants and have inspected the electrical infrastructure in more detail, this has enabled the Estates team to upgrade the power availability from the utility company UKPN to 700kva from 400kva at DSS1. Further works are required to upgrade the sub mains switch rooms and cupboards across the site to lower the risk further. Electrical inspections and replacement infrastructure electrical equipment currently being tendered Electrical inspections currently being tendered	Estates infrastructure and environment	Property maintenance and management

Risk 00000048	Open	Due to the lack of a L1 fire alarm system across all areas of the site, faults with existing fire alarm cabling and fire alarm panels	There is a risk that a fire could occur and the fire alarm system may not alert the area(s) appropriately	Which may result in risks to those on site, switchboard not being notified of a fire activation, fire enforcement action, damage to the estate	Organisational	3	3	9	3	3	9	2	2	4	30/09/2025	Claire Lowe	Claire Lowe	48 Fire alarm system	Fire alarm panels and communication system to be replaced	0	1	Next phase of fire alarm works to progress within 2025, this will include priority ward areas Chubb have undertaken significant works on the network cabling that have removed the faults on the fire alarm system, with the sounder circuits working correctly across site at this time of writing Chubb Fire are currently undertaking the installation of a new network cabling system and panel replacement project, this will reduce the risk of fire alarm system failure. The Trust are also undertaking the acceleration of the remaining areas across site to be upgraded to an L1 fire alarm system, with Rowntree being started within January 20205. Upgraded to Organisational Register due to risk score increase Issues with fire alarm system identified on 22/11/24. Current risk score therefore increased and risk slightly re-worded to add in issues with cabling and panels Fire alarm works underway, estimated completion Feb 25	Estates infrastructure and environment	Property maintenance and management
Risk 00000049	Open	Due to the incorrect installation of the fire damper system, areas without current coverage, lack of previous maintenance	There is a risk that fire dampers may fail to operate in the event of a fire	Which may result in fire spreading, harm to individuals, loss of services and resulting impacts	Organisational	5	3	15	5	3	15	3	2	6	30/09/2025	Claire Lowe	Claire Lowe	49 Dampers	Replace and repair dampers	0	1	The estates team have engaged an external professional team due to the lack of an in house fire officer, this is required to provide technical design and formal strategy around the installation of the new fire damper systems needed across site. Surveys complete. Awaiting programme of works	Estates infrastructure and environment	Property maintenance and management
Risk 00000053	Open	Due to the heating and hot water systems running on gas only (no dual fuel capability)	There is a risk that the site suffers a loss of heating and hot water systems in the event of a gas outage	Which may result in the inability to continue to delivery services, financial and reputational impact	Organisational	5	3	15	5	3	15	5	1	5	31/03/2026	Claire Lowe	Claire Lowe	53 Energy centre	Establish funding for energy centre	0	1	The estates team have designs and plans in action to install new electric heaters through out the hospital, this will include new electric waters heaters also, this will reduce the reliance on GAS heating only, this also feeds into the NHS Green Plan in terms of decarbonisataion. Energy centre required to remove risk	Estates infrastructure and environment	Property maintenance and management
Risk 00000054	Open	Due to the age and condition of some boilers on site, and inability to obtain replacement parts	There is a risk that a boiler might fail and require full boiler replacement	Which may result in financial impact, impact to services and resulting impacts	Organisational	5	5	25	5	3	15	2	2	4	31/03/2026	Claire Lowe	Claire Lowe	54 Energy Centre 54 Temporary boilers	Seek funding for new energy centre (£4.5m)	0	1	We currently have a 2 year contract for the temporary boiler system, this started 1st April 2025. The proposed new energy centre will need significant design input from a professional design team within 2025 to be able to make the scheme feasible within the 2 year time scale we currently have. The estates team are waiting budget allocation / funding for a new energy centre, this will fully upgrade the current GAS boiler systems across site. We have installed a 2MW temporary boiler and pipe work system to reduce the risk of failure Temporary boilers being installed in areas where boilers have failed completely	Estates infrastructure and environment	Property maintenance and management
Risk 00000073	Open	Due to limited dedicated EPRR resources and skills and experience of trust staff	There is a risk that the trust may not be able to maintain full compliance rating for EPRR.	Which may result in reputational damage to the trust.	Organisational	4	3	12	3	3	9	3	2	6	31/03/2026	Kirsten Timmins	Ashley Hunt	EPRR exercising schedule EPRR policy and procedures in place EPRR resources On call rota TNA	Recruitment of substantive EPRR officer Internal resources EPRR resource update	0	3	Risk rating reduced from previous 12 to 9. Following discussions with CNO, the Dep CNO and Dep COO will both support EPRR given we do not have a dedicated role. This adds some resilience, and both have experience in EPRR. Risk has not increased given we did not have a specific EPRR lead previously. Resource conversations are taking place to ensure the trust is implementing the actions from the previous annual assurance review. Upgrading risk given decision not to go out for recruitment for an EPRR lead. Conversations will need to follow about internal resourcing this work. Risk approved for escalation to the Organisational Risk Register at the ECQR 16/12/24 No changes to current risk score, although JD is currently with HR for evaluation.	Regulatory and Compliance	External regulatory standards
Risk 00000077	Open	Due to a larger overall patient waiting list following the pandemic and the increased complexity of patient treatments, fluctuating demand and capacity	There is a risk that patients may come to harm whilst waiting for treatment	Which may result in delayed patient treatment, potential patient harm, reputational impact	Organisational	5	3	15	3	2	6	2	2	4	31/03/2026	Kirsten Timmins	Victoria Worrell	Cancer plan Waiting list management action plan Weekly access meeting Weekly RTT PTL meeting	Weekly update to COO and CMO Harm review	0	2	Trust currently reaching out to other trusts to receive best practice Clinical Harm review process Risk approved for escalation to the Organisational Risk Register at the ECQR 16/12/24	Patient safety, outcomes and experience	Clinical safety/quality of care
Risk 00000088	Open	Due to challenges in performance resulting from internal and external factors	There is a risk we fail to deliver compliance with operational and NHS constitutional standards in relation to performance	Which may result in a negative impact in patient outcomes/experience, reputational impact, financial impact	Organisational	4	4	16	4	3	12	3	3	9	31/03/2026	Kirsten Timmins	Victoria Worrell	88 Policy and training 88 Referral to Treatment monitoring 88 Reporting of data to Sussex ICB 88 Reporting to clinical governance meetings (Plastics) 88 Reporting to weekly system DMO1 and sleep planning meeting Improved operational governance Internal Audit	Cancer Action Plan Waiting List Action Plan Delivery in 2024/25	1	2	The trust has met key targets for UEC, cancer, DM01. 65ww has been a key focus for 2025/26, and the trust has delivered The trust has met key targets for UEC, cancer, DM01. 65ww has been a key focus for 2025/26, and the trust has delivered Risk approved for escalation to the Organisational Risk Register at the ECQR 16/12/24	Governance and sustainability	Organisational sustainability

Risk 00000117	Open	Due to the lack of a strategic overview of medical devices across the trust (age, condition etc.) and the lack of a capital replacement plan for Medical Device replacement	There is a risk that our Medical devices may fail to the point where we cannot repair due to age and unavailability of the parts of the device	Which may result in service delivery disruption to our patients	Organisational	4	4	16	4	3	12	3	2	6	31/03/2026	Edmund Tabay	Jan Somera	117 Finance capital replacement plan 117 Finance planning 117 Medical Devices register Contract in place with MTS to provide EBME services Monitoring of end of life equipment by Medical devices group Monthly oversight of progress made by MTS-meetings between QVH and MTS	Reinstigated the medical devices under the leadership of the Interim CNO Pull together a tender specification for the medical devices contract Engaging with the current contract supplier to improve service level Working with contract supplier (MTS) to ensure that asset register is up to date	3	1	The rating score remains unchanged. There is a priority list of medical and clinical devices for 2025/26 and this was presented at the Medical Devices Group and Executive Leadership Team for oversight. Further work is required to fully assess the impact of these devices are not purchased/secured for this financial year. MTS commenced as the EBME services provider at QVH on 2 June 2025. As part of their role, they will undertake a full assessment and review of all existing medical and clinical equipment across the Trust. At present, the risk rating score remains unchanged , as the capital funding allocated for medical and clinical devices in 2025/26 is limited, reserved for emergency needs only. We will continue to monitor the situation closely and prioritise equipment replacement based on risk and clinical necessity. MTS commenced as the EBME services provider at QVH on 2 June 2025. As part of their role, they will undertake a full assessment and review of all existing medical and clinical equipment across the Trust. At present, the risk rating score remains unchanged , as the capital funding allocated for medical and clinical devices in 2025/26 is limited, reserved for emergency needs only. We will continue to monitor the situation closely and prioritise equipment replacement based on risk and clinical necessity. The score remains the same. There are clinical and	Patient safety, outcomes and experience	Clinical safety/quality of care
Risk 00000121	Open	Due to end of life contract for supplier of Paging system infrastructure and no availability of parts, if the system fails there is no guarantee of repair	There is a risk that the paging system fails, Business continuity response will be instigated. A new supplier has been sourced and a contract signed for new pagers which will be implemented in 2025/26.	Emergency page not received by Resuscitation team	Organisational	4	3	12	4	3	12	4	2	8	30/09/2025	Kirsten Timmins	Bill Gordon	Ashley Hunt	Scope to understand number of pagers required for emeregency response teams Identify alternative supplier for pager solution and place order Scope and agree alternative solution for those not on Resuscitation team Replacement bleep system Contract in place	2	3	CDIO to arrange a meeting with supplier to work through timescales for implementation Third party supplier awaiting licence agreements form OFCOM before confirming detailed project plan for implementation. Kick off meeting with supplier on 9th May. Expected lead time to start project in 2 weeks. Plan to go live in Sept 2025 Order has been place and received (5 year contract) A company has been identified and a contract signed for new pagers to be delivered in early 2025/26. Replacement of bleep system on priority one for purchase by the financial year end	Patient safety, outcomes and experience	Clinical safety/quality of care
Risk 00000125	Open	Due to lack of an SLA with a mental health provider	There is a risk that patients suffering a mental health crisis or requiring mental health support whilst undergoing an inpatient stay may not get the help they need	Which may result in inappropriate transfers of care or inability to provide targeted interventions that improve the patient's recovery and rehabilitation	Organisational	3	4	12	3	4	12	2	3	6	01/10/2025	Tamara Everington	Tamara Everington	Access to agency RMNs Psychology services input for patients with MH difficulties SLA with SPFT for mental health liaison	SLA with SPFT	0	1	Target date of 01/04/2025 for achieving this has not been met due to the complexity involved in rebuilding and developing an SLA with the mental health provider, as well as financial challenges. A revised target date has now been set. Rebuilding SLA is a cost pressure that needs to be balanced against other priorities with potential benefits.	Patient safety, outcomes and experience	Clinical safety/quality of care
Risk 00000132	Open	Due to competing internal and external priorities, such as internal organisational priorities, financial resources, adherence to planning guidance priorities	There is a risk that the implementation of the QVH strategy is delayed or unable to progress	Which may result in failure to deliver the QVH strategy, reputational impact, uncertainty for the future direction or financial impact	Organisational	5	3	15	5	3	15	4	2	8	30/09/2025	Abigail Jago	Kathy Brasier	132 Accountability and ownership 132 Driving performance through strategy 132 External engagement 132 Financial sustainability 132 Internal engagement 132 Priority development	Operational Plan Stress test of approved organisational strategy 2025-30	0	2		Governance and sustainability	Organisational sustainability
Risk 00000133	Open	Due to the impact of national shortages of specific roles (eg radiology, sonography, histopathology, sleep physiologist).	There is a risk that if these roles become vacant we may not be able to recruit to them in a timely manner.	Which may result in increased waiting times for patients, cancellation of clinics / appointments. Increase in temporary staffing costs to cover the roles.	Organisational	3	3	9	3	2	6	2	2	4	31/03/2026	Helen Edmunds	Helen Edmunds	Apprenticeships to support growing our own System networks for hard to recruit roles	Undertake succession planning across directorates	0	1		Workforce	Recruitment and retention
Risk 00000138	Open	Due to various internal and external factors around the delivery of the EPR programme (e.g. funding, medical engagement, benefits realisation)	There is a risk of failure to deliver the EPR programme	Which may result in impact to patient care, reputational impact, impact on strategy, challenges with partnership working, lack of data driven culture, digital maturity, staff recruitment/retention, legacy software challenges	Organisational	5	3	15	5	2	10	5	1	5	30/11/2025	Tamara Everington	Bill Gordon	138 External assurance 138 Governance and reporting 138 Programme plan and risk register 138 Programme resource	Revised Business Case summary	0	1	Autumn go live now approved by Trust Board	Information technology and digital	Digital transformation and innovation
Risk 00000139	Open	Due to the age and design of the electrical cabling and switch room equipment within the American Wing radiology department	There is a risk of an electrical fire	Which may result in loss of life and property	Organisational	5	3	15	5	3	15	5	1	5	04/12/2025	Claire Lowe	Peter Boag					Weekly inspection still being carried out. Fire detection within room and adjacent rooms. Weekly visual inspection by estates management team to confirm no damage to electrical equipment within room has been put on the PPM system The cabling is red and black cables which high light the need for a full rewire of the space, currently the electrical equipment is also over 50 years old and poses a considerable risk of fire	Estates infrastructure and environment	Estates development
Risk 00000144	Open	Due to the NHS financial pressures, the significant level of savings required within the QVH plan and the uncertainty of ERF funding.	There is a risk that the Trust will fail to deliver a break even position in 2025/26	Which may result in additional financial restrictions and controls being implemented by the ICB or NHSE, critical cash pressures, reduced access to capital and loss of deficit funding c£1.2m	Organisational	4	3	12	4	3	12	4	2	8	30/04/2026	Simon Marshall	Jonathan Wharton	Monthly Monitoring	Contract agreements	0	1	There is still a risk to the loss of deficit support funding as Q1/2 funding has been secured but Q3/4 has not yet been confirmed and remains linked to the system position. Target date updated to cover the whole year. The Trust has delivered its plan for months 1-4 however their is still a risk on the CIP which means the risk score remains unchanged.,	Finance	Budgetary control
Risk 00000148	Open	Due to the significant level of the CIP programme in 2025/26 and the required phasing of the programme	There is a risk that the Trust will be unable to deliver the full value of CIP or that a significant proportion will be non-recurrent	Which may result in failure to deliver the Trust break even plan which would lead to additional external financial controls on the Trust, critical cash issues, restriction in capital and an increase in the underlying run rate.	Organisational	5	4	20	5	4	20	4	3	12	31/12/2025	Simon Marshall	Jonathan Wharton	Efficiency steering group					Finance	Budgetary control
Risk 00000149	Open	Due to uncertainty regarding the contractual arrangements for ERF funding and the ICB financial positions	There is a risk that the current assumptions for ERF funding in the Trust plan are not agreed	Which may result in failure to deliver the break even position, to meet performance targets and fund unavoidable cost pressures.	Organisational	4	4	16	4	3	12	4	2	8	31/03/2026	Simon Marshall	Jonathan Wharton		ERF Contract sign off	0	1	Kent and Surrey have not included the additional ERF in the baseline contract and they will need to be delivered through activity recognition. This will continue to be monitored to confirm that ERF is being delivered inline with the plan assumptions. Sussex agreed and Kent updating the base ERF along with the contract to pay on delivery of activity rating has been updated. Sussex ICB have agreed. Other ICBs not agreed yet.	Finance	Revenue generation

Risk 00000153	Open	Due to lack of fire compartmentalisation within the plant room above theatres.	There is a risk fire would spread quickly to other larger parts of the plant room above theatres.	Which may result in catastrophic loss of property and life	Organisational	5	3	15	4	3	12	3	3	9	22/03/2026	Claire Lowe	Peter Boag	Fire alarm system Fire damper system	External company to inspect and advise regarding course of action	0	1	Current score updated to 12 on the basis that we would be alerted to a fire an its early stage by the alarm system. Appropriate action would be taken to mitigate it spreading. The score will remain 12 until the external contractor has completed the survey and remedial works is finished. The theatre complex was built in 2012, and due to value engineering the roof plant room fire compartmentalisation was omitted. Unfortunately this has left the Trust at risk since 2012. We now need this element of remedial works to be completed urgently to remove this risk.	Estates infrastructure and environment	Property maintenance and management
Risk 00000161	Open	Due to overspending, shortfall of CIPs, late collection of income and un-forecast cash requirements.	There is a risk that the Trust operational cash balance will reduce to zero or fall to a level lower than the Trust aims to keep in reserve (£1m)	Which may result in delays/difficulties in paying suppliers or capital.	Organisational	4	4	16	4	4	16	3	2	6	31/01/2026	Simon Marshall	Jonathan Wharton	Efficiency steering group meetings Financial controls meeting Weekly cash flow monitoring	Review of cash controls	0	1		Finance	Financial compliance and standards
Risk 00000176	Open	Due to failure of the air conditioning units	There is a risk that medicines in pharmacy will be exposed to temperatures exceeding the licensed storage temperature during periods of hot weather.	Which may result in increased the rate of degradation of the product and potentially affect the clinical effectiveness of the medicine.	Organisational	4	5	20	4	3	12	4	1	4	18/08/2025	Judy Busby	Judy Busby	Investigate option for portable unit in case of second unit failing Prioritisation of which stock to main colder Regularly twice daily monitoring of room tempertaures Separate air conditioning units Temporary reduction of temperature burden by not switching on some lights	New circuit board to be purchased and installed New air conditioning unit to be sourced and installed	0	1		Patient safety, outcomes and experience	Clinical safety/quality of care

Queen Victoria Hospital
NHS Foundation Trust

Report cover-page					
References					
Meeting title:	Board of Directors				
Meeting date:	11 September 2025		**Agenda reference:**	**67-25**	
Report title:	NHS Workforce Race Equality Standards (WRES) Report 2024/25 & NHS Workforce Disability Equality Standards (WRES) Report 2024/25				
Sponsor:	Helen Edmunds, Chief People Officer				
Author:	Helen Edmunds, Chief People Officer Lawrence Anderson, Deputy Chief People Officer				
Appendices:	Appendix 1 - Workforce Race Equality Standards (WRES) Report 2024/25 Appendix 2 - Workforce Disability Equality Standards (WDES) Report 2024/25				
Executive summary					
Purpose of report:	This paper sets out the 2024/25 WRES and WDES reports and associated actions that will be taken, based on data collected on 31 March 2025.				
Summary of key issues	• There is an increase of 0.78**%** BME staff, from 21.20% in 23/24 to **21.98%** in 24/25 • There is an increase of 2% of BME staff experiencing harassment, bullying or abuse from patients, relatives or the public, from 26.1% (26/101) in 23/24 to 28.1% (36/128) in 24/25, an increase of 10 individuals. • There is an increase of 5.5% of BME staff experiencing harassment, bullying or abuse from staff in the last 12 months, from 19.7% (20/101) in 23/24 to 25.2% (32/127) in 24/25, an increase of 12 individuals • There is an increase of 0.22 in the relative likelihood of white applicants being appointed from shortlisting compared to BME applicants, from 2.72 in 23/24 to **2.94** in 24/25. • There has been an increase in the number of disabled staff, from 6.67% in 23/24 to **7.62%** in 24/25. • There is an increase of 9.1% in disabled staff who felt pressure to come to work, from 22.7% (22/97) in 23/24 to 31.8% (28/88) in 24/25, an increase of 6 individuals				
Recommendation:	The Board of Directors are asked to note the information within the report and the proposed actions to support ongoing cultural transformation and improvement and to approve the report for publication on the Trust website.				
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:	BAF2				
Corporate risk register:	None				
Regulation:	None				
Legal:	None				
Resources:	None				
Assurance route					
Previously considered by:	Executive Leadership Team Finance and Performance Committee				
	Date:	June 2025	Decision:	To be presented to Board of Directors	
Next steps:	To be presented to Board in September 2025 and then published on our Trust website by 31st October 2025.				

Report to:	Board of Directors
Agenda item:	NHS Workforce Race Equality Standards (WRES) & NHS Workforce Disability Equality Standards (WDES) Reports 2024/25
Date of meeting:	11 September 2025
Report from:	Lawrence Anderson, Deputy Chief People Officer
Report author:	Helen Edmunds, Chief People Officer Lawrence Anderson, Deputy Chief People Officer
Date of report:	16 June 2025
Appendices:	1. 2024/25 WRES Report 2. 2024/25 WDES Report

NHS Workforce Race Equality Standards (WRES) and NHS Workforce Disability Equality Standards (WDES) Report 2024/25

National context - WRES

The Workforce Race Equality Standard (WRES) programme has now been collecting data on race inequality for seven years, holding up a mirror to the service and revealing the disparities that exist for black and minority ethnic staff compared to white colleagues. The Covid-19 pandemic put in the spotlight the disadvantage experienced by staff with protected characteristics. As the NHS recovers its services following the pandemic, addressing the issues of equality and inclusion are core to the success for the workforce.

The WRES uses statistical data to demonstrate the experience and outcomes for BME staff compared to white staff through many stages of the employment journey. The standard requires NHS Trusts to develop action plans to address any areas of inequity that the data highlights. It is an annual process to review and improve working conditions for BME staff in the NHS.

The report uses the acronym BME, recognising that within this there are a multitude of ethnic backgrounds and diversity included within the WRES analysis. It does not suggest that the identified issues affect all BME staff equally or that each group's treatment or needs are the same.

This report contains a data snapshot comparison between 1 April 2024 and 31 March 2025, and highlights the improvements that have been seen and the areas that require further action.

In line with the categories taken from the 2001 Census:

The BME category includes:	**The White category includes:**	**The unknown category includes:**
• D – Mixed white and black Caribbean • E – Mixed white and black African • F – Mixed white and Asian • G – Any other mixed background • H – Asian or Asian British – Indian • J – Asian or Asian British – Pakistani • K – Asian or Asian British – Bangladeshi • L – Any other Asian background • M – Black or black British – Caribbean • N – Black or black British – African	• A – White – British • B – White – Irish • C – Any other white background	• Z – not stated • Null (NHS Electronic Staff Records code) • Unknown (NHS Electronic Staff Records code)

• P – Any other black background • R – Chinese • S – Any other ethnic group		

National context – WDES
The Workforce Disability Equality Standard (WDES) is mandated for all Trusts in England with the aim of furthering equality and inclusion for Disabled staff in the NHS. Introduced in 2019, it has now been collecting data on disability inequality for four years, highlighting the collective experiences of Disabled NHS staff and shines a light on disparities between Disabled and non-disabled staff.

The WDES is a collection of 10 metrics that aim to compare the workplace and career experiences of Disabled and non-disabled staff through stages of the employment journey. The standard requires NHS Trusts to develop action plans to address any areas of inequity that the data highlights. It is an annual process to review and improve working conditions for Disabled staff in the NHS.

The report uses a capital 'D' when referring to Disabled staff. This is a conscious decision, made to emphasise that barriers continue to exist for people with long-term conditions. The capital 'D' also signifies that Disabled people have a shared identity and are part of a community that continues to fight for equality.

The evidence set out in the first three data analysis reports for the WDES in the NHS overall highlights that Disabled NHS staff continued to experience inequalities across all of the metrics. The data provides a robust evidence-base and reinforces the need for the WDES to act as a catalyst for change in creating a fairer and more equal NHS.

Executive Summary

The full details for the Workforce Race Equality Standard and Workforce Disability Quality Standard reports are detailed in appendices 1 and 2, with summary highlights as follows:

Workforce Race Equality Standard
Note: 2023 results for WRES indicator 5 (Q14a) and 6 (Q14b & Q14c) are now reported using corrected data. Please see https://www.nhsstaffsurveys.com/survey-documents/ for more details.

Workforce & Board Representation
There is an increase of 0.78% BME staff, from 21.20% 23/24 to 21.98% in 24/25. Our representation of BME staff in non-clinical roles rose by 1.3% and clinical roles by 0.76%.

Most BME staff remain clustered at Band 5 (25.30%), closely followed by Band 6 (22.94%) and Band 7 (21.99%). Representation at Band 8B has grown from 0% to 6.67%. There is still low representation at Band 4 (12.08%) although this has grown from 23/24 and none from Band 8D to Band 9 (0%).

Discrimination
BME staff that have personally experienced discrimination at work from manager/team leader or other colleagues has decreased from 17.5% (20/114) in 23/24 to 13.3% (17/128) in 24/25. This is a continued reduction from 21.8% in 22/23. BME staff are almost twice as likely to experience discrimination compared to white staff, 13.3% compared to 6.9% (17/128 vs 36/525).
Career Progression
The percentage of BME staff who believe there are equal opportunities for career progression or promotion decreased by 3.7% — from 58.8% (67/114) in 23/24 to 55.1% (70/127) in 24/25. Despite the percentage drop, this reflects an increase of 3 individuals.

As per the national WRES Summary for the 2023/2024 reporting year, the Trust performed better than the national average of 48.8%.

Accessing CPD and Non-Mandatory Training
The Trust has continued to achieve equal access to non-mandatory training and CPD for 24/25 (0.96).

Bullying and Harassment
There is an increase of 2% of BME staff experiencing harassment, bullying or abuse from patients, relatives or the public, from 26.1% (26/101) in 23/24 to 28.1% (36/128) in 24/25, an increase of 10 individuals.

This is below the national average of 28.63% for BME staff experiencing harassment, bullying or abuse from patients, relatives or the public.

Harassment, bullying or abuse from staff towards BME colleagues has also increased 5.5%, from 19.7% (20/101) in 23/24 to 25.2% (32/127) in 24/25, an increase of 12 individuals.

Disciplinary Processes
There is a decline in the relative likelihood of BME staff entering the formal disciplinary process from 1.82 in 23/24 to 1.15 in 24/25.

In 23/24 there were a total of 9 cases. The difference in disparity is 0.006 vs 0.01 however this was auto calculated to 1.82, in 24/25. We had 3 employee relations cases which auto calculates at 0.0032 vs 0.0036.

Recruitment
There is an increase of 0.22 in the relative likelihood of white applicants being appointed from shortlisting compared to BME applicants, from 2.72 in 23/24 to 2.94 in 24/25.

The data for this metric is taken from the TRAC recruitment system and includes data from applicants who do not have the right to work in the UK and who the Trust cannot legally sponsor owing to not meeting the salary cap set by the government to qualify.

Board Representation
The difference between the Boards' membership and the Trust Workforce has increased by 19% in 24/25 to -2.00%. As per the national WRES Summary for the 2023/2024 reporting year, The Trust performed better than the national average of 12.2%.

Workforce Disability Equality Standard
Note: 2023 results for WDES metric 4a (Q14a), 4b (Q14b) 4c (Q14c) and 4d (Q14d) are now reported using corrected data. Please see https://www.nhsstaffsurveys.com/survey-documents/ for more details.

Workforce & Board Representation
There has been an increase in the proportion of disabled staff, from 6.67% in 23/24 to 7.62% in 24/25. The highest reported under representation is in Medical and Dental roles. In 24/25 Board representation has decreased to 0% from 6.7 in 23/24.

Feeling Valued
There is an increase of 9.1% in disabled staff who felt pressure to come to work, from 22.7% (22/97) in 23/24 to 31.8% (28/88) in 24/25, an increase of 6 individuals.

The percentage of disabled staff who felt valued by the Trust fell from 45.3% (68/150) in 23/24 to 34.6% (57/165) in 24/25—a drop of 10.7% and 11 individuals.

Staff Engagement
There is a small 0.2 point decline (out of 10) in the staff engagement score for disabled staff and a 0.05 decline for non-disabled staff.

Career Progression
The percentage of disabled staff who believe the Trust provides equal opportunities for career progression fell by 3.6%—from 61.1% (91/149) in 23/24 to 57.8% (96/166) in 24/25. Despite the percentage drop, this reflects an increase of 5 individuals.

Recruitment
There has been a further improvement in the likelihood of disabled candidates being appointed into roles from 2.05 in 22/23 to 1.11 in 23/24 and 1.09 in 24/25. As per the national WDES Summary for the 2023/2024 reporting year, the overall ranking compared to 212 trusts nationally, QVH ranked as 32% nationally* for the likelihood of appointing from shortlisting.

Reasonable Adjustments
This is a slight decrease of 1.09% in the number of disabled staff saying that their employer has made reasonable adjustment(s) to enable them to carry out their work, from 84.6% in 23/24 (77/91) to 83.5% (71/85) in 24/25. As per the national WDES Summary for the 2023/2024 reporting year, the overall rank compared to 212 trusts nationally, QVH ranked as 3% nationally* for making reasonable adjustments.

Bullying and Harassment
There is a decrease of 3.9% in bullying and harassment towards disabled staff from patients, service users, relatives and members of public, from 28.1% (39/139) in 23/24 to 24.2% (40/165) in 24/25. Although the percentage has steadily declined over the past four years, the number of incidents is reasonably static, while the number of staff identifying as disabled increased.

Bullying and harassment towards disabled staff from managers has also decreased by 4.1%, from 15.7% (22/139) in 23/24 to 11.6% (19/164) in 24/25. As per the national WDES Summary for the 2023/2024 reporting year, the overall ranking compared to 212 trusts nationally, QVH ranked as 43% nationally* for the likelihood of bullying and harassment towards disabled staff from managers.

There is a decrease of 3.6% in bullying and harassment towards disabled staff from colleagues, from 23.7% (33/139) in 23/24 to 20.1% in 24/25 (33/164).

There has however been a decrease of 8.3% in the number of disabled staff reporting incidents, from 52.8% (32/61) in 23/24 to 44.4% in 24/25 (28/63), a drop of 4 individuals.

*ranks the Trust from 0% (best in the country) to 100% (worst in the country) on each indicator, based on effect size.

Conclusions

It is encouraging there has been a further increase of 0.78**%** BME staff, from 21.20% 23/24 to **21.98%** in 24/25.

The lack of representation of BME staff in clinical and non-clinical roles amongst the more senior roles remains a concern, however it is important to consider the statistical relevance as there are fewer roles at these levels. Work will continue to support attraction and recruitment of diverse staff across all roles throughout 2024/25.

The number of incidences of bullying, harassment or abuse experienced towards BME colleagues has increased 5.6% in 2024/25, from 19.7% in 23/24 to 25.2% in 24/25, an increase of 12 individuals.

Whilst there is improvement of BME staff that have personally experienced discrimination at work from manager/team leader or other colleagues from **17.5%** 23/24 to **13.3%** in 24/25, BME staff remain almost twice as likely to experience discrimination compared to white staff, 13.3% compared to 6.9%. Work will continue to improve the experiences of BME staff through our culture transformation steering group, EDI champions, culture reviews, manager and staff workshops and promotion of the freedom to speak up guardian creating a safe space to report incidents.

There has been an increase in the proportion of disabled staff, from 5.77% in 22/23 to **6.67%** in 23/24.

It's encouraging that there has been a further narrowing in the likelihood of a disabled candidate being appointed into roles from 1.11 in 23/24 to 1.09 in 24/25. This is a significant reduction from a position of 2.05 in 22/23. Ongoing work relating to succession planning, talent management and a coaching culture will continue to ensure all colleagues have quality appraisal conversations to support their learning and development.

Bullying and harassment towards disabled staff from managers has decreased by 4.2%, from 15.7% in 23/24 to **11.6%** in 24/25. There is also a decrease in bullying and harassment towards disabled staff from colleagues by 3.5%, and from members of the public and service users by 3.9%. Work will continue to support disabled staff feel psychologically safe to speak up and report their concerns, with ongoing manager training being provided to support a just and learning coaching culture, with coaching for managers being delivered throughout 2025/26.

Please note that percentage differences in responses may be misleading when based on small sample sizes. In such cases, even minimal changes in response numbers can produce large percentage shifts, which may not accurately represent the overall workforce experience or sentiment. These figures should be considered indicative rather than definitive.

Action plan

Within Appendix 1 and 2, details are provided for key areas of progress from 2024/25 and ongoing actions relating to these areas for 2025/26.

Also detailed are additional actions for 2025/26 to address the main areas of concern, including reducing discrimination at work for BME staff, and reducing incidents of bullying and harassment by colleagues and managers towards disabled staff, therefore improving the experience of colleagues with protected characteristics at work.

Recommendation
The Board of Directors are asked to note the information within the report and the proposed actions to support ongoing cultural transformation and improvement and to approve the report for publication on the Trust website.

Queen Victoria Hospital
NHS Foundation Trust

WRES-Workforce Race Equality Standard

Report 2024-25

Introduction

Nationally, it is known, based on various sources of data and lived experiences, colleagues from a Black, Asian and Minority Ethnic background have a poorer experience of working within the NHS. QVH are committed to improving those lived experiences and strive towards creating a culture where race and ethnicity are not barriers to progression, individuals feel safe in the workplace and difference is embraced.

The importance of race equality is embedded into the NHS People Plan where it states *'The NHS must welcome all, with a culture of belonging and trust. We must understand, encourage and celebrate diversity in all its forms'. T*he People Promise declares *'a commitment to creating and maintaining a compassionate and inclusive culture where diversity is valued and celebrated as a critical component, and not just a desirable one*.' The Trust must also meet its legal obligations under the Equality Act 2010 and The Human Rights Act 1998.

QVH's 5 year People and Culture strategy has been published, where the voices of our workforce will be key to our aims and objectives. This approach is also strengthened by the NHS EDI Improvement Plan, which sets out targeted actions to address the prejudice and discrimination –direct and indirect –that exists through behaviour, policies, practices and cultures against certain groups and individuals across the NHS workforce.

As a Trust we want to focus on working in partnership with our patients, service users and workforce, to change our workforce systems, rather than trying to change individuals. This enables our staff to thrive and deliver the best possible services and care to our patients and working environment to our colleagues.

Each year the Trust is required to publish Workforce Race Equality Standard (WRES) data.

The WRES provides a framework for NHS organisations to report, demonstrate and monitor progress against nine indicators of workforce equality. The indicators are a combination of workforce data and results from the NHS national staff survey and help to ensure employees receive fair treatment in the workplace and have equal access to career opportunities.

The WRES is included in the NHS Standard Contract and has been a requirement of NHS commissioners and NHS healthcare providers since July 2015.

The information in this report details key findings from the data collated for 2024/2025, comparisons of data from previous years, the progress made and actions we will be put in place to address the findings.

We encourage anyone reading this report, to give us feedback about the contents and suggest improvements, so we can enable appropriate and effective lived experiences for our diverse colleagues.

WRES Metrics

There are nine WRES indicators. Four of the indicators focus on **workforce data**, four are based on data from the **national NHS Staff Survey** questions, and one indicator focuses upon **BME representation on boards**. Based on the requirement from the National team, the Trust submitted the WRES data for Indicators 1 -4 and indicator 9 on the National Data Collection Framework (DCF) on **31st May 2024**.The staff survey results for Indicators 5 to 8, are taken directly from the WRES publications available on the NHS Staff Survey website.

Workforce Indicators:

1. Percentage of staff in each of the AfC Bands 1-9 or Medical and Dental subgroups and VSM (including executive Board members) compared with the percentage of staff in the overall workforce disaggregated by:

a) Non-Clinical Staff
b) Clinical Staff-of which
- Non-Medical Staff
- Medical and Dental Staff

Data Sourced from ESR

2. Relative likelihood of staff being appointed from shortlisting across all posts (both external and internal posts). **Data Sourced from ESR**

3. Relative likelihood of staff entering the formal disciplinary process, as measured by entry into a formal disciplinary investigation. **Data sourced from Human resources team records**

4. Relative likelihood of staff accessing non-mandatory training and CPD. **Data sourced from ESR and Organisational Development records**

National NHS Staff Survey indicators (or equivalent):

5. Percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 months

6. Percentage of staff experiencing harassment, bullying or abuse from staff in last 12 months

7. Percentage of staff believing that the trust provides equal opportunities for career progression or promotion

8. In the last 12 months have you personally experienced discrimination at work from any of the following?

b) Manager/team leader or other colleagues

Data Sourced from NHSS

Board representation indicator: For this indicator, compare the difference for white and BME staff

9. Percentage difference between the organisations' Board membership and its overall workforce disaggregated:
- By voting membership of the Board
- By executive membership of the Board

Data Sourced from ESR

Data Limitations

Four of the WRES indicators (5 to 8) are drawn from questions in the National NHS staff survey.

The reliability of the data drawn from those indicators is dependent upon the overall size of samples surveyed, the response rates to the survey questions, and whether the numbers of BME staff are large enough to not undermine confidence in the data.

Potential issues have been identified with the National Staff Survey Results affecting all NHS Trusts. Close to publication date, a problem was identified with the quality of the data. Further investigation determined that, for respondents at some organisations working with one of the main providers of survey services who had completed the survey using an iPhone, questions 13 a to d and question 14 a to d. This affects approximately 20,000 of the 707,460 respondents. Accompanying this report is the NHS Briefing (Appendix 3).

Definitions

Definitions as per Technical Guidance by NHS WES Team	
Term	Definitions
White Staff	Includes White British, Irish and Eastern European and any “white other”.
BME Staff	Staff that are from a Black or Minority Ethnic background that is not white.
Unknown	Refers to anyone who has not declared ethnicity. (i.e., staff who have either indicated that they ‘Prefer not to say’ or have not responded to the ethnic background monitoring question in ESR)
Non-mandatory training	Any learning, education, training, or staff development activity undertaken by an employee, the completion of which is neither a statutory requirement (e.g. fire safety training) or mandated by the organisation. Accessing non-mandatory training and CPD, in this context refers to courses and developmental opportunities for which places were offered and accepted.

Queen Victoria Hospital
NHS Foundation Trust

Yearly comparison 2019-2025

	WRES Metrics		Year							Trend	Difference between 2024 & 2025	
			2018-2019	2019-2020	2020-2021	2021-2022	2022-2023	2023-2024	2024-2025			
1	Percentage of black and minority ethnic (BME) staff	Overall	14.68%	15.91%	18.81%	19.33%	19.57%	21.20%	21.98%		0.78%	↑
		Non-Clinical	7.06%	7.61%	8.83%	8.50%	9.36%	10.00%	11.30%		1.30%	↑
		Clinical (inc M&D)	18.93%	20.39%	24.19%	25.17%	25.03%	27.06%	27.82%		0.76%	↑
2	Relative likelihood of staff being appointed from shortlisting across all posts (both external and internal posts).		1.32	1.47	1.79	1.27	2.31	2.72	2.94		0.22	↑
3	Relative likelihood of staff entering the formal disciplinary process, as measured by entry into a formal disciplinary investigation		0.00	1.27	0.00	0.00	0.00	1.82	1.15		-0.67	↑
4	Relative likelihood of staff accessing non-mandatory training and CPD		0.65	1.04	0.90	0.89	1.04	1.00	0.96		-0.04	↑
5	Percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 months	BME	27.6%	27.4%	18.3%	15.4%	28.0%	26.1%	28.1%		2.00%	↑
		Non-BME	24.6%	25.3%	16.0%	20.0%	19.2%	20.7%	19.1%		-1.60%	↑
6	Percentage of staff experiencing harassment, bullying or abuse from staff in last 12 months	BME	22.8%	34.3%	34.9%	36.0%	30.0%	19.7%	25.2%		5.50%	↑
		Non-BME	24.5%	21.2%	21.4%	19.5%	18.0%	19.9%	20.2%		0.30%	↑
7	Percentage of staff believing that the trust provides equal opportunities for career progression or promotion	BME	51.8%	52.8%	48.2%	48.9%	47.0%	58.8%	55.1%		-3.67%	↑
		Non-BME	61.2%	58.1%	60.2%	60.8%	59.1%	62.5%	63.1%		0.58%	↑
8	In the last 12 months have you personally experienced discrimination at work from a manager, team leader or other colleague?	BME	13.0%	14.5%	23.2%	18.3%	21.8%	17.5%	13.3%		-4.24%	↑
		Non-BME	4.1%	5.8%	5.6%	5.3%	5.5%	4.0%	6.9%		2.91%	↑
9	Percentage difference between the organisations' Board membership and its overall workforce disaggregated	Voting Membership	N/A	N/A	N/A	N/A	N/A	-21.0%	3.0%		24.00%	↑
		Executive Membership	N/A	N/A	N/A	N/A	N/A	-21.0%	-5.0%		16.00%	↑
		Overall Board	-6.5%	-7.6%	-18.8%	-10.9%	-11.8%	-21.0%	-2.0%		19.00%	↑

Please note that 2023 results for WRES indicator 5 (Q14a) and indicator 6 (Q14b & Q14c) are now reported using corrected data.

Executive Summary

Queen Victoria Hospital NHS Foundation Trust

Workforce Representation

There is an increase of 0.78**%** BME staff, from 21.20% 23/24 to **21.98%** in 24/25. Our non clinical staff rose by 1.3% and clinical staff by 0.76%

Most BME staff are still clustered at **Band 5** (25.30%), closely followed by **Band 6** (22.94%) and **Band 7** (21.99%). Representation at **Band 8B** has grown from 0% to 6.67%. There is still low representation at **Band 4** (12.08%) although this has grown from 23/24 and none from **Band 8d to Band 9** (0%).

Discrimination

BME staff that have personally experienced discrimination at work from a manager/team leader or other colleagues has decreased from **17.5%** (20/114 respondents) in 23/24 to **13.3%** (17/128) in 24/25. This is a reduction from **21.8**% in 22/23.

BME staff are twice as likely to experience discrimination compared to white staff, **13.3%** compared to **6.9% .**

As per the NHS national Staff Survey, the Trust performed slightly worse than the national average of 16.4%.

Career Progression

There is a decrease of **3.7%** in BME staff that believe there is equal opportunity for career progression or promotion, in comparison to white staff, from **61.1%** (91/149 respondents) in 23/24 to **57.8%** in 24/25 (96/166). The Trust performed better than the national average of 48.8% per the national WRES Summary for 2023/2024.

Disciplinary Processes

There is a decline in the relative likelihood of BME staff entering the formal disciplinary process from **1.82** in 23/24 to **1.15** in 24/25.

In 23/24 there were a total of 9 cases. The difference in disparity is 0.006 vs 0.01 however this was auto calculated to 1.82, in 24/25 we had 3 employee relations cases which auto calculates at 0.0032 vs 0.0036

Board Representation

The difference between the board's membership and the Trust Workforce has increased by **19%** in 24/25 to **-2.00%**.

As per the national WRES Summary for the 2023/2024 reporting year, The Trust performed better than the national average of 12.2%.

Accessing CPD and Non-Mandatory Training

The Trust has continued to achieve equal access to non-mandatory training and CPD for 24/25 (0.96)

Recruitment

There is an increase of **0.22** in the relative likelihood of white applicants being appointed from shortlisting compared to BME applicants, from **2.72** in 23/24 to **2.94** in 24/25.

The data for this metric is taken from the TRAC recruitment system and includes data from applicants who do not have the right to work in the UK and who the Trust cannot legally sponsor owing to not meeting the salary cap set by the government to qualify.

Bullying and Harassment

There is an increase of **2%** of BME staff experiencing harassment, bullying or abuse from patients, relatives or the public, from **26.1%** (26/101 respondents) in 23/24 to **28.1%** in 24/25 (36/128).

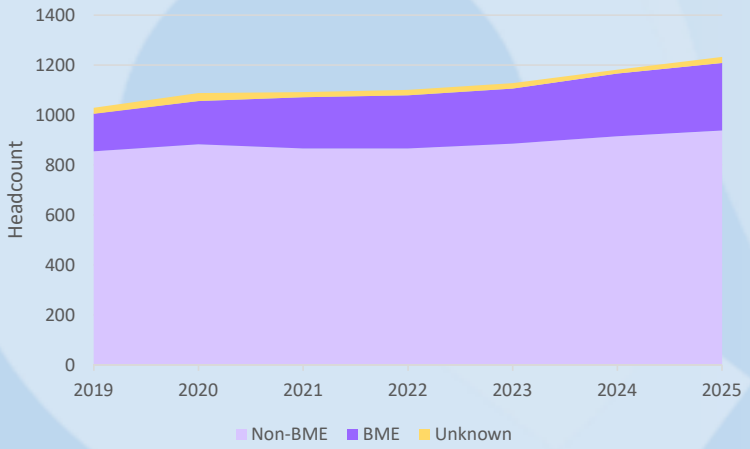
Harassment, bullying or abuse from staff towards BME colleagues has also increased **5.5%**, from **19.7%** in 23/24 to **25.2%** in 24/25.

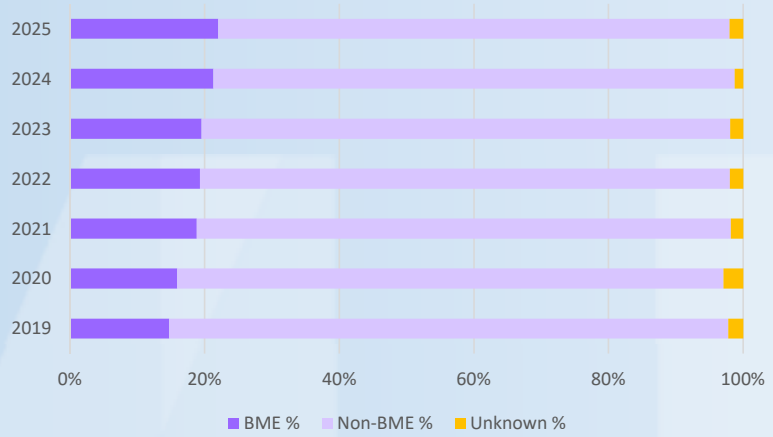
This is below the national average of 28.63%

WRES Indicator 1

Workforce Representation

	Headcount				Percentage		
	Non-BME	BME	Unknown	Total	Non-BME %	BME %	Unknown %
2019	854	151	23	1028	83.1%	14.7%	2.24%
2020	882	173	32	1087	81.1%	15.9%	2.94%
2021	866	205	20	1091	79.4%	18.8%	1.83%
2022	866	212	22	1100	78.7%	19.3%	2.00%
2023	885	220	22	1127	78.5%	19.5%	1.95%
2024	915	251	15	1181	77.48%	21.25%	1.27%
2025	937	271	25	1233	75.99%	21.98%	2.03%





The overall headcount for the Trust is **1233**. This has increased between 2024 and 2025 with the number of staff declaring as BME increasing to **271 (21.98%),** an additional **20** people. The Data shows the percentage of BME staff at the Trust continues to increase, growing by 0.78% in the last year.

There has also been an increase in the proportion of staff who have not declared their ethnicity (unknown), which is now at **25 (2.03%)**.

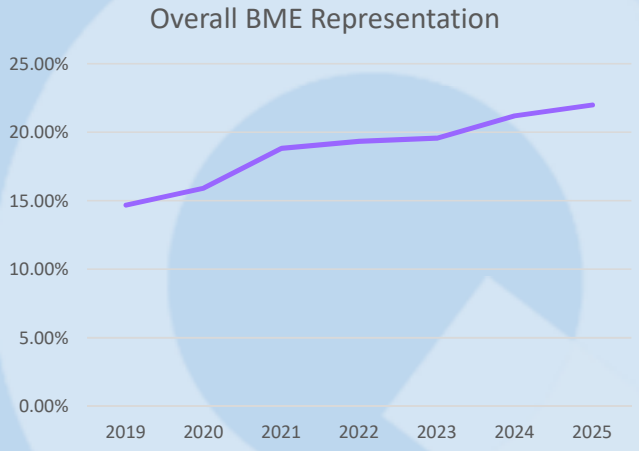
NHS Workforce Race Equality Standard 2023/24

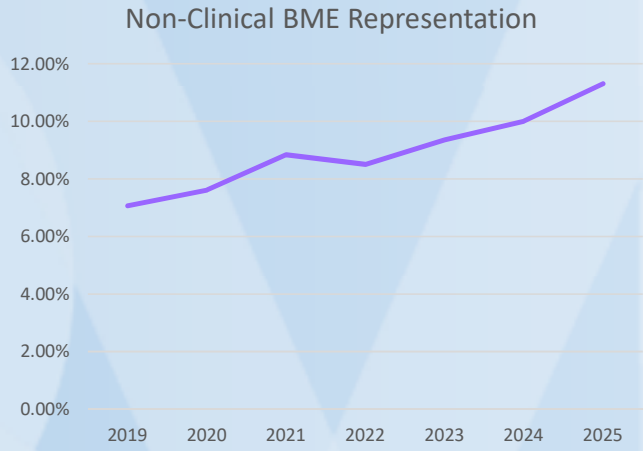
National Average
BME: 28.6%
Non-BME: 72.4%

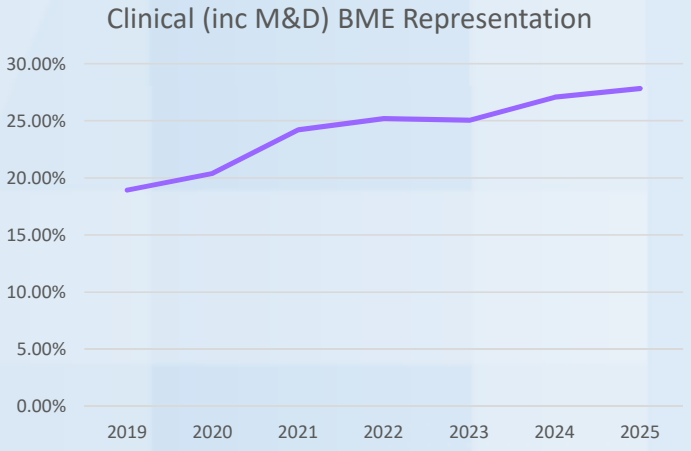
WRES Indicator 1

Workforce Representation

	Year						
	2019	2020	2021	2022	2023	2024	2025
Overall	14.68%	15.91%	18.81%	19.33%	19.57%	21.20%	21.98%
Non-Clinical	7.06%	7.61%	8.83%	8.50%	9.36%	10.00%	11.30%
Clinical (inc M&D)	18.93%	20.39%	24.19%	25.17%	25.03%	27.06%	27.82%



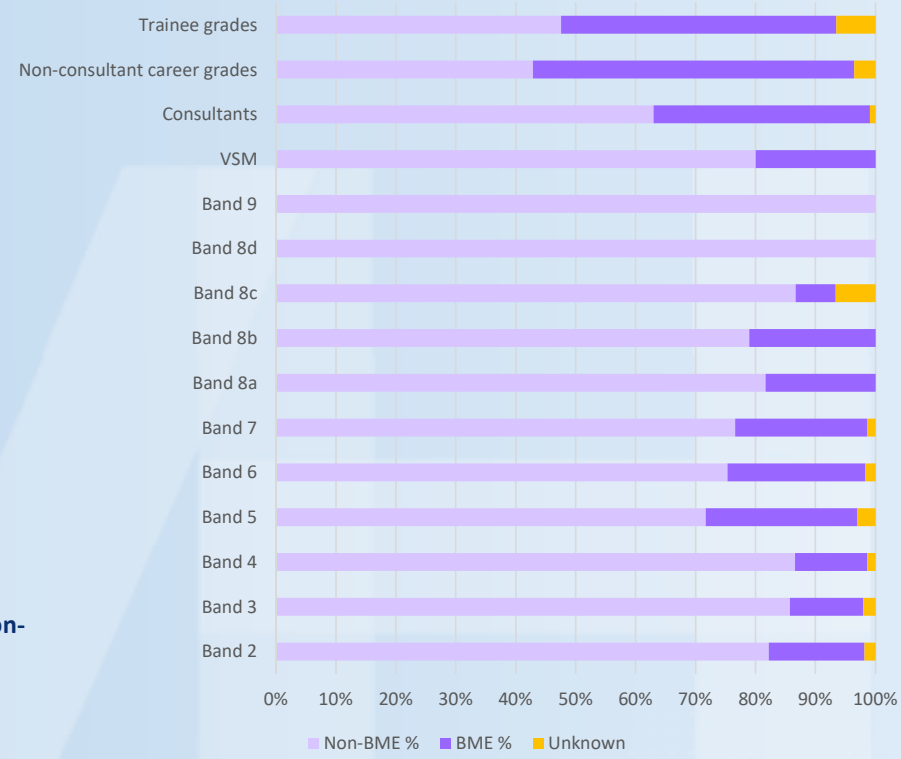




WRES Indicator 1

Workforce Representation

Pay banding	White	BME	Unknown	Total	White %	BME %	Unknown
Band 2	134	26	3	163	82.21%	15.95%	1.84%
Band 3	126	18	3	147	85.71%	12.24%	2.04%
Band 4	129	18	2	149	86.58%	12.08%	1.34%
Band 5	119	42	5	166	71.69%	25.30%	3.01%
Band 6	128	39	3	170	75.29%	22.94%	1.76%
Band 7	108	31	2	141	76.60%	21.99%	1.42%
Band 8a	40	9	0	49	81.63%	18.37%	0.00%
Band 8b	15	4	0	19	78.95%	21.05%	0.00%
Band 8c	13	1	1	15	86.67%	6.67%	6.67%
Band 8d	6	0	0	6	100.00%	0.00%	0.00%
Band 9	6	0	0	6	100.00%	0.00%	0.00%
VSM	4	1	0	5	80.00%	20.00%	0.00%
Consultants	68	39	1	108	62.96%	36.11%	0.93%
Non-consultant career grades	12	15	1	28	42.86%	53.57%	3.57%
Trainee grades	29	28	4	61	47.54%	45.90%	6.56%



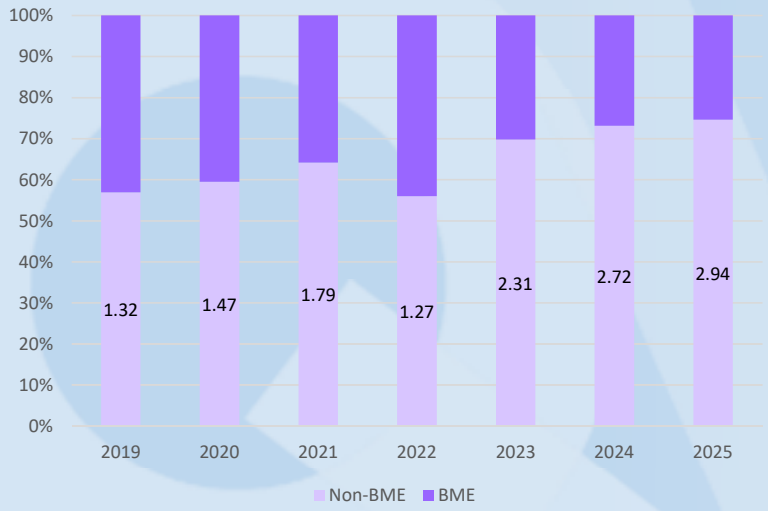
The majority of BME representation in the workforce are remain clustered at **Consultant** (36.11%) **Non-Consultant Career Grade** (53.57%) and **medical trainees** (47.54%) Of our Agenda for Change staff representation mainly falls within **Band 5** (25.30%), closely followed by **Band 6** (22.94%).

Representation at **Band 8b** has grown from 0% to 6.67%. There is still low representation at **Band 4** (12.08%) although this has grown from 23/24 and none from **Band 8d to Band 9**(0%).

WRES Indicator 2

Recruitment

	Year						
	2019	2020	2021	2022	2023	2024	2025
Relative likelihood of staff being appointed from shortlisting across all posts (both external and internal posts).	1.32	1.47	1.79	1.27	2.31	2.72	2.94



The relative likelihood of white applicants being appointed from shortlisting compared to BME applicants has increased since last year by **0.22**.

It is important to recognise that the data for this metric is taken from the TRAC recruitment system and includes data from applicants who do not have the right to work in the UK and who the Trust cannot legally sponsor owing to not meeting the salary cap set by the government to qualify.

This issue has a significant impact upon this metric as these are not excluded from the data

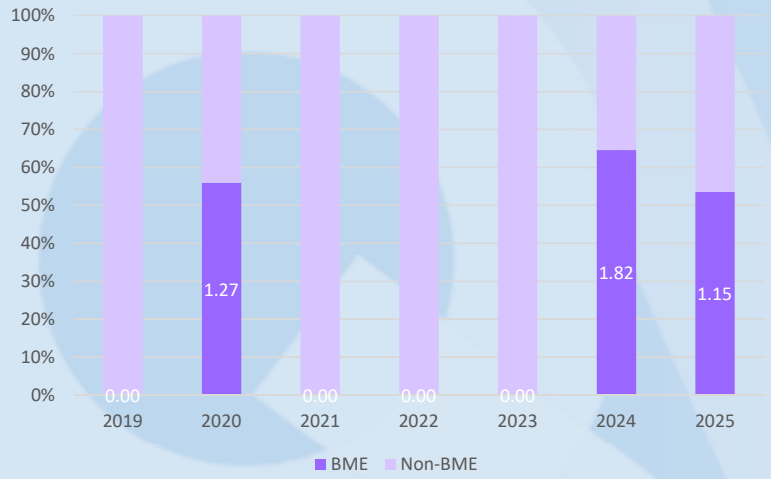
NHS Workforce Race Equality Standard 2023/2024

National Average
1.62

WRES Indicator 3

Disciplinary

	Year						
	2019	2020	2021	2022	2023	2024	2025
Relative likelihood of staff entering the formal disciplinary process, as measured by entry into a formal disciplinary investigation	0.00	1.27	0.00	0.00	0.00	1.82	1.15



There is a decline in the relative likelihood of BME staff entering the formal disciplinary process from **1.82** in 23/24 to **1.15** in 24/25.

In 23/24 there were a total of 9 cases. The difference in disparity is 0.006 vs 0.01 however this was auto calculated to 1.82, in 24/25 we had 3 employee relations cases which auto calculates at 0.0032 vs 0.0036

NHS Workforce Race Equality Standard 2023/2024

National Average
1.09

WRES Indicator 4

Training and Continual Professional Development

	Year						
	2019	2020	2021	2022	2023	2024	2025
Relative likelihood of staff accessing non-mandatory training and CPD	0.65	1.04	0.90	0.89	1.04	1.00	0.96

The Trust has continued to achieve equal access to non mandatory training and CPD for 24/25 **(0.96)**

NHS Workforce Race Equality Standard 2023/2024

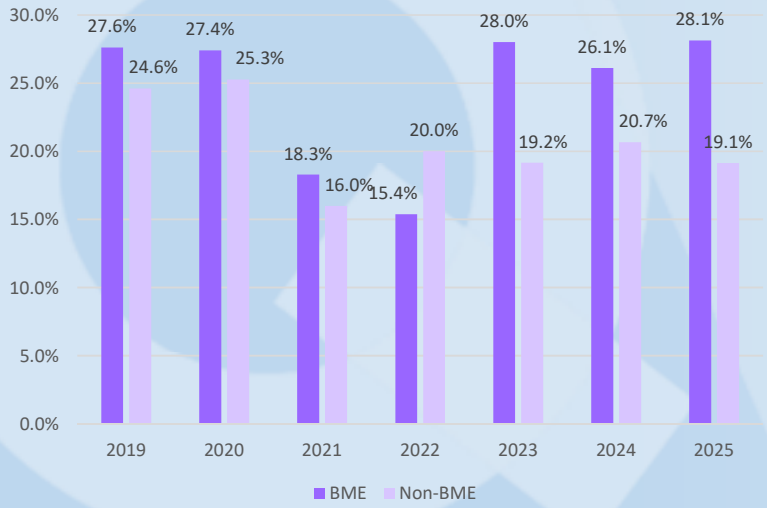
National Average
1.06

WRES Indicator 5

Bullying, harassment or abuse from patients, relatives or the public

Percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 months

		Year						
		2019	2020	2021	2022	2023	2024	2025
Percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 months	BME	27.6%	27.4%	18.3%	15.4%	28.0%	26.1%	28.1%
	Non-BME	24.6%	25.3%	16.0%	20.0%	19.2%	20.7%	19.1%



This data is from the National Staff Survey results.

Over 20% of all staff experience harassment, bullying or abuse from patients, relatives or the public

There is an **increase of 2%** of BME staff experiencing harassment, bullying or abuse from patients, relatives or the public, from 26.1% (26 of 101 respondents) to 28.1% (36 of 128 respondents) in 24/25.

Please note that 2023 results for WRES indicator 5 (Q14a) and indicator 6 (Q14b & Q14c) are now reported using corrected data.

NHS Staff Survey Data 2024

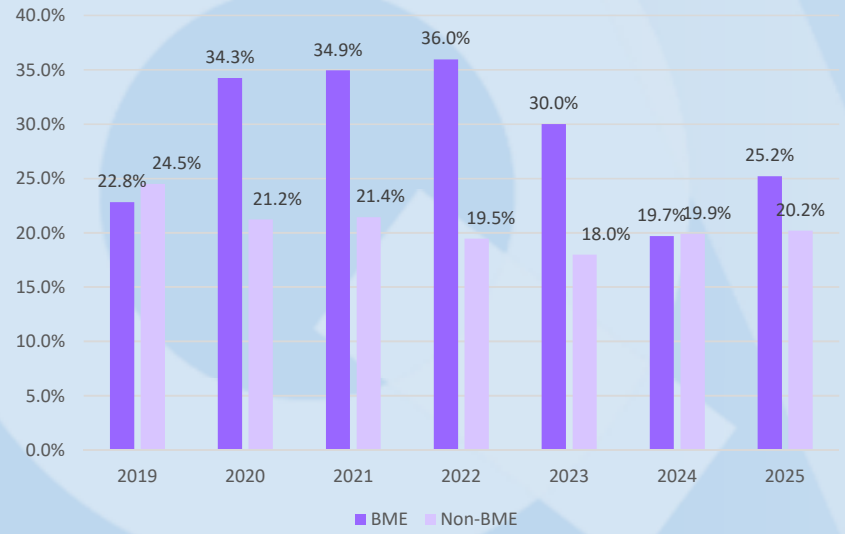
National Average
BME: 28.63%
Non-BME: 23.51%

WRES Indicator 6

Bullying, harassment or abuse from colleagues

Percentage of staff experiencing harassment, bullying or abuse from staff in last 12 months

		Year						
		2019	2020	2021	2022	2023	2024	2025
Percentage of staff experiencing harassment, bullying or abuse from staff in last 12 months	BME	22.8%	34.3%	34.9%	36.0%	30.0%	19.7%	25.2%
	Non-BME	24.5%	21.2%	21.4%	19.5%	18.0%	19.9%	20.2%



This data is from the National Staff Survey results.

Over 20% of all staff experience harassment, bullying or abuse from patients, relatives or the public.

There is an **increase of 5.5%** of BME staff experiencing harassment, bullying or abuse from staff, from 19.7% (20 of 101 respondents) to 25.2% (32 of 127 respondents) in 24/25.

Please note that 2023 results for WRES indicator 5 (Q14a) and indicator 6 (Q14b & Q14c) are now reported using corrected data.

NHS Staff Survey Data 2024

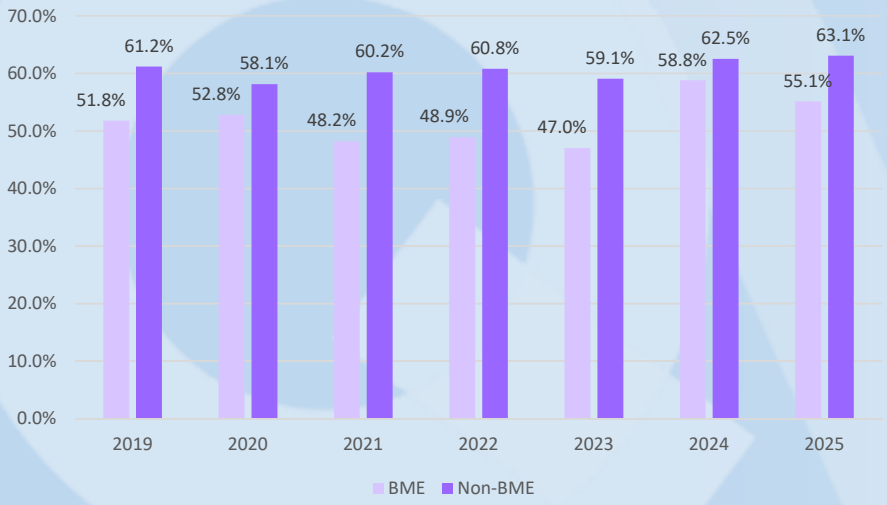
National Average
BME: 24.29%
Non-BME: 15.20%

WRES Indicator 7

Career Progression

Percentage of staff believing that the trust provides equal opportunities for career progression or promotion

	Year						
	2019	2020	2021	2022	2023	2024	2025
BME	51.8%	52.8%	48.2%	48.9%	47.0%	58.8%	55.1%
Non-BME	61.2%	58.1%	60.2%	60.8%	59.1%	62.5%	63.1%



This data is from the National Staff Survey results.

There has been a decrease by **3.7%** for the number BME staff that believe the Trust provides equal opportunities for career progression or promotion. This is alongside the percentage of staff who believe that the Trust provided equal opportunities for career progression or promotion being lower for BME staff than for non-BME staff.

The Trust is significantly better than the national average for both BME and Non-BME staff

NHS Staff Survey Data 2024

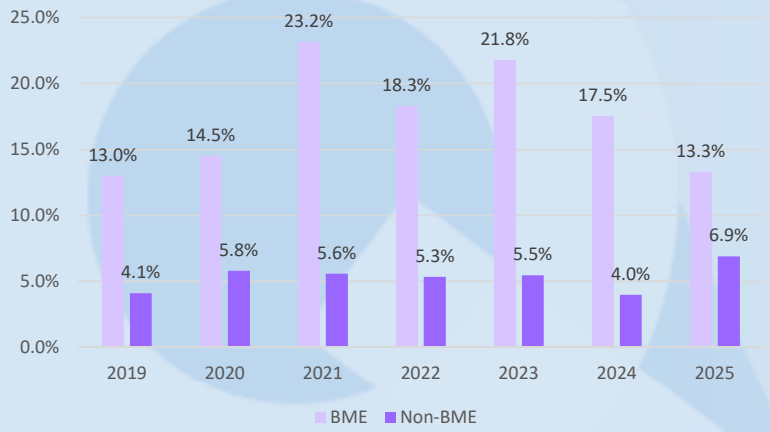
National Average
BME: 49.51%
Non-BME: 58.85%

WRES Indicator 8

Discrimination at work

In the last 12 months have you personally experienced discrimination at work from a manager, team leader or other colleague?

	Year						
	2019	2020	2021	2022	2023	2024	2025
BME	13.0%	14.5%	23.2%	18.3%	21.8%	17.5%	13.3%
Non-BME	4.1%	5.8%	5.6%	5.3%	5.5%	4.0%	6.9%



This data is from the National Staff Survey results.

There is a decrease in BME staff that have personally experienced discrimination at work from manager/team leader or other colleagues, from **17.5%** (20 of 114 respondents) in 23/24 to **13.3%** (17 of 128 respondents) in 24/25.

The overall percentage of staff who personally experienced discrimination from manager/team leader or other colleague is significantly higher for BME staff, being twice as likely to experience discrimination compared to white staff, **(13.3%** compared to **6.9%).**

As per the NHS England Staff Survey results, the Trust performed better than the national average of 15.2%.

NHS Staff Survey Data 2024

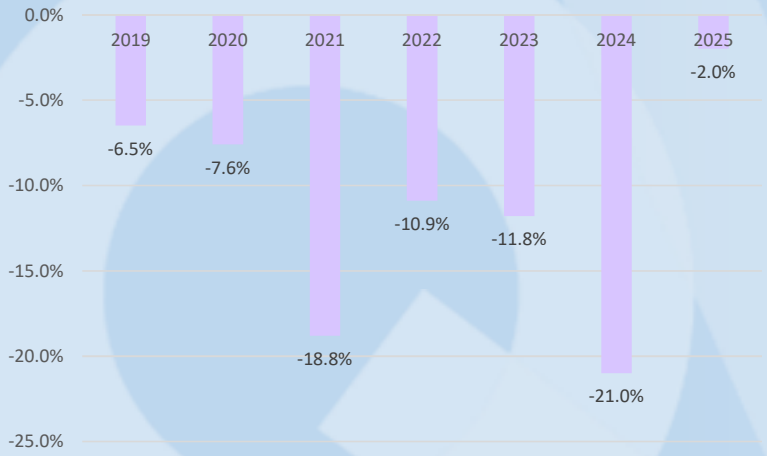
National Average
BME: 15.20%
Non-BME: 6.77%

WRES Indicator 9

Board Representation

Percentage difference between the organisations' Board membership and its overall workforce disaggregated

	2019	2020	2021	2022	2023	2024	2025
Overall Board	-6.5%	-7.6%	-18.8%	-10.9%	-11.8%	-21.0%	-2.0%



The number of BME board members has increased in 23/24 to 3 members. There is now a 20% representation

Since 2019 the Trust board representation has been below the workforce representation and has fluctuated each year . In 24/25 This has increased significantly to reduce the gap.

100% of the board have declared their ethnicity.

As per the summary for the 2023/2024 reporting year, the Trust is significantly above the national average of 12.2%

NHS Workforce Race Equality Standard 2023/2024

National Average 12.2%

Additional Insights

- BME staff represent 28.26% of the Trust's voluntary resignations in 2024-25. This is higher than the Trust's total BME workforce representation of 21.98% which has grown year on year since WRES reporting commenced

- Analysis of retention data shows BME staff cite the following as the reason for their resignation:
  - Care of adult dependants
  - Relocation
  - Undertaking further education or training
  - Work-life balance
  - Promotion

  This suggests that while the Trust has taken positive steps to improve attraction and recruitment of BME candidates, there is work to be done to support the balance of work and personal responsibilities. This also suggests that there are improvements to be made to career development options for our BME colleagues to support retention.

  This may also be linked to our 2024 Staff Survey results, which show a 3.7% reduction in the number of BME colleagues reporting a belief that the Trust provides equal opportunities for career progression.

Key Areas of Progress and Ongoing Actions for Next 12 Months

Culture Change	1. **Refreshed Vision and Values & Behavioral Framework -** These were launched in late 2024, with a behaviour framework to support an inclusive learning culture, increasing psychological safety of staff and supporting the embedding of an enhanced speak up process for staff. 2. **Workforce Belonging & Value** – The Trust has in place a comprehensive action plan aligned with NHS England's EDI Improvement Plan to to create an environment that eliminates the conditions in which bullying, discrimination, harassment and physical violence at work occur. The Trust commissioned an external company (Absolute Diversity) to conduct a listening exercise with our BME staff to understand areas of progress for inclusion and are working through the specific actions identified to support our staff's needs. 3. **Inclusive Behaviours** – The Exec team will be undertaking Diversity MOTs with Absolute Diversity to better understand cultural competence. The Trust has also implemented a Cultural Transformation Steering Group, with the aim to embed inclusion into business-as-usual practices. This group is attended by the Trust's CEO and CMO. 4. **Freedom to Speak Up** – The Trust's speak up provision has been enhanced and supported by an external provider to provide 24/7 support to staff. This service is available to all staff, and compliments the Trusts embedded mechanisms for raising concerns. The Freedom to Speak Up Guardian for QVH meets with the Employee Relations team to triangulate case work and feedback. 5. **Cultural Listening Exercises** – The Wellbeing & Inclusion team have supported cultural listening exercises across several teams to understand and tackle behaviours than contribute to a less inclusive environment for our BME staff.
Recruitment	1. **Inclusive Recruitment Process & Practice –** There has been an improvement in BME representation across staff groups. However, BME candidates are significantly less likely to be appointed from shortlisting than white candidates, and approximately 45% of our BME colleagues have reported feeling that opportunities for career development and/or promotion are not equal, suggesting that improvements can be made in this area, particularly as representation at Bands 8a and above is low. 2. **Career development through Apprenticeships -** Apprenticeships are key to support career development across all staffing areas. There was significant increase of apprentices from BAME backgrounds from 9.3% in 23/24 to 13.0% in 24/25. However, work is needed over 25/26 to ensure diversity of staff accessing apprentice opportunities carry on growing and the use of the levy continues to increase. Work experience opportunities have been offered to a more diverse range of students due to the introduction of work experience events to complement traditional work experience placements.
Career Development	1. **Appraisal Process Revised with a focus on Wellbeing and career development-** As part of the revised process, we ask for feedback and monitor effectiveness of appraisal alongside our National Staff Survey results. Any areas of concern are raised at an appropriate level to address concerns. 2. **Developing a management and leadership strategic framework-** In light of the new Management and Leadership Framework that is being co-developed by NHS England in response to the Messenger (2022) and Kark (2019) reviews, QVH is awaiting the publication of the framework before launching a local version. The purpose of this framework is to equip NHS managers – both clinical and non-clinical - with a code of practice, defined set of standards and competencies, a national development curriculum, and practical, accessible learning resources to enable them to lead and manage with confidence, care, and consistency and elevate NHS management and leadership as a recognised professional discipline. We are also developing a local management and leadership programme to include inclusive and compassionate leadership, which will be publicized to all staff once finalized 3. **Leadership through Education for Excellent Patient Care Programme (LEEP) -** The Trust continues to deliver our LEEP programme with a focus on multidisciplinary teamwork, increasing opportunities for staff from BME backgrounds both from a clinical and non-clinical staff groups.

Key Areas of Progress and Actions for next 12 Months

Bullying and Harassment	1. **Violence, Aggression & Abuse -** The Trust's Violence Prevention and Reduction group has increased compliance against the national standards to 91% in 24/25. The Trust has published its VPR policy which details how to manage inappropriate telephone calls and the procedure for withholding treatment from violent and abusive patients. The Trust's Domestic Abuse for staff policy has been re-written with safeguarding oversight. The key milestones of this work in 25/26 is to ensure compliance with the revised 2025 VPR standards where the Trust are currently 75% compliant 2. **NHS England High Impact Actions -** The Trust has in place a comprehensive action plan aligned with NHS England's EDI Improvement Plan, to address High Impact Action 6, which is to 'Create an environment that eliminates the conditions in which bullying, discrimination, harassment and physical violence at work occur. The Trust commissioned an external company (Absolute Diversity) to conduct a listening exercise with our BME staff to understand areas of progress for inclusion and are working through the specific actions identified to support our staff needs. 3. **Restorative and Just Learning Culture** - A key pillar within the People and Culture strategy will be to start the work on introducing a Restorative and Just Learning Culture in the Trust. The key focus will be the psychological safety of staff and civility and respect. This not only extends to Employee Relations but also through Patient Safety Incident Response Framework (PSIRF) and learning from incidents, understanding what has happened and what the learning is rather than seek a punitive approach. To support this approach, the Employee Relations and Wellbeing & Inclusion teams have been trained in implementing RJLC into people management practices.
Staff Engagement	1. **Engagement of BME staff** – The Wellbeing & Inclusion team have worked to engage our diverse staff and amplify their voices, including hosting drop in sessions to plan Black History Month activities to tailor these to areas of challenge. We have also launched EDI Champions and re-introduced monthly Team Brief (now Team Talk) sessions to drive organisational engagement. 2. **Wellbeing & Inclusion Resources** – The Wellbeing & Inclusion team have introduced a monthly bulletin and all-staff email to promote inclusive activities and initiatives. The team have also launched monthly drop-in sessions to allow staff at all levels to ask questions and build knowledge in a confidential space.
Board Sponsorship	1. **Board Accountability -** The Trust has agreed each Board member will act as a sponsor for one of the Staff Networks once established. This will result in dedicated and targeted leadership support, provide accountability and governance from senior leaders, reinforce the commitment to improving lived experiences and develop an inclusive leadership culture. Most importantly, it will enable Board members to hear the voices of BME staff. The CEO and CMO are members of the Culture Transformation Steering Group. 2. **People Committee –** This will be created in 2024-25 to highlight areas of challenge to the Trust Board relating to our BME colleagues. The Workforce Sub-committee commenced in 2024/25.

Actions for next 12 months

Action	By When	Lead
A module on EDI and inclusive management (including reasonable adjustments) will be added to the line manager's training offer in 2025-26.	Q3 2025-26	Wellbeing & Inclusion Manager
Triangulate Employee Relations case work, Freedom to Speak Up reports, Occupational Health data, Staff Survey and Pulse Survey results and Wellbeing & Inclusion insights to capture and act on themes highlighted by our BME colleagues on a quarterly basis.	Q2 2025-26	Employee Relations Team
Apply an EDI lens through lived experience to an ongoing end-to-end review of our current internal and external recruitment processes, with an EDI representative available for interview panels to support the de-biasing of the recruitment process.	Q3 2025-26	DCPO
Conduct an EDI audit of all applications for career development, including apprenticeships and external learning, to establish how our BME colleagues can be better supported to develop their careers and tackle any potential barriers.	Q3 2025-26	DCPO
Ongoing review of the structures and roles across departments specifically looking at succession planning and talent management from Band 8a to VSM	Ongoing through 2025/26	CPO, supported by Head of OD & L
Exploration of a reverse mentoring programme, using our networks to determine areas of initial focus to support career progression	Ongoing through 2025/26	CPO, supported by Head of OD & L
Development and implementation of a shadow board programme to develop future leaders, build board level experience and confidence to support succession planning and talent management	Ongoing through 2025/26	CPO

NHS
Queen Victoria Hospital
NHS Foundation Trust

WDES-Workforce Disability Equality Standard

Report 2024-25

Introduction

Nationally, it is known, based on various sources of data and lived experiences, that disabled colleagues have a poorer experience of working within the NHS. Our workforce consists of people with varied disabilities and long-term health conditions. They include a whole range of hidden and often changing conditions that will affect different individuals in different ways, in terms of their ability to work, so we need to cater for all their bespoke needs.

The importance of disability equality is embedded into the NHS People Plan where it states *'The NHS must welcome all, with a culture of belonging and trust.We must understand, encourage and celebratediversity in all its forms'. T*he People Promise declares *'a commitment to creating and maintaining a compassionate and inclusive culture where diversity is valued and celebrated as a critical component, and not just a desirable one.'* The Trust must also meet its legal obligations under the Equality Act 2010 and The Human Rights Act 1998.

QVH's People and Culture strategy which was published in late 2024, where the voices of our workforce will be key to our aims and objectives.. This approach is also strengthened by the NHS EDI Improvement Plan, which sets out targeted actions to address the prejudice and discrimination –direct and indirect –that exists through behaviour, policies, practices and cultures against certain groups and individuals across the NHS workforce.

As a Trust we want to focus on working in partnership with our patients, service users and workforce, to change our workforce systems, rather than trying to change individuals. This enables our staff to thrive and deliver the best possible services and care to our patients and working environment to our colleagues.

Each year the Trust is required to publish Workforce Disability Equality Standard (WDES) data.

The WDES is a set of ten specific measures (metrics) that enable NHS organisations to compare the experiences of Disabled and Non-disabled staff. This information informs the development of an action plan to demonstrate progress against the metrics to improve equality and inclusion for Disabled staff. The WDES was mandated for all Trust's from April 2017. It is included in the NHS Standard Contract .

The WDES is important because research shows that a motivated, included and valued workforce helps to deliver high quality patient care, increased patient satisfaction and improved patient safety. It supports positive change for existing employees and enables a more inclusive environment for disabled people working in the NHS.

The following information in the report details key findings from the data collated for 2024/2025, comparisons of data from previous years, the progress made and actions that will be implemented to address the findings.

We encourage anyone reading this report, to give us feedback about the contents and suggest improvements, so that we can enable appropriate and effective lived experiences for our diverse colleagues.

WDES Metrics

There are ten (10) WDES metrics. Three (3) metrics focus on **workforce data**; Five (5) are based on questions from the **NHS Staff Survey**; One (1) metric focuses on disability representation on boards; One (1) metric (metric 9b) focuses on the voices of Disabled staff. Based on the requirement from the National team, the Trust submitted the WDES data for Metrics 1 –3, and Metric 9b and Metric 10 on the National Data Collection Framework (DCF) on 31st May 2025. The staff survey results for the Metrics 4 –9a, are taken directly from the WDES publications available on the NHS Staff Survey website.

Workforce Metrics:

1. Percentage of staff in AfC (Agenda for Change) paybands or medical and dental subgroups and very senior managers (including Executive Board members) compared with the percentage of staff in the overall workforce. This calculation should be undertaken separately for non-clinical and for clinical staff for clusters 1 to 4. **Data Sourced from ESR**

2. Relative likelihood of non-disabled staff compared to disabled staff being appointed from shortlisting across all posts. **Data Sourced from ESR**

3. Relative likelihood of disabled staff compared to non-disabled staff entering the formal capability process as measured by entry into the formal capability procedure**. Data sourced from HR records**

National NHS Staff Survey metrics (or equivalent): For each of the following four metrics, compare the responses for both Disabled and non-disabled staff. Data Sourced from NHSS

4. Percentage of disabled staff compared to non-disabled staff experiencing harassment, bullying or abuse from:

a) Patients/service users, their relatives or other members of the public

b) Managers

c) Other colleagues,

d) Percentage of disabled staff compared to non-disabled staff saying that the last time they experienced harassment, bullying or abuse at work, they or a colleague reported it.

5. Percentage of disabled staff compared to non-disabled staff believing that the organisation provides equal opportunities for career progression or promotion.

6. Percentage of disabled staff compared to non-disabled staff saying that they have felt pressure from their manager to come to work, despite not feeling well enough to perform their duties

7. Percentage of disabled staff compared to non-disabled staff saying that they are satisfied with the extent to which their organisation values their work.

The following NHS Staff Survey metric only includes the responses of Disabled staff

8. Percentage of disabled staff saying that their employer has made reasonable adjustment(s) to enable them to carry out their work.

9. NHS Staff Survey and the engagement of disabled staff For part a)compare the staff engagement scores for Disabled, non-disabled staff.

a)The staff engagement score for Disabled staff, compared to nondisabled staff. b) Have you taken action to facilitate the voices of disabled staff in your organisation to be heard (Yes or No)?

Board representation metric: For this metric, compare the difference for Disabled and non-disabled staff.

10. Percentage difference between the organisation's Board voting membership and its organisation's overall workforce, disaggregated:

By voting and non-voting membership of the board. **Data Sourced from ESR**

By Executive and non-exec membership of the board.**Data Sourced from ESR**

Data Limitations

Five of the WDES metrics (4 to 9a) are drawn from questions in the National NHS staff survey.
The reliability of the data drawn from those metrics is dependent upon the overall size of samples surveyed, the response rates to the survey questions, and whether the numbers of disabled staff are large enough to not undermine confidence in the data.

Some of QVH's staff groups within services are below the 11 required to generate meaningful staff survey data, therefore a larger sample is sometimes used which can lead to limitations for specific areas or departments.

For WDES, the National NHS staff survey (NHSS) Benchmark report has been used

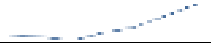
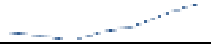
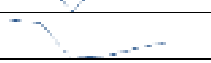
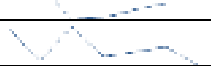
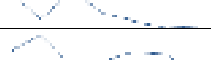
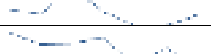
Benchmarking groups
NHS organisations vary in the services they provide and relatedly, the challenges they face. Organisations are assigned to a benchmarking group based on the services they offer. This means that comparisons are only made between organisations of a similar type and ensures comparisons are fair. In the benchmark reports organisations' results are presented in the context of their benchmarking group's best, average and worst results.

Data from ESR is provided based on those staff who had declared their disability to the Trust. Staff survey data is not on this basis and is provided anonymously by the individual carrying out the survey a disability recorded if they self identify. In 24/25 figures 7.62% of staff declared a disability, however in the staff survey 24.7% of respondents identified as disabled (166 out of 671 respondents).

Definitions

Definitions as per Technical Guidance by NHS WDES Team	
Term	Definitions
Disabled staff	Disabled staff refers to those staff who have recorded a disability in Electronic Staff Record (ESR).
Non-disabled staff	Non-Disabled staff may include staff who are disabled but have not recorded it.
Unknown	"Unknown" disability status (i.e., staff who have either indicated that they 'Prefer not to say' or have not responded to the disability monitoring question in ESR)
Clusters	The WDES standard requires organisations to 'group' staff into 'clusters.' Cluster 1: AfC Band 1, 2, 3 and 4 Cluster 2: AfC Band 5, 6 and 7 Cluster 3: AfC Band 8a and 8b Cluster 4: AfC Band 8c, 8d, 9 and VSM (including Executive Board members) Cluster 5: Medical and Dental staff, Consultants Cluster 6: Medical and Dental staff, non-consultant career grade Cluster 7: Medical and Dental staff, Medical and Dental trainee grades

Yearly comparison 2019-2024

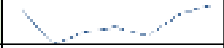
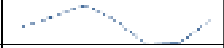
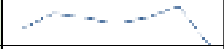
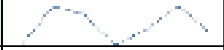
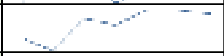
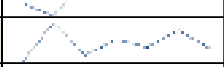
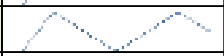
	WDES Metrics		Year							Trend	Difference between 2023 & 2024	
			2018-2019	2019-2020	2020-2021	2021-2022	2022-2023	2023-2024	2024-2025			
1	Percentage of staff in AfC (Agenda for Change) paybands or medical and dental subgroups and very senior managers (including Executive Board members) compared with the percentage of staff in the overall workforce	Overall	5.23%	5.02%	4.70%	5.36%	5.77%	6.67%	7.62%		0.95%	↑
		Non-Clinical	6.20%	6.30%	6.00%	5.90%	7.30%	8.30%	9.90%		1.60%	↑
		Clinical	5.50%	5.30%	4.90%	5.60%	5.90%	6.80%	7.50%		0.70%	↑
2	Relative likelihood of non-disabled staff compared to disabled staff being appointed from shortlisting across all posts		2.18	1.71	2.41	0.68	2.05	1.11	1.09		-2.00%	↑
3	Relative likelihood of disabled staff compared to non-disabled staff entering the formal capability process as measured by entry into the formal capability procedure		0.00	5.78	0.00	0.00	0.00	4.49	2.93		-1.56	↑ *
4a	Percentage of disabled staff compared to non-disabled staff experiencing harassment, bullying or abuse from Patient/Service users, their relatives or other members of the public	Disabled	24.7%	31.0%	18.6%	30.1%	28.5%	28.1%	24.2%		-3.86%	↑
		Non-disabled	24.9%	23.8%	16.2%	16.6%	18.3%	19.8%	19.9%		0.04%	↑
4b	Percentage of disabled staff compared to non-disabled staff experiencing harassment, bullying or abuse from managers	Disabled	19.5%	12.8%	20.0%	13.5%	14.6%	15.7%	11.6%		-4.15%	↑
		Non-disabled	10.2%	7.3%	9.9%	7.9%	7.1%	6.4%	6.6%		0.21%	↑
4c	Percentage of disabled staff compared to non-disabled staff experiencing harassment, bullying or abuse from other colleagues	Disabled	24.1%	27.2%	21.4%	22.6%	24.3%	23.7%	20.1%		-3.54%	↑
		Non-disabled	16.0%	15.4%	18.5%	15.6%	14.1%	14.1%	15.2%		1.10%	↑
4d	Percentage of disabled staff compared to non-disabled staff experiencing harassment, bullying or abuse at work and they or a colleague reported it	Disabled	57.9%	53.4%	53.7%	55.8%	46.3%	52.8%	44.4%		-8.32%	↑
		Non-disabled	59.6%	47.5%	52.1%	47.3%	59.5%	61.0%	54.1%		-6.86%	↑

***In 2 years we have had an average of 1 disabled, 4 Non-disabled and 0 unknown enter into a formal capability process. The difference in disparity is 0.010 vs 0.0036 however this is auto calculated to 2.29.**

Please note that 2023 results for WDES metric 4a (Q14a), 4b (Q14b) 4c (Q14c) and 4d (Q14d) are now reported using corrected data.

Queen Victoria Hospital
NHS Foundation Trust

Yearly comparison 2019-2024

5	Percentage of disabled staff compared to non-disabled staff believing that the organisation provides equal opportunities for career progression or promotion	Disabled	53.4%	61.3%	54.8%	57.8%	55.4%	61.1%	57.8%		-3.24%	↑
		Non-disabled	61.6%	56.1%	58.1%	58.9%	57.4%	60.7%	62.3%		1.62%	↑
6	Percentage of disabled staff compared to non-disabled staff saying that they have felt pressure from their manager to come to work, despite not feeling well enough to perform their duties	Disabled	29.3%	33.3%	38.0%	31.8%	22.0%	22.7%	31.8%		9.14%	↑
		Non-disabled	25.3%	27.8%	25.5%	17.7%	20.0%	17.5%	12.3%		-5.19%	↑
7	Percentage of disabled staff compared to non-disabled staff saying that they are satisfied with the extent to which their organisation values their work	Disabled	39.3%	43.2%	41.9%	40.7%	42.0%	45.3%	34.6%		-10.78%	↑
		Non-disabled	52.0%	57.1%	55.9%	51.8%	54.1%	57.1%	53.6%		-3.49%	↑
8	Percentage of disabled staff saying that their employer has made reasonable adjustment(s) to enable them to carry out their work	Disabled	77.4%	73.7%	82.4%	80.7%	84.8%	84.6%	83.5%		-1.09%	↑
9	NHS Staff Survey and the engagement of disabled staff For part a)compare the staff engagement scores for Disabled, non-disabled staff	Disabled	6.8	7.3	6.9	7.1	7.0	7.2	6.99		-0.21	↑
		Non-disabled	7.4	7.6	7.5	7.4	7.5	7.6	7.5		-0.10	↑
10	Percentage difference between the organisation's Board voting membership and its organisation's overall workforce, disaggregated		5%	5%	5.00%	5%	5%	3%	0%		-3.00%	↑

Executive Summary

Queen Victoria Hospital NHS Foundation Trust

Workforce & Board Representation

There has been an increase in the proportion of disabled staff, from **6.67%** in 23/24 to **7.62%** in 24/25. The highest reported under representation is in Medical and Dental roles.

Feeling Valued

There is a significant increase of **9.1%** in disabled staff who felt pressure to come to work, from **22.7%** (22 of 97 respondents) in 23/24 to **31.8%** (28 of 88 respondents) in 24/25.

This is echoed by disabled staff feeling valued by the Trust. This has significantly decreased in 24/25 by **10.7%** from **45.3%** (68 of 150) in 23/24 to **34.6%** (57 of 165).

Staff Engagement

There is a slight decrease of 0.2 points (out of 10) in the staff engagement score for disabled staff. This has declined for non-disabled staff by 0.05.

Career Progression

There is a decrease of **3.3%** in the number of disabled staff believing that the Trust provides equal opportunities for career progression or promotion, from **61.1%** (91 of 149 respondents) in 23/24 to **57.8%** (96 of 166) in 24/25.

Recruitment

There has been a further improvement in the likelihood of disabled candidates being appointed into roles from **2.05** in 22/23 to **1.11** in 23/24 and **1.09** in 24/25

As per the national WDES Summary for the 2023/2024 reporting year, the overall rank compared to 212 trusts nationally, QVH ranked **as 32% nationally*** for the likelihood of appointing from shortlisting

Reasonable Adjustments

This is a slight decrease of **1.09%** in the number of disabled staff saying that their employer has made reasonable adjustment(s) to enable them to carry out their work, from **84.6%** in 23/24 to 83.5% in 24/25.

As per the national WDES Summary for the 2023/2024 reporting year, the overall rank compared to 212 trusts nationally, QVH ranked **as 3% nationally*** for making reasonable adjustments.

Bullying and Harassment

There is a decrease of **3.9%** in bullying and harassment towards disabled staff from patients, service users, relatives and members of public, from **28.1%** (39 of 139 respondents) in 23/24 to **24.2%** (40 of 165) in 24/25. This has been steadily decreasing over the past 4 years.

Bullying and harassment towards disabled staff from managers has also decreased by **4.1%,** from **15.7%** (22 of 139 respondents) in 23/24 to **11.6%** (19 of 164) in 24/25. As per the national WDES Summary for the 2023/2024 reporting year, the overall rank compared to 212 trusts nationally, QVH ranked **as 43% nationally*** for the likelihood of Bullying and Harassment

There is a significant decrease of **3.6%** in bullying and harassment towards disabled staff from colleagues, from **23.7%** (33 of 139 respondents) in 23/24 to **20.1%** (33 of 164) in 24/25.

There has however been a decrease of **8.3%** in the number of disabled staff reporting incidents, from **52.8%** (32 of 61 respondents) in 23/24 to **44.4%** (28 of 63) in 24/25.

Board Representation

In 24/25 Board representation has decreased to **0**% from 6.7 in 23/24.

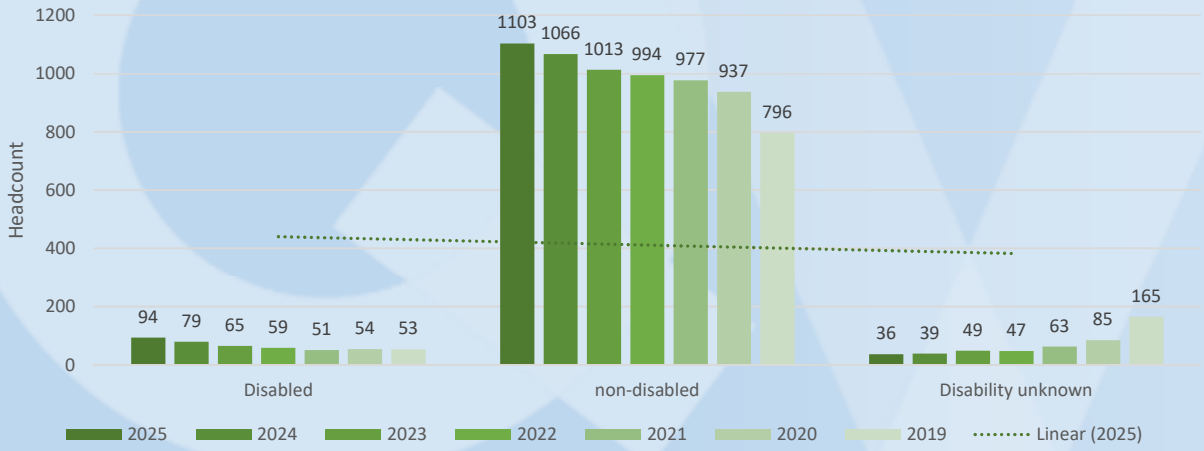
* ranks the Trust from 0% (best in the country) to 100% (worst in the country) on each indicator, based on effect size.

WDES Metric 1

Workforce Representation

Percentage of staff in AfC (Agenda for Change) paybands or medical and dental subgroups and very senior managers (including Executive Board members) compared with the percentage of staff in the overall workforce

Staff Group	2025	2024	2023	2022	2021	2020	2019
Disabled	94	79	65	59	51	54	53
non-disabled	1103	1066	1013	994	977	937	796
Disability unknown	36	39	49	47	63	85	165
Total headcount	1233	1184	1127	1100	1091	1076	1014
Percentages							
Disabled	7.62%	6.67%	5.80%	5.40%	4.70%	5.00%	5.20%
non-disabled	89.46%	90.03%	89.90%	90.40%	89.60%	87.10%	78.50%
Disability unknown	2.92%	3.29%	4.30%	4.30%	5.80%	7.90%	16.30%



QVH has 94 individuals with a recorded disability amongst its workforce (7.62%) which is an increased from 79 (6.67%) in 2024. The national average for reporting is 4.9%*

Since 2019 the Trust has undertaken a number data cleanse activities, alongside communication to staff to ensure disclosure is encouraged. Staff can undertake this via ESR self service or with support from their line manager or Trust Workforce team

* national average for 2023

WDES Metric 1

Workforce Representation

	Pay banding	Disabled	non-disabled	Unknown	Total	Disabled %	non-disabled %
Non-Clinical	Cluster 1 (Bands 1-4)	28	253	6	287	9.8%	88.2%
	Cluster 2 (Bands 5-7)	10	88	1	99	10.1%	88.9%
	Cluster 3 (Bands 8a-8b)	2	25	0	27	7.4%	92.6%
	Cluster 4 (Bands 8c-9 & VSM)	3	18	1	22	13.6%	81.8%
	All non-clinical roles	**43**	**384**	**8**	**435**	**9.9%**	**88.3%**
Clinical	Cluster 1 (Bands 1-4)	13	159	0	172	7.6%	92.4%
	Cluster 2 (Bands 5-7)	32	336	10	378	8.5%	88.9%
	Cluster 3 (Bands 8a-8b)	0	39	2	41	0.0%	95.1%
	Cluster 4 (Bands 8c-9 & VSM)	0	9	1	10	0.0%	90.0%
	Total clinical	**45**	**543**	**13**	**601**	**7.5%**	**90.3%**
Medical and Dental	Cluster 5 (M&D: Consultants)	2	100	6	108	1.9%	92.6%
	Cluster 6 (M&D: Non-Consultant career grades)	0	26	2	28	0.0%	92.9%
	Cluster 7 (M&D: trainee grades)	4	50	7	61	6.6%	82.0%
	Total Medical and Dental	**6**	**176**	**15**	**197**	**3.0%**	**89.3%**

The overall headcount for QVH is 1233 which includes:

- 94 disabled staff
- 1103 non-disabled staff
- 36 who have not provided monitoring information to the Trust

Non-Clinical staff in Cluster 1 (Bands 1-4) have the highest headcount of workforce with a recorded disability (28)

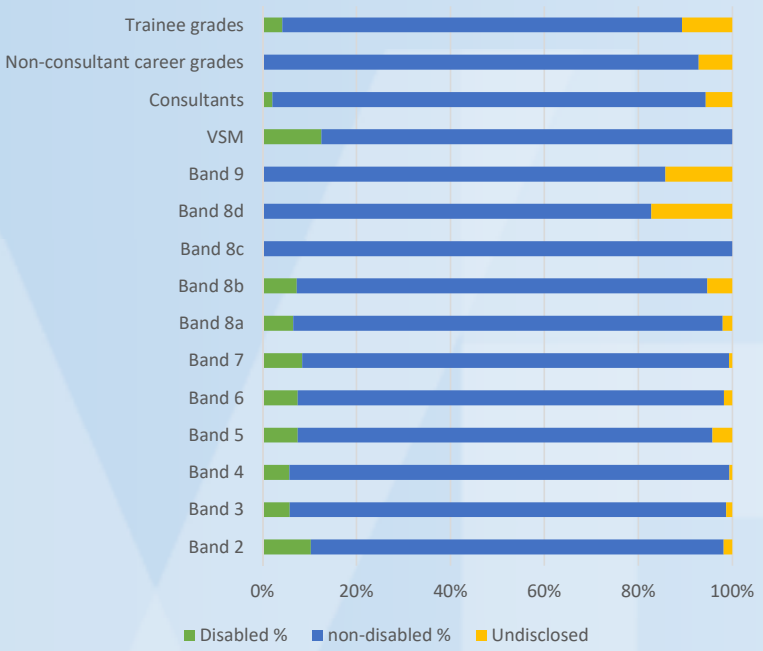
Clinical staff in Cluster 2 (Band 5-7) have the highest headcount of workforce who have recorded a disability (32)

Clinical Cluster 3 and 4 (Band 8a-VSM) and Cluster 6 (M&D Non-Consultant career grades) have no staff with a recorded disability

WDES Metric 1

Workforce Representation

Pay banding	Disabled	non-disabled	Unknown	Total	Disabled %	non-disabled %
Band 2	14	146	3	163	8.59%	89.57%
Band 3	16	129	2	147	10.88%	87.76%
Band 4	11	137	1	149	7.38%	91.95%
Band 5	13	146	7	166	7.83%	87.95%
Band 6	15	152	3	170	8.82%	89.41%
Band 7	14	126	1	141	9.93%	89.36%
Band 8a	2	46	1	49	4.08%	93.88%
Band 8b	0	18	1	19	0.00%	94.74%
Band 8c	0	15	0	15	0.00%	100.00%
Band 8d	1	4	1	6	16.67%	66.67%
Band 9	2	3	1	6	33.33%	50.00%
VSM	0	5	0	5	0.00%	100.00%
Consultant	2	100	6	108	1.85%	92.59%
Non-consultant career grades	0	26	2	28	0.00%	92.86%
Trainee grades	4	50	7	61	6.56%	81.97%



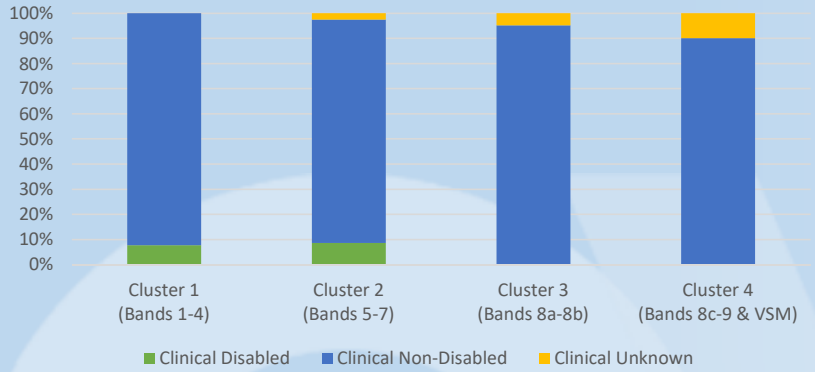
Data shows that we have no disabled staff in senior banded positions 8b, 8c VSM and non-consultant career grades. The highest declaration of disability is amongst Band 9 although this only affects 5 staff for context

WDES Metric 1

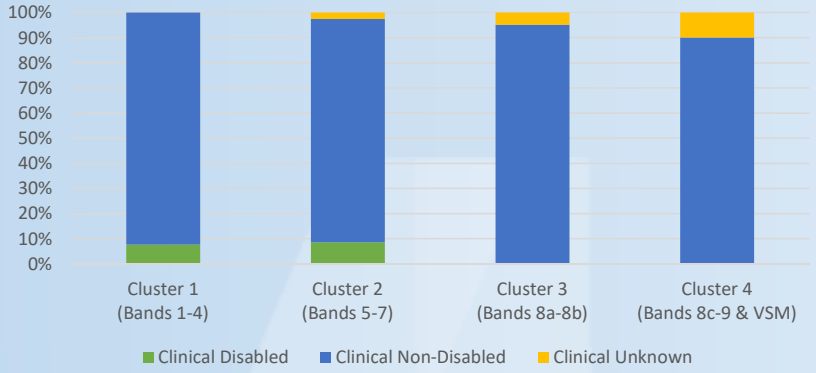
Workforce Representation

Queen Victoria Hospital NHS Foundation Trust

Non-Clinical



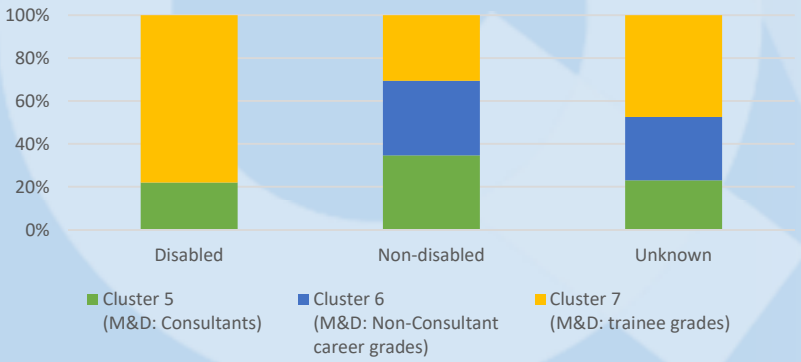
Clinical



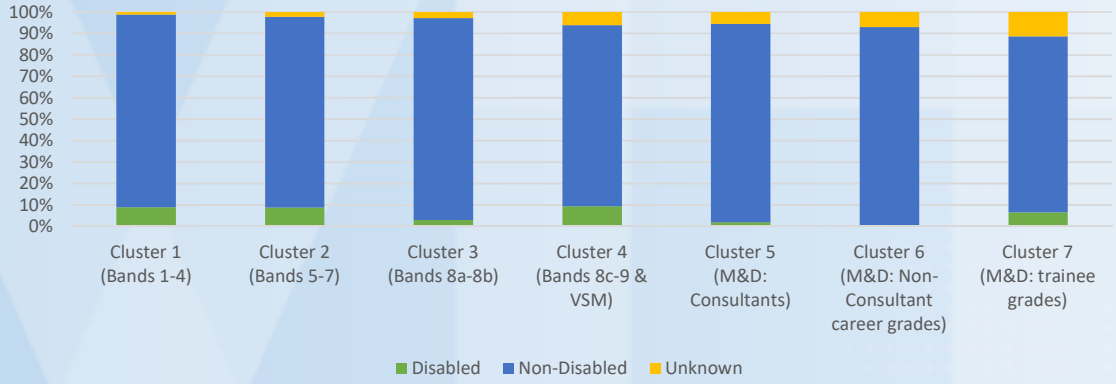
This metric demonstrates the proportion of declaration reduces as pay banding increases.

The data also demonstrates that declaration rates amongst our workforce in Clusters 3 and 4 (Band 8a to VSM)

Medical and Dental



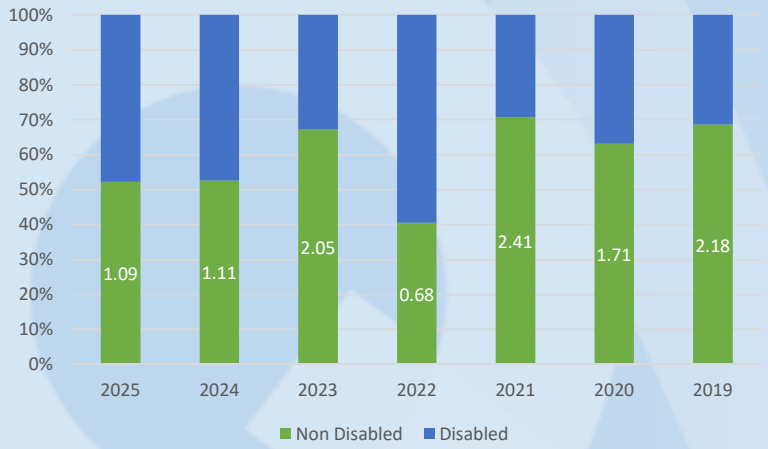
Overall Workforce



WDES Metric 2

Recruitment

	2025	2024	2023	2022	2021	2020	2019
Non Disabled	1.09	1.11	2.05	0.68	2.41	1.71	2.18



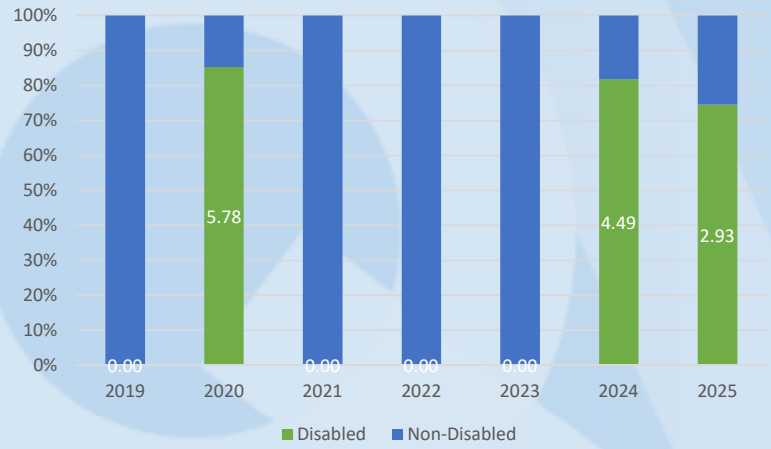
This metric shows non-disabled candidates are 1.09 times more likely to be appointed from shortlisting to Disabled candidates

This demonstrates a significant progress from 2023 where candidates were more than 2 times likely to be appointed.

WDES Metric 3

Capability

	Year to March						
	2019	2020	2021	2022	2023	2024	2025
Relative likelihood of disabled staff compared to non-disabled staff entering the formal capability process as measured by entry into the formal capability procedure	0.00	5.78	0.00	0.00	0.00	4.49	2.93



Data shows that disabled staff are 2.23 times more likely to enter into a formal capability process. It is important to stress that QVH has incredibly low numbers which provides a distorted picture.

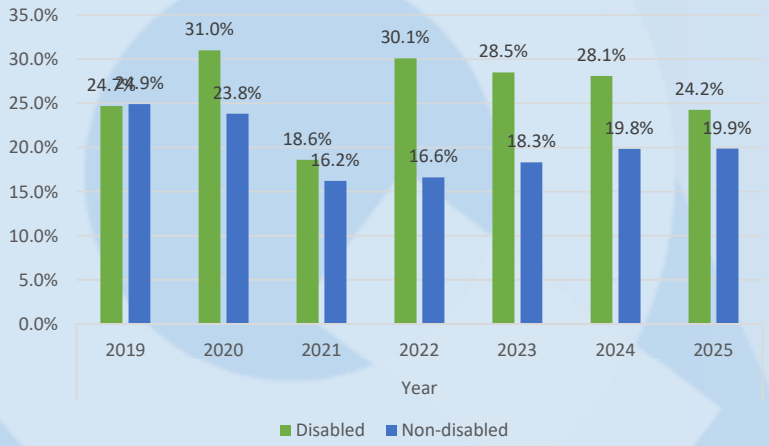
In the last 2 years we have had an average of 1 disabled, 4 Non-disabled and 0 unknown (5 cases in total) enter into a formal capability process. The difference in disparity is 0.010 vs 0.0036 however this is auto calculated to 2.29.

WDES Metric 4a

Harassment, bullying or abuse

Percentage of disabled staff compared to non-disabled staff experiencing harassment, bullying or abuse from Patient/Service users, their relatives or other members of the public

	Year						
	2019	2020	2021	2022	2023	2024	2025
Disabled	24.7%	31.0%	18.6%	30.1%	28.5%	28.1%	24.2%
Non-disabled	24.9%	23.8%	16.2%	16.6%	18.3%	19.8%	19.9%



There is a decrease of **3.9%** in bullying and harassment towards disabled staff from patients, service users, relatives and members of public, from **28.1%** (39/139 respondents) in 23/24 to **24.2%** (40/165 respondents) in 24/25.

A higher proportion of disabled staff experience bullying, harassment and abuse from the public than non-disabled staff.

These results are below the national average.

Please note that 2023 results for WDES metric 4a (Q14a), 4b (Q14b) 4c (Q14c) and 4d (Q14d) are now reported using corrected data.

NHS Staff Survey Benchmark report 2024

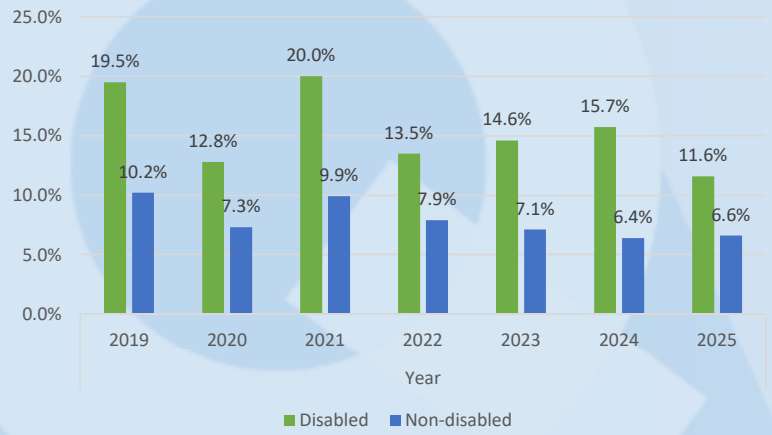
National Average
Disabled: 29.59%
Non-Disabled: 22.28%

WDES Metric 4b

Harassment, bullying or abuse

Percentage of disabled staff compared to non-disabled staff experiencing harassment, bullying or abuse from managers

	Year						
	2019	2020	2021	2022	2023	2024	2025
Disabled	19.5%	12.8%	20.0%	13.5%	14.6%	15.7%	11.6%
Non-disabled	10.2%	7.3%	9.9%	7.9%	7.1%	6.4%	6.6%



There has been decrease of **4.1%** in the number of disabled staff experiencing bullying, harassment or abuse from managers, from **15.7%** (22/139 respondents) in 23/24 to **11.6%** (19/164 respondents) in 24/25.

A higher proportion of disabled staff experience bullying, harassment or abuse than non-disabled staff.

QVH are below the national benchmark.

Please note that 2023 results for WDES metric 4a (Q14a), 4b (Q14b) 4c (Q14c) and 4d (Q14d) are now reported using corrected data.

NHS Staff Survey Benchmark report 2024

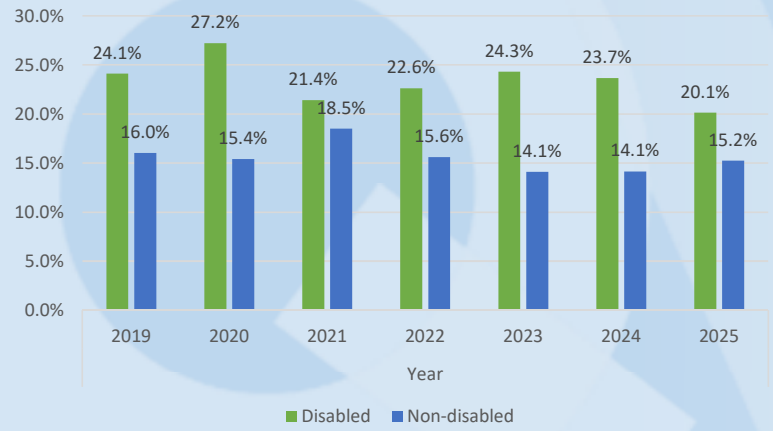
National Average
Disabled: 14.6%
Non-Disabled: 7.75%

WDES Metric 4c

Harassment, bullying or abuse

Percentage of disabled staff compared to non-disabled staff experiencing harassment, bullying or abuse from other colleagues

	Year						
	2019	2020	2021	2022	2023	2024	2025
Disabled	24.1%	27.2%	21.4%	22.6%	24.3%	23.7%	20.1%
Non-disabled	16.0%	15.4%	18.5%	15.6%	14.1%	14.1%	15.2%



There has been a decrease of **3.6%** in the number of disabled staff that have experienced harassment, bullying or abuse from colleagues, from **23.7%** (33/139 respondents) in 23/24 to **20.1%** in 24/25 (33/164 respondents).

A higher proportion of disabled staff experience bullying, harassment or abuse than non-disabled staff.

QVH are below the national benchmark.

Please note that 2023 results for WDES metric 4a (Q14a), 4b (Q14b) 4c (Q14c) and 4d (Q14d) are now reported using corrected data.

NHS Staff Survey Benchmark report 2024

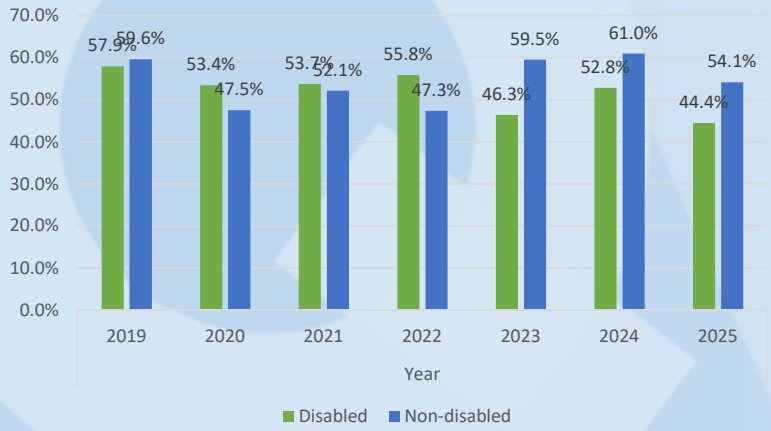
National Average
Disabled: 23.60%
Non-Disabled: 15.27%

WDES Metric 4d

Harassment, bullying or abuse

Percentage of disabled staff compared to non-disabled staff experiencing harassment, bullying or abuse at work and they or a colleague reported it

	Year						
	2019	2020	2021	2022	2023	2024	2025
Disabled	57.9%	53.4%	53.7%	55.8%	46.3%	52.8%	44.4%
Non-disabled	59.6%	47.5%	52.1%	47.3%	59.5%	61.0%	54.1%



There has been a decrease of **8.3%** in the number of disabled staff that have experienced harassment, bullying or abuse from colleagues and have reported it – from **52.8%** (32/61 respondents) in 23/24 to **44.4%** in 24/25 (28/63 respondents).

A lower proportion of disabled staff have reported these behaviours compared to non-disabled staff, which has also decreased.

QVH are below the national benchmark for disabled staff but slightly above for non-disabled staff.

Please note that 2023 results for WDES metric 4a (Q14a), 4b (Q14b) 4c (Q14c) and 4d (Q14d) are now reported using corrected data.

NHS Staff Survey Benchmark report 2024

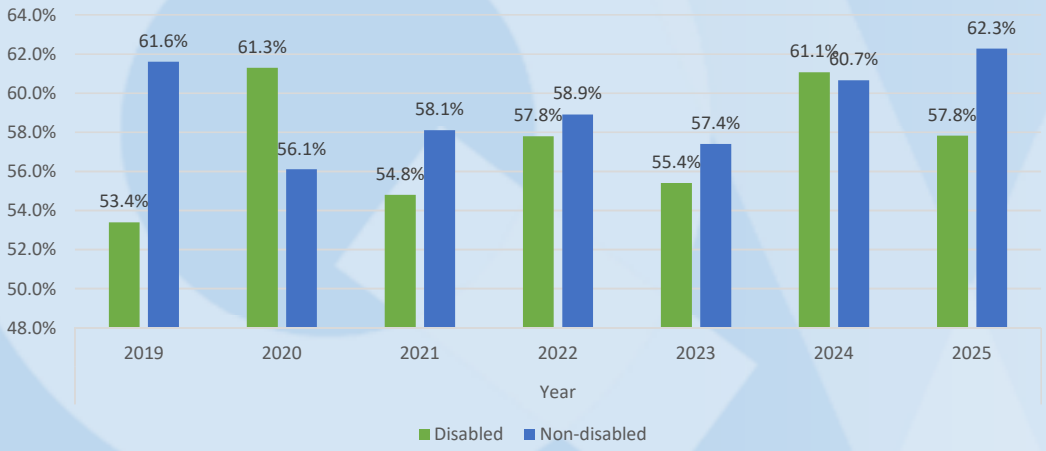
National Average
Disabled: 54.42%
Non-Disabled: 53.76%

WDES Metric 5

Career Progression

Percentage of disabled staff compared to non-disabled staff believing that the organisation provides equal opportunities for career progression or promotion

Year						
2019	2020	2021	2022	2023	2024	2025
53.4%	61.3%	54.8%	57.8%	55.4%	61.1%	57.8%
61.6%	56.1%	58.1%	58.9%	57.4%	60.7%	62.3%



57.8% of disabled staff believe the Trust provides equal opportunities compared to **62.3%** of non-disabled staff.

There is a decrease of **3.3%** in the number of disabled staff believing that the trust provides equal opportunities for career progression or promotion, from **61.1%** (91/149 respondents) in 23/24 to **57.8%** (96/166 respondents) in 24/25.

QVH are above the national average for disabled staff.

NHS Staff Survey Benchmark report 2024

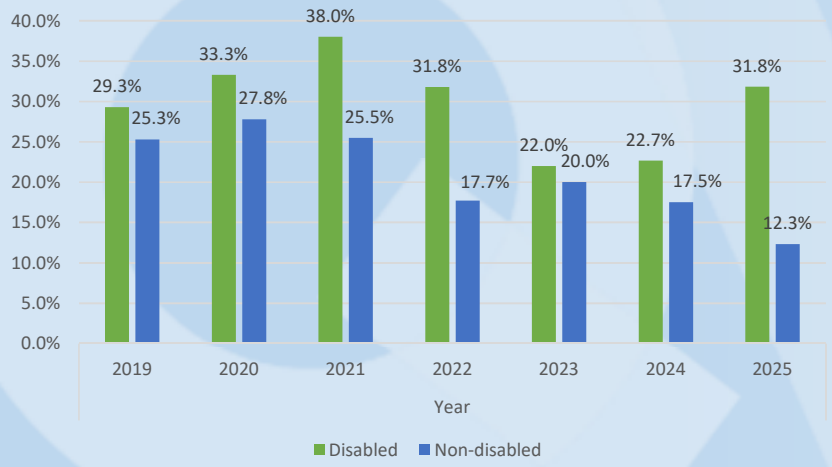
National Average
Disabled: 51.52%
Non-Disabled: 57.67%

WDES Metric 6

Presenteeism

Percentage of disabled staff compared to non-disabled staff saying that they have felt pressure from their manager to come to work, despite not feeling well enough to perform their duties

	Year						
	2019	2020	2021	2022	2023	2024	2025
Disabled	29.3%	33.3%	38.0%	31.8%	22.0%	22.7%	31.8%
Non-disabled	25.3%	27.8%	25.5%	17.7%	20.0%	17.5%	12.3%



There is a significant increase of **9.1%** in disabled staff who felt pressure to come to work, from **22.7%** (22/97 respondents) in 23/24 to **31.8%** (28/88 respondents) in 24/25.

31.8% (1 in 3) of QVH disabled staff have felt pressure from their manager to come to work when not feeling well enough to perform their duties.

This has increased since 2024, and has returned to levels seen in 2022.

QVH is 6.4% above the national average for disabled staff

NHS Staff Survey Benchmark report 2024

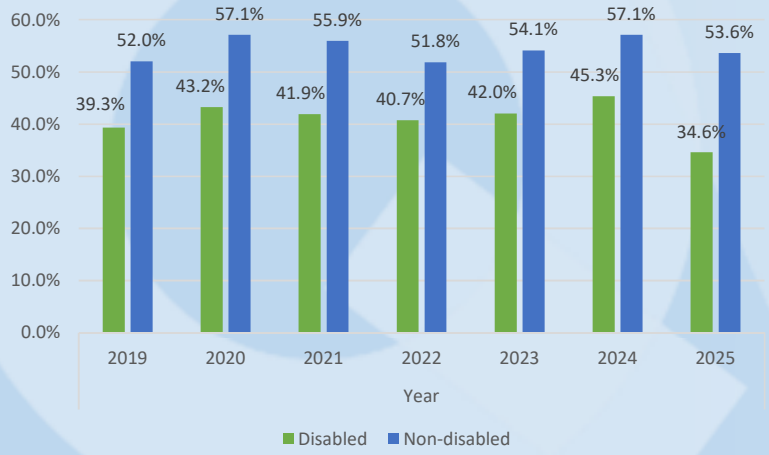
National Average
Disabled: 25.40%
Non-Disabled: 17.74%

WDES Metric 7

Feeling Valued

Percentage of disabled staff compared to non-disabled staff saying that they are satisfied with the extent to which their organisation values their work

	Year						
	2019	2020	2021	2022	2023	2024	2025
Disabled	39.3%	43.2%	41.9%	40.7%	42.0%	45.3%	34.6%
Non-disabled	52.0%	57.1%	55.9%	51.8%	54.1%	57.1%	53.6%



34.6% of disabled staff feel the Trust values their work compared to **53.6%** of non-disabled staff – this represents a decrease of **10.7%,** from **45.3%** (68/150 respondents) in 23/24 to **34.6%** (57/165 respondents).

This was improving year on year since 2019 but is now at the lowest level since records began being taken for disabled staff. For non disabled staff this has remained fairly consistent since 2019.

QVH is below the national average for disabled staff.

NHS Staff Survey Benchmark report 2024

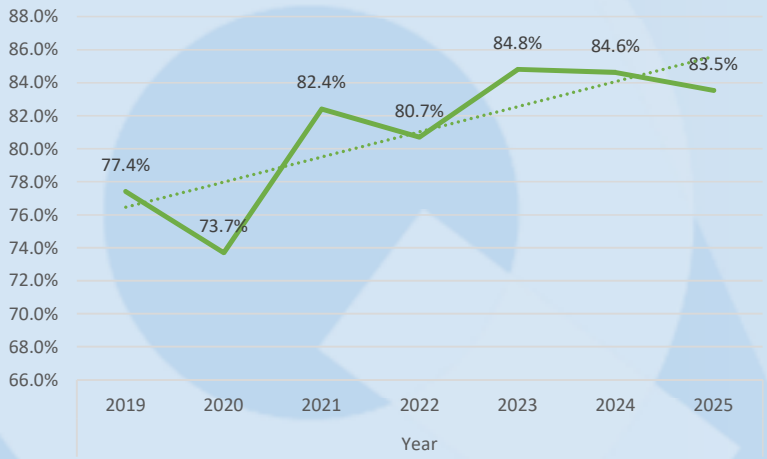
National Average
Disabled: 36.32%
Non-Disabled: 47.41%

WDES Metric 8

Workplace Adjustments

Percentage of disabled staff saying that their employer has made reasonable adjustment(s) to enable them to carry out their work

Year						
2019	2020	2021	2022	2023	2024	2025
77.4%	73.7%	82.4%	80.7%	84.8%	84.6%	83.5%



83.5 % of disabled staff say that the Trust has made reasonable adjustments, which is significantly above the national average.

This has reduced very slightly since 2024, however has remained consistently over the current national average since 2019

NHS Staff Survey Benchmark report 2024

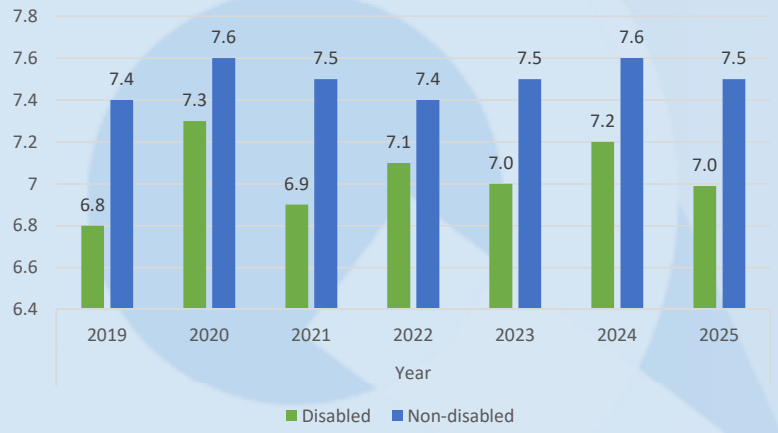
National Average
75.12%

WDES Metric 9

Staff Engagement

NHS Staff Survey and the engagement of disabled staff For part a) compare the staff engagement scores for Disabled, non-disabled staff

	Year						
	2019	2020	2021	2022	2023	2024	2025
Disabled	6.8	7.3	6.9	7.1	7.0	7.2	7.0
Non-disabled	7.4	7.6	7.5	7.4	7.5	7.6	7.5



The staff engagement score for non-disabled staff (7.5) is higher than disabled staff (7.0).

There is a slight decrease of 0.2 points (out of 10) in the staff engagement score for disabled staff and a 0.05 decline for non-disabled staff.

QVH is above the national average for both disabled and non-disabled staff.

NHS Staff Survey Benchmark report 2024

National Average
Disabled: 6.44
Non-Disabled: 6.99

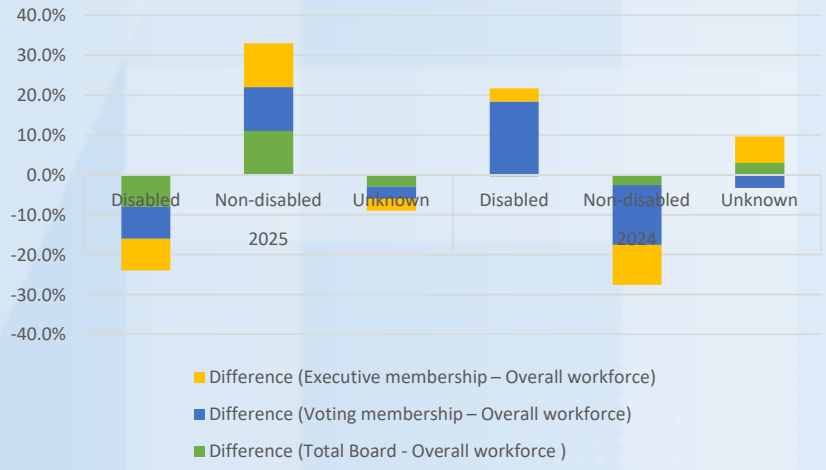
WDES Metric 10

Board Representation

Percentage difference between the organisation's Board voting membership and its organisation's overall workforce, disaggregated

	2025				2024				2023				2022			
	Disabled	Non-disabled	Unknown	Total	Disabled	Non-disabled	Unknown	Total	Disabled	Non-disabled	Unknown	Total	Disabled	Non-disabled	Unknown	Total
Total Board members	0	15	0	15	1	14	1	16	2	10	1	13	1	11	0	12
of which voting	0	4	0	5	1	3	0	4	1	2	1	4	1	3	0	4
of which non-voting	0	11	0	11	0	11	1	12	1	8	0	9	0	8	0	8
Total Board members	0	15	0	15	1	14	1	16	1	9	2	13	1	11	0	12
of which Executive	0	6	0	6	1	8	1	10	1	6	1	8	0	7	0	7
of which Non-Executive	0	9	0	9	0	6	0	6	1	4	0	5	1	4	0	5

	2025				2024			
	Disabled	Non-disabled	Unknown	Total	Disabled	Non-disabled	Unknown	Total
Number of staff in overall workforce	94	1103	36	1233	79	1066	39	1184
Total Board members - % by Disability	0.0%	100.0%	0.0%		6.3%	87.5%	6.3%	
Voting Board Member - % by Disability	0.0%	100.0%	0.0%		25.0%	75.0%	0.0%	
Non-Voting Board Member - % by Disability	0.0%	100.0%	0.0%		0.0%	91.7%	8.3%	
Executive Board Member - % by Disability	0.0%	100.0%	0.0%		10.0%	80.0%	10.0%	
Non-Executive Board Member - % by Disability	0.0%	100.0%	0.0%		0.0%	100.0%	0.0%	
Overall workforce - % by Disability	7.6%	89.5%	2.9%		6.7%	90.0%	3.3%	
Difference (Total Board - Overall workforce)	-8.0%	11.0%	-3.0%		-0.4%	-2.5%	3.0%	
Difference (Voting membership – Overall workforce)	-8.0%	11.0%	-3.0%		18.3%	-15.0%	-3.3%	
Difference (Executive membership – Overall workforce)	-8.0%	11.0%	-3.0%		3.3%	-10.0%	6.7%	



0% of Trust board membership has a declaration of a disability, which is not broadly reflective of the overall workforce of 7.6%. This is a significant reduction from last year as the Trust board has grown as from both in 2023 and 2024 and there has been a reduction in members who have declared a disability.

The national average is 5.7%

Additional Insights

- The percentage of leavers with a declared disability (6.50%) is lower than the overall Trust representation (7.62%)

- Disabled staff are most likely to cite the following as the reason for their resignation (33% of total voluntary resignations respectively):
  - Health
  - Promotion
  - Work-life balance

  This suggests that while the Trust has taken positive steps to improve attraction and recruitment of disabled candidates, there is work to be done to improve access to career development.

  This may also be linked to our 2024 Staff Survey results, which show a slight reduction in the availability of reasonable adjustments compared to 2023-24.

Key Areas of Progress and Actions for next 12 Months

Culture Change	1. **Refreshed Vision and Values & Behavioral Framework -** These were launched in late 2024, with a behaviour framework to support an inclusive learning culture, increasing psychological safety of staff and supporting the embedding of an enhanced speak up process for staff. 2. **Workforce Belonging & Value** – The Trust has in place a comprehensive action plan aligned with NHS England's EDI Improvement Plan to to create an environment that eliminates the conditions in which bullying, discrimination, harassment and physical violence at work occur. The Trust commissioned an external company (Absolute Diversity) to conduct a listening exercise with our disabled staff to understand areas of progress for inclusion and are working through the specific actions identified to support our staff needs. 3. **Inclusive Behaviours** – The Exec team will be undertaking Diversity MOTs with Absolute Diversity to better understand unconscious biases. The Trust has also developed a Cultural Transformation Steering Group, with the aim to embed inclusion into business-as-usual practices. This group is attended by the Trust's CEO and CMO. 4. **Freedom to Speak Up** – The Trust's speak up provision has been enhanced and supported by an external provider to provide 24/7 support to staff. This service is available to all staff, and compliments the Trusts embedded mechanisms for raising concerns. The Freedom to Speak Up Guardian for QVH meets with the Employee Relations team to triangulate case work and feedback. 5. **Cultural Listening Exercises** – The Wellbeing & Inclusion team have supported cultural listening exercises across several teams to understand and tackle behaviours than contribute to a less inclusive environment for our disabled staff.
Recruitment Career Development	1. **Inclusive Recruitment Process & Practice –** There has been an improvement in the likelihood of disabled candidates being appointed to positions in the Trust. However, our disabled colleagues have reported feeling that opportunities for career development and/or promotion are not equal, suggesting that improvements can be made in this area, particularly as representation at Bands 8a and above is low. 2. **Appraisal Process Revised with a focus on Wellbeing and career development-** As part of the revised process, we ask for feedback and monitor effectiveness of appraisal alongside our National Staff Survey results. Any areas of concern are raised at an appropriate level to address concerns. 3. **Career development through Apprenticeships –** Apprenticeships are key to support career development across all staffing areas. There was a significant increase of apprentices declaring a disability from 5.6% in 23/24 to 9.25% in 24/25. However, ongoing work is needed to ensure diversity of staff accessing apprentice opportunities is maintained and the use of the levy continues to increase. Work experience opportunities have been offered to a more diverse range of students due to the introduction of work experience events to complement traditional work experience placements.
Staff Engagement	1. **Staff Engagement** – Scores for our staff with disabilities have steadily increased since 2023-24, suggesting that good work has been achieved in this area. This is likely underpinned by activities to support these colleagues, such as holding a group session for disabled colleagues to come together, launching EDI Champions and re-introducing monthly Team Brief (now Team Talk) sessions to drive organisational engagement. 2. **Reasonable Adjustments –** Throughout 2024-25, the Wellbeing & Inclusion team supported 4 applications to the government's Access to Work scheme and published a flowchart to clarify the process for prospective applicants and their line managers. The Flexible Working & Reasonable Adjustments Policy was updated to detail how this can support inclusion. Rejected requests for flexible working are reviewed by the EDRA team to ensure that impacts to equality at QVH are minimised. 3. **Wellbeing & Inclusion Resources** – The Wellbeing & Inclusion team have introduced a monthly bulletin and all-staff email to promote inclusive activities and initiatives. The team have also launched monthly drop-in sessions to allow staff at all levels to ask questions and build knowledge in a confidential space.

Key Areas of Progress and Actions for next 12 Months

Bullying and Harassment	1. **Violence, Aggression & Abuse -** The Trust's Violence Prevention and Reduction group has increased compliance against the national standards to 91% in 24/25. The Trust has published its VPR policy which details how to manage inappropriate telephone calls and the procedure for withholding treatment from violent and abusive patients. The Trust's Domestic Abuse for staff policy has been re-written with safeguarding oversight. The key milestones of this work in 25/26 is to ensure compliance with the revised 2025 VPR standards where the Trust are currently 75% compliant 2. **NHS England High Impact Actions -** The Trust has in place a comprehensive action plan aligned with NHS England's EDI Improvement Plan, to address High Impact Action 6, which is to 'Create an environment that eliminates the conditions in which bullying, discrimination, harassment and physical violence at work occur. The Trust commissioned an external company (Absolute Diversity) to conduct a listening exercise with our disabled staff to understand areas of progress for inclusion and are working through the specific actions identified to support our staff needs.
Board Sponsorship	1. **Board Accountability -** The Trust has agreed each Board member will act as a sponsor for one of the Staff Networks once established. This will result in dedicated and targeted leadership support, provide accountability and governance from senior leaders, reinforce the commitment to improving lived experiences and develop an inclusive leadership culture. Most importantly, it will enable Board members to hear the voices of disabled staff. 2. **People Committee –** The Trust has established the Workforce Sub-Committee in 2024-25 to highlight areas of challenge to the Trust Board relating to those with a disability or long-term health condition.

Actions for next 12 months

Action	By When	Lead
A module on EDI and inclusive management (including reasonable adjustments) will be added to the mandatory line manager's training offer in 2025-26.	Q3 2025-26	Wellbeing & Inclusion Manager
Reduce felt pressure to attend work when unwell by encouraging, promoting and role-modelling healthy work-life balance options, such as flexible working hours and patterns, hybrid working and disconnecting after work.	Q2 2025-26	Employee Relations Team
Produce a checklist and guidance document for managers to use when staff call in to report a sickness absence, detailing how to manage sickness absence compassionately and sensitively to reduce presenteeism among our disabled colleagues.	Q2 2025-26	Wellbeing & Inclusion Manager
Triangulate Employee Relations case work, Freedom to Speak Up reports, Occupational Health data, Staff Survey and Pulse Survey results and Wellbeing & Inclusion insights to capture and act on themes highlighted by our colleagues with disabilities or long-term health conditions on a quarterly basis.	Q3 2025-26	Wellbeing & Inclusion Manager
Apply an EDI lens through lived experience to an end-to-end review of our current internal and external recruitment processes, with an EDI representative available for interview panels to support the de-biasing of the recruitment process.	Q3 2025-26	DCPO
Conduct an EDI audit of all applications for career development, including apprenticeships and external learning, to establish how our disabled colleagues can be better supported to develop their careers and tackle any potential barriers.	Q4 2025-26	DCPO
Demonstrate recognition and value of our disabled colleagues through inclusion events and resources that challenge assumptions and stereotypes, reinforcing the strengths and capabilities our diverse workforce bring to QVH.	Q4 2025-26	Wellbeing & Inclusion Manager

Report cover-page					
References					
Meeting title:	Board of Directors				
Meeting date:	11 September 2025	**Agenda reference:**	**68-25**		
Report title:	Gender Pay Gap Report 2025				
Sponsor:	Helen Edmunds, Chief People Officer				
Author:	Helen Edmunds, Chief People Officer Lawrence Anderson, Deputy Chief People Officer				
Appendices:	Gender Pay Gap report 2025				
Executive summary					
Purpose of report:	To provide the position of the QVH Gender Pay Gap for as of 31 March 2025, the reasons behind our gender pay gap and actions on how QVH are planning to continue to work to seek to reduce the Gender Pay Gap.				
Summary of key issues	• Our gender pay gap continues to be driven by a greater number of men in more senior admin roles among our Agenda for Change (AfC) workforce and Board, alongside senior male clinicians earning top of grade and bonus payments relative to our total workforce. • Staff in Admin & Clerical have seen the pay gap grow from 2024 by 5.64% to 32.71% • The overall Trust gender pay gap has grown for 2025. Our trust gap is now 36.7% (Mean) and 35.1% (Median). • The AfC gender pay gap is 13.5% (Mean) and 14.6% (Median). The Medical and Dental gender pay gap is 10.7% (Mean) and 9.8% (Median)				
Recommendation:	To note the content of the report and approve the report for publication on the Trust's website.				
Action required	**Approval**	Information	Discussion	**Assurance**	Review
Link to key strategic objectives (KSOs):	KSO1: *To deliver outstanding care*	KSO2: *To innovate and improve*	KSO3: ***To be an excellent employer***	KSO4: *To deliver sustainable services*	KSO5: *To collaborate with others*
Implications					
Board assurance framework:	None				
Corporate risk register:	None				
Regulation:	None				
Legal:	None				
Resources:	None				
Assurance route					
Previously considered by:	Finance and Performance Committee				
	Date:	30 June 2025	Decision:	To be presented to the Board of Directors	
Next steps:	Presentation at Board in September 2025 prior to publication of the report on Trust website.				

Report to:	Board of Directors
Agenda item:	Gender Pay Gap Report 2024
Date of meeting:	11 September 2025
Report from:	Helen Edmunds, Chief People Officer
Report author:	Helen Edmunds, Chief People Officer Lawrence Anderson, Deputy Chief People Officer
Date of report:	4 June 2025
Appendices:	Gender Pay Gap report 2025

Gender Pay Gap Report 2025

Executive Summary

Our overall workforce is predominantly female (74.66%) and has remained relatively constant over the past several years. The majority of Medical and Dental (M&D) staff fall within the 4th pay quartile (this is the highest of the four quartiles), the majority of which are male.

Our gender pay gap continues to be driven in part by a greater number of men in more senior admin roles among our Agenda for Change (AfC) workforce and senior male clinicians earning top of grade and bonus payments relative to our total workforce.

Staff in Admin & Clerical have seen the pay gap grow from 2024 by 5.64% to 32.71%

The overall Trust gender pay gap has grown for 2025. Our trust gap is now 36.7% (Mean) and 35.1% (Median).

The AfC gender pay gap is 13.5% (Mean) and 14.6% (Median). The M&D gender pay gap is 10.7% (Mean) and 9.8% (Median)

1. Introduction

Organisations with 250 or more employees are mandated under the Equality Act 2010 (Gender Pay Gap Information) Regulations 2017 to publish information annually on their gender pay gap using specific measures, as detailed in this report.

The gender pay gap is the difference between average hourly earnings (excluding overtime) of men and women as a proportion of men's average hourly earnings (excluding overtime). **The gender pay gap is a measure across all jobs in the hospital, not of the difference in pay between men and women for doing the same job.**

The intention of pay gap reporting is to focus attention on the evidence for taking action to reduce pay inequality, improve staff experience, retention and make Queen Victoria NHS Foundation Trust (QVH) a great place to work.

The gender pay gap report is a snapshot as at 31 March 2025.

As at 31 March 2025, QVH employed 1235 people in full time and part time positions compared to 2024, where there were 1,221 staff. For the purposes of this report, electronic staff record (ESR) data has been used to undertake this analysis, and therefore it is dependent on staff reporting their gender via ESR self-service. There were no gaps in the reporting of gender this year.

2. Data Used to Calculate Gender Pay Gap Figures

There are six key indicators against which an employer must publish its calculations

- **Mean gender pay gap** – The difference between the mean hourly rate of pay of male full-pay relevant employees and that of female full-pay relevant employees.

- **Median gender pay gap** – The difference between median hourly rate of pay of male full-pay relevant employees and that of female full-pay relevant employees.
- **Mean bonus gender pay gap** – The difference between the mean bonus pay paid to male relevant employees and that paid to female relevant employees.
- **Median bonus gender pay gap** – The difference between the median bonus pay paid to male relevant employees and that paid to female relevant employees.
- **Bonus proportions** – The proportion of males and females receiving a bonus payment.
- **Quartile pay bands** – The proportion of males and females in each of the four pay quartiles

3. Definitions

- Full-pay relevant employee - the employee must be paid their full usual pay during the pay period in which the snapshot date falls. If the employee is paid less than their usual rate because of leave for that period, they should not be counted as a full-pay relevant employee.

- If an employee is on any kind of leave and not being paid their full usual amount in the pay period, they are not full-pay relevant employees. For example, if they are paid Statutory Sick Pay or Statutory Maternity Pay which is less than their usual pay.

- "Pay" includes;
    - basic pay
    - full paid leave including annual, sick, maternity, paternity, adoption or parental leave,
    - bonus pay received in the pay period in which the snapshot date falls (bonus pay should be pro-rated where it relates to a period longer than the pay period)
    - area, on-call and other allowances such as recruitment and retention allowances shift premium pay
    - pay for piecework.

  It does not include;
    - overtime pay
    - expenses (payments made to reimburse expenditure wholly and necessarily incurred in the course of employment, for example, mileage for use of vehicle)
    - remuneration in lieu of leave
    - benefits in kind (for example, child care vouchers)
    - redundancy pay and tax credits.

4. Methodology

The data used in this report has been generated using the Electronic Staff Record (ESR) Business Intelligence report designed specifically for gender pay gap reporting

5. Data Analysis- Gender

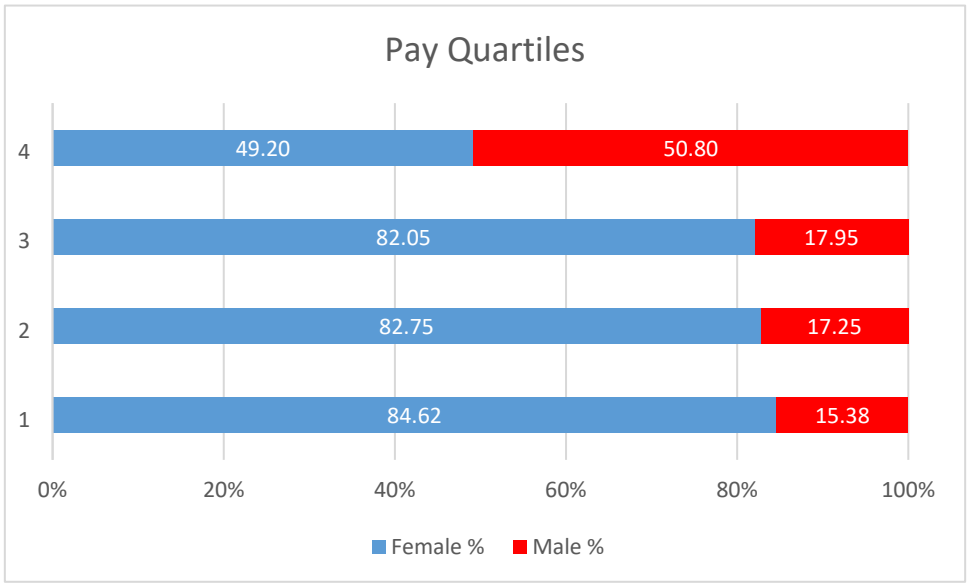
5.1 Gender Profiles

Our workforce is predominantly female (74.66%) and has remained relatively constant over the past several years.

Gender Distribution Pay Quartiles

The data below demonstrate the proportion of female to male staff members separately across all quartiles by Gender, Band and Staff Group

Quartile	Female	Male	Female %	Male %
1	264.00	48.00	84.62	15.38
2	259.00	54.00	82.75	17.25
3	256.00	56.00	82.05	17.95
4	154.00	159.00	49.20	50.80



The majority of female staff at QVH are located in quartiles 1, 2 and 3. Representation in the highest quartile becomes more evenly distributed between male and female staff.

Pay Quartile	1		2		3		4	
AfC Pay Grade	**Female**	**Male**	**Female**	**Male**	**Female**	**Male**	**Female**	**Male**
Band 1		2						
Band 2	109	28	31	21	3	1		
Band 3	124	23	22	3				
Band 4	65	5	83	12				
Band 5			125	18	41	6		
Band 6	1		32	7	121	18	25	6
Band 7			2		102	26	16	9
Band 8 - Range A					21	5	14	11
Band 8 - Range B					1		16	3
Band 8 - Range C							8	6
Band 8 - Range D							3	4
Band 9							3	3
Other	0	0		1	11	7	90	141

*based on ordinary pay which includes bank work

The gender distribution of staff by Agenda for Change (AfC) Band demonstrates women are predominant at all bands and pay quartiles (1 being the lowest and 4 the highest paid) up to and including Band 8b. From Band 8c to 8d the proportion of men and women become more equal and at Band 9 there is an equal distribution, though the numbers are small.

The majority of M&D staff fall within the 4th Quartile, the majority of which are male.

Upon a further deep dive of the quartile data, it is apparent the banding is not the only thing that influence where an individual sits within the quartiles. Additional payments also impact this as they contribute to overall earning. This is particularly seen in roles where a number of band 2, band 5 and band 6 sit within the upper quartiles because of additional earnings. This is because of the frequency of call outs resulting in significant levels of overtime payments on the given date of the report. This would further compound and extend pay gaps within this staff group.

5.2 Mean and Median Hourly Rate

The mean pay gap is the difference between the average earnings of two groups, in this case male and female colleagues. This is widely considered the most suitable way to calculate the average as it incorporates all of data.

The median pay gap is the difference in hourly pay gap between the mid-point of the two groups when their salaries are listed by size. It therefore is not influenced by extremes in salaries and so the median would be more reflective of what the majority of individuals are paid.

Exploring the data from the 31st March 2025, it demonstrates that there is still a significant gender pay gap in favour of male colleagues. However, when comparing this to data from the 31st March 2023 it is apparent that the mean gap has slightly decreased by 0.7% however the median gap has increased by 1.2%.

Overall Workforce

	2025		2024	
Gender	**Mean average hourly rate**	**Median average hourly rate**	**Mean average hourly rate**	**Median average hourly rate**
Male	£34.22	£28.37	£30.66	£25.60
Female	£21.61	£18.42	£20.51	£17.36
Difference	£12.61	£9.95	£10.15	£8.24
Pay Gap %	**36.9%**	**35.1%**	**33.1%**	**32.2%**

Gender pay gap – Agenda for Change (AfC) workforce

Agenda for Change Staff				
	2025	**2025**	**2024**	**2024**
Gender	**Mean average hourly rate**	**Median average hourly rate**	**Mean average hourly rate**	**Median average hourly rate**
Male	£22.07	£19.09	£19.56	£16.64
Female	£19.08	£16.31	£18.03	£15.67
Difference	£2.99	£2.78	£1.53	£0.97
Pay Gap %	**13.5%**	**14.6%**	**7.83%**	**5.83%**

In respect of Agenda for Change (AfC) staff (excluding Executives, Non-Executives and Medical & Dental), the mean pay gap was 13.5% a gap of £2.99 an hour in favour of male staff. The median pay gap was 14.6% a gap of £2.78 an hour in favour of men.

Gender pay gap – Medical and Dental (M&D) workforce

Medical & Dental Staff				
	2025	**2025**	**2024**	**2024**
Gender	**Mean average hourly rate**	**Median average hourly rate**	**Mean average hourly rate**	**Median average hourly rate**
Male	£52.69	£51.55	£46.28	£40.15
Female	£47.06	£46.52	£38.46	£35.61
Difference	£5.63	£5.03	£7.82	£4.54
Pay Gap %	**10.7%**	**9.75%**	**16.9%**	**11.31%**

With regard to Medical and Dental (M&D) staff, the mean pay gap has reduced to 10.7%, a gap of £5.63 an hour in favour of male staff. The median pay gap has greatly improved since 2023 to 9.75%, a gap of £5.03 an hour in favour of male staff. This is expected given there are a higher percentage of men in the M&D consultant workforce and therefore more males are able to undertake bank and additional work which attract a higher rate premium.

5.3 Staff Groups

The extent of the gender pay gap varies considerably across the 8 different staff groups within the Trust.

	2025				2024			
Staff Group	**Female**	**Male**	**Difference**	**Pay Gap %**	**Female**	**Male**	**Difference**	**Pay Gap %**
Add Prof Scientific and Technic	£26.79	£24.31	-£2.48	-10.20	£23.84	£21.73	-£2.11	-9.71
Additional Clinical Services	£13.76	£13.62	-£0.13	-0.98	£13.05	£12.86	-£0.19	-1.48
Administrative and Clerical	£17.94	£26.66	£8.72	32.71	£16.94	£23.22	£6.29	27.07
Allied Health Professionals	£23.82	£21.72	-£2.10	-9.66	£23.22	£19.25	-£3.97	-20.64
Estates and Ancillary	£13.88	£14.96	£1.08	7.22	£12.71	£14.33	£1.62	11.32
Healthcare Scientists	£26.45	£29.58	£3.13	10.58	£26.80	£29.95	£3.15	10.53
Medical and Dental	£45.51	£49.75	£4.24	8.52	£38.46	£46.28	£7.82	16.90
Nursing and Midwifery Registered	£22.67	£26.43	£3.76	14.23	£22.28	£23.72	£1.43	6.04
Students	£13.43	£12.31	-£1.12	-9.07	£12.90	£11.45	-£1.46	-12.73

Reviewing the areas with the largest pay gaps in 2025, staff in Admin & Clerical have seen the pay gap increase from 2024 to 32.71%. This is mainly due to a number of males being recruited to senior positions which are either new to the organisation or replacing female staff who have left the Trust.

Medical and Dental staff have seen the gap reduce since 2024 by 8.38% to 8.52% in 2025. Staff in Estates and Ancillary have a gap of 7.32% which has reduced from 11.32% the previous year.

The Allied Health Professional gender pay gap has reduced in favour of female staff. In 2024 the gap was -20.64% and this has reduced to -9.66%. The pay gap within nursing staff has grown between 2024 and 2025 by 8.19%

5.4 Bonus Pay

Bonus payments - overall workforce

In 2025, QVH made bonus payments in respect of the national and local Clinical Excellence Awards (CEAs) for medical and dental consultants, and new starter premium for Agenda for Change staff.

Of the 1235 relevant employees, 51 received bonus payments which equates to 2.43% of women and 1.7% of men of the overall workforce.

The bonus payments totalled £289,734 which is a significant reduction from 2024 (£520,474.44). The bonuses which were paid were awarded to 41.2% male and 58.9% to female. In 2025 the mean bonus gender pay gap for the entire workforce was 73.57% and the median bonus gender pay gap

was 80.94%. The main contributor to this was the historic distribution of CEA awards within the Medical Consultant body as the equal distribution of CEA payments since 2021 has been removed following the national pay deal agreed in 2024.

Pro-rata bonuses received by part-time employees are not adjusted for the purpose of the gender bonus gap calculations, this impacts the gender pay bonus gap.

Gender	Mean Total Bonus	Median Total Bonus
Male	£10,014.91	£7,868.34
Female	£2,647.36	£1,500.00
Difference	£7,367.55	£6,368.34
Pay Gap %	**73.57%**	**80.94%**

Bonus payments - Consultant workforce

There are 98 consultants in the workforce at QVH; of which 28 (28.6% of the consultant workforce) are women and 70 (71.4%) are men. Considerably more men (n=19) compared to women (n=4) received bonus payments in the form of Clinical Excellence Awards (CEA's) awarded by the Trust.

CEA payments totalled £257,234.03. The **mean** (-14.38%) was in favour of women who on average received £1,569.01 more in bonuses than women. The **median** was 2.04% in favour of men.

Gender	Mean CEA	Median CEA
Male	£10,911.22	£10,775.61
Female	£12,480.23	£10,555.98
Difference	-£1,569.01	£219.63
Pay Gap %	**-14.38%**	**2.04%**

Bonus payments - Agenda for Change workforce

In the year 2024-5 the Trust offered a new starter premium payments to AfC staff who referred a candidate subsequently employed. The value of this bonus totalled £32,000; of which 92.8% was awarded to females and 7.1% to males. These payments were paid to a total of 28 individuals.

Gender	Mean Total Bonus	Median Total Bonus
Female	£1,500.00	£1,500.00
Male	£1,134.62	£1,500.00
Difference	£365.38	£0.00
Pay Gap %	**24.36%**	**0.00%**

6. Priorities for 2025/2026

Action	By When	Lead
A module on EDI and inclusive management will be added to the line manager's training offer in 2025-26.	Q3 2025-26	Wellbeing & Inclusion Manager
Continue to offer Menopause Café sessions to facilitate discussion and support at work	Q3 2025-26	Wellbeing & Inclusion Manager
Encourage, promote and role-model healthy work-life balance and family-friendly options, such as flexible working hours and patterns, hybrid working and disconnecting after work.	Q2 2025-26	Wellbeing & Inclusion Manager
Triangulate Employee Relations case work, Freedom to Speak Up reports, Occupational Health data, Staff Survey and Pulse Survey results and Wellbeing & Inclusion insights to capture and act on themes highlighted on a quarterly basis.	Q3 2025-26	Wellbeing & Inclusion Manager
Apply an EDI lens through lived experience to continue an end-to-end review of our current internal and external recruitment processes, with an EDI representative available for interview panels to support the de-biasing of the recruitment process.	Q3 2025-26	DCPO
Conduct an EDI audit of all applications for career development, including apprenticeships and external learning, to establish how our disabled colleagues can be better supported to develop their careers and tackle any potential barriers.	Q4 2025-26	DCPO
Conduct an exercise to understand the experience of women at QVH, particularly in respect of career development, work-life balance, family-friendly policies and support for those returning from parental leave.	Q4 2025-26	Wellbeing & Inclusion Manager

Conclusion

There is clear evidence the gender pay gap across the organisation, and specifically within Admin and Clerical roles has grown in 2024-25. Work continues to support flexible working, de-biasing of job descriptions and adverts and supporting learning and development to attract a more diverse staff group at all levels.

Recommendation

To note the content of the report and approve the report for publication on the Trust’s website.

Queen Victoria Hospital
NHS Foundation Trust

Gender Pay Report 2025

Executive Summary

Queen Victoria Hospital NHS Foundation Trust's mean gender pay gap has increased from 33.1% in 2024 to 36.9% in 2025. The median gap has also increased from 32.2% to 35.1%.

The AfC gender pay gap for 2025 is 13.5% (Mean) and 14.6% (Median). The M&D gender pay gap for 2025 is 10.7% (Mean) and 9.75% (Median). Our gender pay gap continues to be driven in part by a greater number of men in more senior admin roles among our Agenda for Change (AfC) workforce and senior male clinicians earning top of grade and bonus payments relative to our total workforce.

In relation to the bonus pay gap, male employees received a higher amount of bonus pay compared to female employees. The pay gap for bonus pay is 24.4%. This is mainly attributed to Consultant medical staff receiving historical Clinical Excellence Awards which ceased to be awarded in 2018.

Our workforce profile is 74.66% female as at 31 March 2025, which represents a 0.41% increase against our 2024 data. 2025 saw a positive movement of female staff in each of the pay quartiles. There was a positive increase of 1.12% of female employees in the upper pay quartile and a 0.13% increase in the upper middle quartile. There were decreases of 2.21% in the lower middle and 5.67% of the lower quartiles across the organisation, showing that the staff representation in these pay bands is getting closer to the overall gender split for the Trust.

Reporting Requirements

There are six key indicators against which an employer must publish its calculations

1. **Mean gender pay gap** – The difference between the mean hourly rate of pay of male full-pay relevant employees and that of female full-pay relevant employees.
2. **Median gender pay gap** – The difference between median hourly rate of pay of male full-pay relevant employees and that of female full-pay relevant employees.
3. **Mean bonus gender pay gap** – The difference between the mean bonus pay paid to male relevant employees and that paid to female relevant employees.
4. **Median bonus gender pay gap** – The difference between the median bonus pay paid to male relevant employees and that paid to female relevant employees.
5. **Bonus proportions** – The proportion of males and females receiving a bonus payment.
6. **Quartile pay bands** – The proportion of males and females in each of the four pay quartiles

"Pay" includes;

- basic pay
- full paid leave including annual, sick, maternity, paternity, adoption or parental leave,
- bonus pay received in the pay period in which the snapshot date falls (bonus pay should be pro-rated where it relates to a period longer than the pay period) area, on-call and other allowances such as recruitment and retention allowances shift premium pay
- pay for piecework.

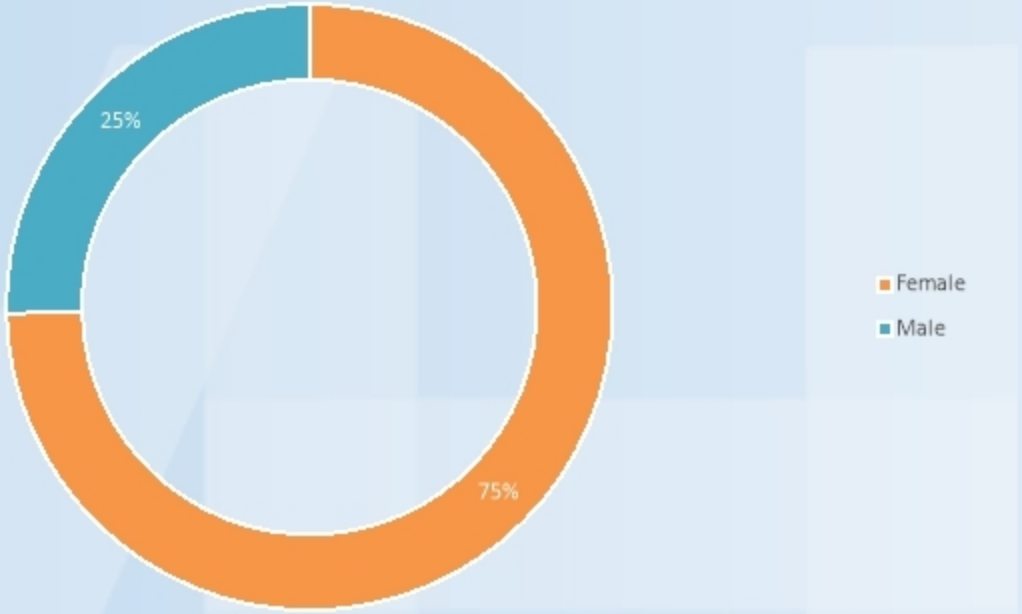
It does not include;

- overtime pay
- expenses (payments made to reimburse expenditure wholly and necessarily incurred in the course of employment, for example, mileage for use of vehicle)
- remuneration in lieu of leave
- benefits in kind (for example, child care vouchers)
- redundancy pay and tax credits.

Our Gender Profile

Snapshot Date-31st March 2025

This chart provides details of the Trust gender profile. There were a total of 1492 employees who fell under the requirements to report the gender pay gap. 1114 were female and 378 were male



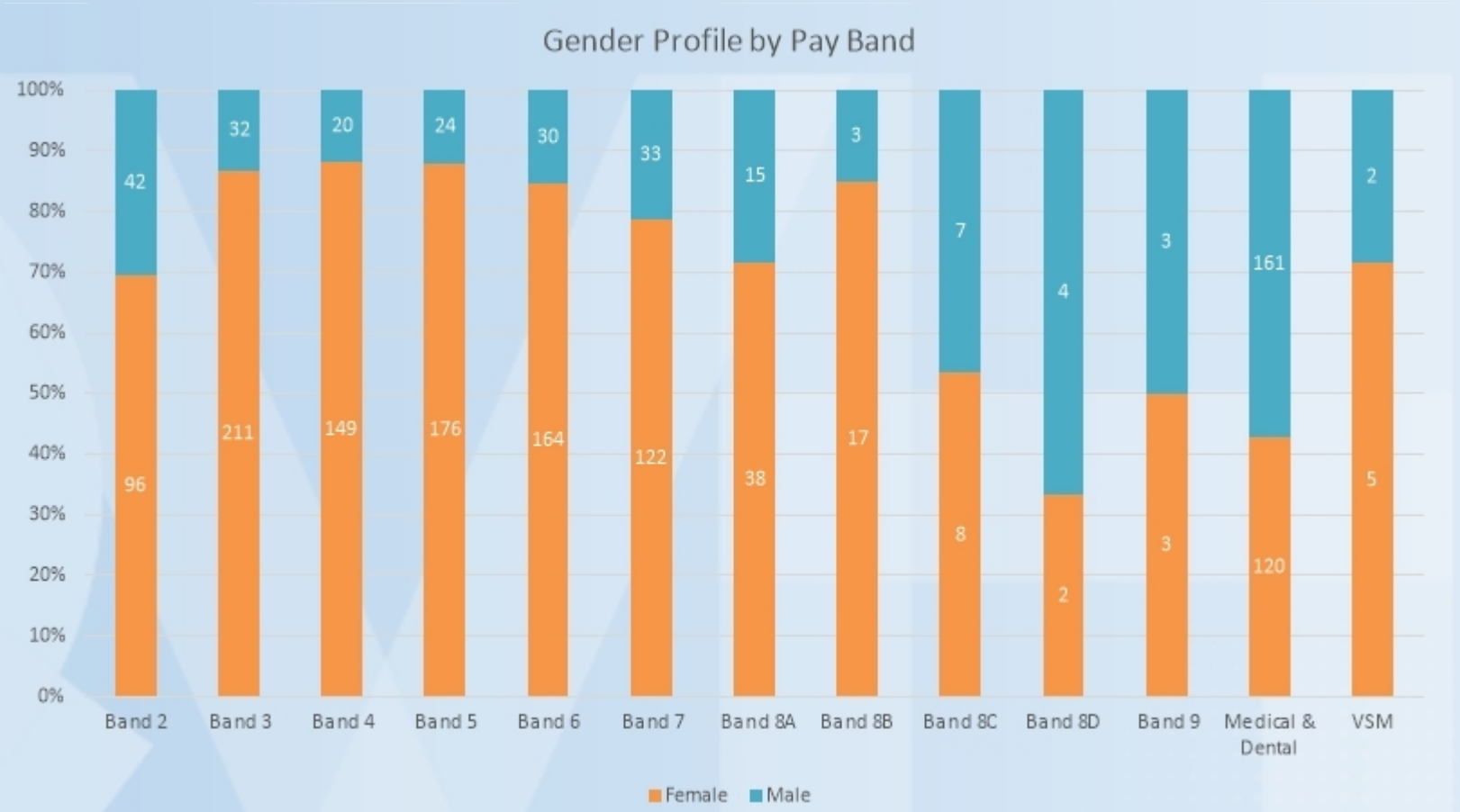
Our Gender Profile by Staff Group

Pay structure

All QVH staff, except for medical and dental staff (M&D) and Trust Executive Managers (VSM) are paid on the National Agenda for Change (AfC) pay, terms and conditions of service. The terms and conditions set out band structures and pay for all employees to ensure transparency, fairness and equal treatment for all.

Profile across bands

This chart details the number and percentage of female and male staff within each pay bands as of 31 March 2025. While band 8a is largely reflective of the organisation's profile, there is an upwards trend in employing proportionally more female staff in bands 3 to 7. Pay band 9 is representative of 6 individuals but a 50:50 gender split.



Our Gender Pay Gap Data

Queen Victoria Hospital NHS Foundation Trust's mean gender pay gap has increased from 33.1% in 2024 to 36.9% in 2025. The median gap has increased from 32.2% in 2024 to 35.1% in 2025.

Ordinary Pay	
Mean Gender Pay Gap	36.86%
Median Gender Pay Gap	35.07%

Bonus Pay	
Mean Gender Pay Gap-bonus pay	73.57%
Median Gender Pay Gap-bonus pay	80.94%

Proportion of staff paid a bonus	
Female	Male
57.70%	42.30%

	2025 rates		2024 rates		Year on Year Change	
	Female %	Male %	Female %	Male %	Female %	Male %
Lower quartile	49.2	50.8	54.87	45.13	-5.67	5.67
Lower middle quartile	82.05	17.95	84.26	15.74	-2.21	2.21
Upper middle quartile	82.75	17.25	82.62	17.38	0.13	-0.13
Upper quartile	84.62	15.38	83.5	16.5	1.12	-1.12

Our Gender Pay Gap Data

Hourly Rate of Pay-by Band

AfC Pay Grade	Female	Male	Difference	Pay Gap %
Band 2	£12.84	£13.77	£0.93	6.77
Band 3	£12.96	£12.72	-£0.24	-1.85
Band 4	£14.30	£14.51	£0.21	1.42
Band 5	£17.65	£17.79	£0.14	0.77
Band 6	£22.43	£22.86	£0.43	1.87
Band 7	£25.67	£26.25	£0.58	2.20
Band 8 - Range A	£28.79	£29.58	£0.78	2.64
Band 8 - Range B	£33.64	£38.53	£4.88	12.68
Band 8 - Range C	£40.35	£42.24	£1.89	4.48
Band 8 - Range D	£46.78	£50.69	£3.90	7.70
Band 9	£45.88	£63.12	£17.24	27.31
Other	£46.57	£50.18	£3.61	7.19

Hourly Rate of Pay-by Staff Group

Staff Group	Female	Male	Difference	Pay Gap %
Add Prof Scientific and Technic	£26.79	£24.31	-£2.48	-10.20
Additional Clinical Services	£13.76	£13.62	-£0.13	-0.98
Administrative and Clerical	£17.94	£26.66	£8.72	32.71
Allied Health Professionals	£23.82	£21.72	-£2.10	-9.66
Estates and Ancillary	£13.88	£14.96	£1.08	7.22
Healthcare Scientists	£26.45	£29.58	£3.13	10.58
Medical and Dental	£45.51	£49.75	£4.24	8.52
Nursing and Midwifery Registered	£22.67	£26.43	£3.76	14.23
Students	£13.43	£12.31	-£1.12	-9.07

Impacts upon our Gender Pay Gap

Higher proportion of Male consultants at top of band and CEA's

We have a total of 98 consultants in the workforce at QVH, of which 28 (28.6% of the consultant workforce) are women and 70 (71.4%) are men. Considerably more men compared to women received bonus payments in the form of Clinical Excellence Awards (CEA's) which were historically awarded prior to 2018

Lower numbers of Male roles in lower bands

At QVH we have considerably less males in lower banded roles compared to other Trusts which impacts negatively upon our pay gap reporting. We only have 76 men in Band 2 or Band 3 roles across the Trust who fall within the scope of the gender pay report compared to 289 women. This accounts for only 5% of the workforce subject to the pay gap reporting.

We have a higher proportion of senior A&C roles at QVH than clinical

As a small specialist NHS Trust, we have a higher proportion of higher banded non-clinical roles across the Trust compared to larger Trusts who will have a higher number of clinical roles. This negatively impacts upon the Trust's pay gap as there are fewer lower banded roles across both clinical and non-clinical roles to help reduce the average pay overall and the gaps we see between men and women. Coupled with this, in 2024/25 QVH have employed a number of men in senior roles which are either new posts or replacing female staff that have left the Trust. This has also had a significant impact upon our pay gap this year.

Female staff are more likely to resign due to pay and reward than male counterparts, representing 80% of all resignations due to pay. Promotion opportunities and work-life balance were also key reasons given by our female leavers.

Our Commitment

Our People and Culture strategy, published in 2024 identifies activities and programmes that QVH continues to drive forward to promote pay balance in the workplace. Some of these activities that can support closing the gender pay gap include:

- promotion of agile, flexible and part-time working
- wider implementation of the apprenticeship programmes.
- Encourage, promote and role-model healthy work-life balance
- Applying an EDI lens through lived experience to an end-to-end review of our current internal and external recruitment processes,
- Conducting an exercise to understand the experience of women at QVH

In addition to the above activities, QVH recognises the importance of minimising the barriers for individuals from all backgrounds right from the start of their journey with the Trust. As such the People and Culture Strategy outlines a key milestone for pay equity.

To achieve this, we seek to Educate and embed strong governance across the organisation to ensure equality of opportunity with a focus on pay equity amongst our workforce. Working actively with senior managers to understand the importance of equality, whilst taking active steps to reduce disparities amongst key areas of our workforce. Active promotion of development opportunities, flexible working initiatives and recruitment of candidates are key to our delivery in this area.

Our Actions

Action	By When	Lead
A module on EDI and inclusive management will be added to the line manager's training offer in 2025-26.	Q3 2025-26	Wellbeing & Inclusion Manager
Continue to offer Menopause Café sessions to facilitate discussion and support at work	Q3 2025-26	Wellbeing & Inclusion Manager
Encourage, promote and role-model healthy work-life balance and family-friendly options, such as flexible working hours and patterns, hybrid working and disconnecting after work.	Q2 2025-26	Wellbeing & Inclusion Manager
Triangulate Employee Relations case work, Freedom to Speak Up reports, Occupational Health data, Staff Survey and Pulse Survey results and Wellbeing & Inclusion insights to capture and act on themes highlighted on a quarterly basis.	Q3 2025-26	Wellbeing & Inclusion Manager
Apply an EDI lens through lived experience to an end-to-end review of our current internal and external recruitment processes, with an EDI representative available for interview panels to support the de-biasing of the recruitment process.	Q3 2025-26	DCPO
Conduct an EDI audit of all applications for career development, including apprenticeships and external learning, to establish how our disabled colleagues can be better supported to develop their careers and tackle any potential barriers.	Q4 2025-26	DCPO
Conduct an exercise to understand the experience of women at QVH, particularly in respect of career development, work-life balance, family-friendly policies and support for those returning from parental leave.	Q4 2025-26	Wellbeing & Inclusion Manager

Report cover-page					
References					
Meeting title:	Board of Directors				
Meeting date:	11 September 2025		**Agenda reference:**	**69-25**	
Report title:	Ethnicity Pay Gap Report 2025				
Sponsor:	Helen Edmunds, Chief People Officer				
Author:	Helen Edmunds, Chief People Officer Lawrence Anderson, Deputy Chief People Officer				
Appendices:	Ethnicity Pay Gap Report 2025				
Executive summary					
Purpose of report:	To provide the position of the QVH Ethnicity Pay Gap as at 31 March 2025, the reasons behind our ethnicity pay gap and actions to give reassurance on how QVH are planning to reduce the Ethnicity Pay Gap.				
Summary of key issues	• Our ethnicity pay gap continues to be driven in part by a higher proportion of BME staff in higher banded clinical roles (Additional Professional, Scientific and Technical along with Healthcare Scientists) as a proportion of our staff among our Agenda for Change (AfC) workforce. • The Trust's mean ethnicity pay gap has increased from -20.79% in 2024 to -22.95% in 2025 in favour of BME staff. The median gap has decreased from -29.67% to -27.53%. • The AfC ethnicity pay gap for 2025 is -2.99%% (Mean) and -18.71% (Median) in favour of BME staff. • The M&D ethnicity pay gap for 2025 is 10.37% (Mean) and 13.52% (Median) in favour of white staff. • BME employees received a higher amount of bonus pay compared to white employees. The pay gap for bonus pay is -14.84% which has reduced significantly since 2024 where the gap was -33.01%				
Recommendation:	To note the content of the report and approve the report for publication on the Trust's website.				
Action required	**Approval**	Information	Discussion	**Assurance**	Review
Link to key strategic objectives (KSOs):	KSO1: *To deliver outstanding care*	KSO2: *To innovate and improve*	**KSO3:** ***To be an excellent employer***	KSO4: *To deliver sustainable services*	KSO5: *To collaborate with others*
Implications					
Board assurance framework:	None				
Corporate risk register:	None				
Regulation:	None				
Legal:	None				
Resources:	None				
Assurance route					
Previously considered by:	Finance and Performance Committee				
	Date:	30 June 2025	Decision:	To be presented to the Board of Directors	
Next steps:	Presentation at Board in September 2025 prior to publication of the report on Trust website.				

Report to:	Board of Directors
Agenda item:	Ethnicity Pay Gap Report 2025
Date of meeting:	11 September 2025
Report from:	Helen Edmunds, Chief People Officer
Report author:	Helen Edmunds, Chief People Officer Lawrence Anderson, Deputy Chief People Officer
Date of report:	4 June 2025
Appendices:	None

Ethnicity Pay Gap Report 2025

1. Introduction

In June 2023 the Equality, Diversity and Inclusion Plan set out six targeted actions to address direct and indirect prejudice and discrimination that exists through behaviour, policies, practices and cultures against certain groups and individuals across the NHS workforce. High Impact action 3 requires us to develop and implement an improvement plan to eliminate pay gaps.

We are required to analyse data to understand pay gaps by protected characteristic and put in place an improvement plan. This will be tracked and monitored by NHS boards. The Trust already report on gender pay gaps separately.

A pay gap is the difference between the average hourly pay of employees in one group in comparison to another group. This is different to equal pay. Equal pay is a person being paid the same for the same role and it is unlawful to pay someone differently for doing the same job based on a protected characteristic.

QVH is committed to understanding any differences identified in the ethnicity pay report and will undertake further analysis to gain a better understanding as to the reason for the differences and to take action where appropriate. Pay gaps can negatively affect the retention of the NHS workforce. They can make it harder to recruit and can have a detrimental impact on staff experience when in post.

This is our second ethnicity pay gap report. We have analysed information using the categories: White, Not Stated (which includes not known) and BME. BME is all other ethnic minority groups combined

The intention of pay gap reporting is to focus attention on the evidence for taking action to reduce pay inequality, improve staff experience, retention and make Queen Victoria NHS Foundation Trust (QVH) a great place to work.

The ethnicity pay gap report is a snapshot as at 31 March 2025.

2. Data Used to Calculate Ethnicity Pay Gap Figures

There are six key indicators against which an employer must publish its calculations

- **Mean ethnicity pay gap** – The difference between the mean hourly rate of pay of white full-pay relevant employees and that of BME full-pay relevant employees.
- **Median ethnicity pay gap** – The difference between median hourly rate of pay of white full-pay relevant employees and that of BME full-pay relevant employees.
- **Bonus proportions** – The proportion of White and BME staff receiving a bonus payment.
- **Quartile pay bands** – The proportion of White and BME in each of the four pay quartiles

3. Definitions

- Full-pay relevant employee - the employee must be paid their full usual pay during the pay period in which the snapshot date falls. If the employee is paid less than their usual rate because of leave for that period, they should not be counted as a full-pay relevant employee.

- If an employee is on any kind of leave and not being paid their full usual amount in the pay period, they are not full-pay relevant employees. For example, if they are paid Statutory Sick Pay or Statutory Maternity Pay which is less than their usual pay.

- "Pay" includes;
    - basic pay
    - full paid leave including annual, sick, maternity, paternity, adoption or parental leave,
    - bonus pay received in the pay period in which the snapshot date falls (bonus pay should be pro-rated where it relates to a period longer than the pay period)
    - area, on-call and other allowances such as recruitment and retention allowances shift premium pay
    - pay for piecework.

  It does not include;
    - overtime pay
    - expenses (payments made to reimburse expenditure wholly and necessarily incurred in the course of employment, for example, mileage for use of vehicle)
    - remuneration in lieu of leave
    - benefits in kind (for example, child care vouchers)
    - redundancy pay and tax credits.

4. Methodology

The data used in this report has been generated using the Electronic Staff Record (ESR) Business Intelligence report designed specifically for ethnicity pay gap reporting

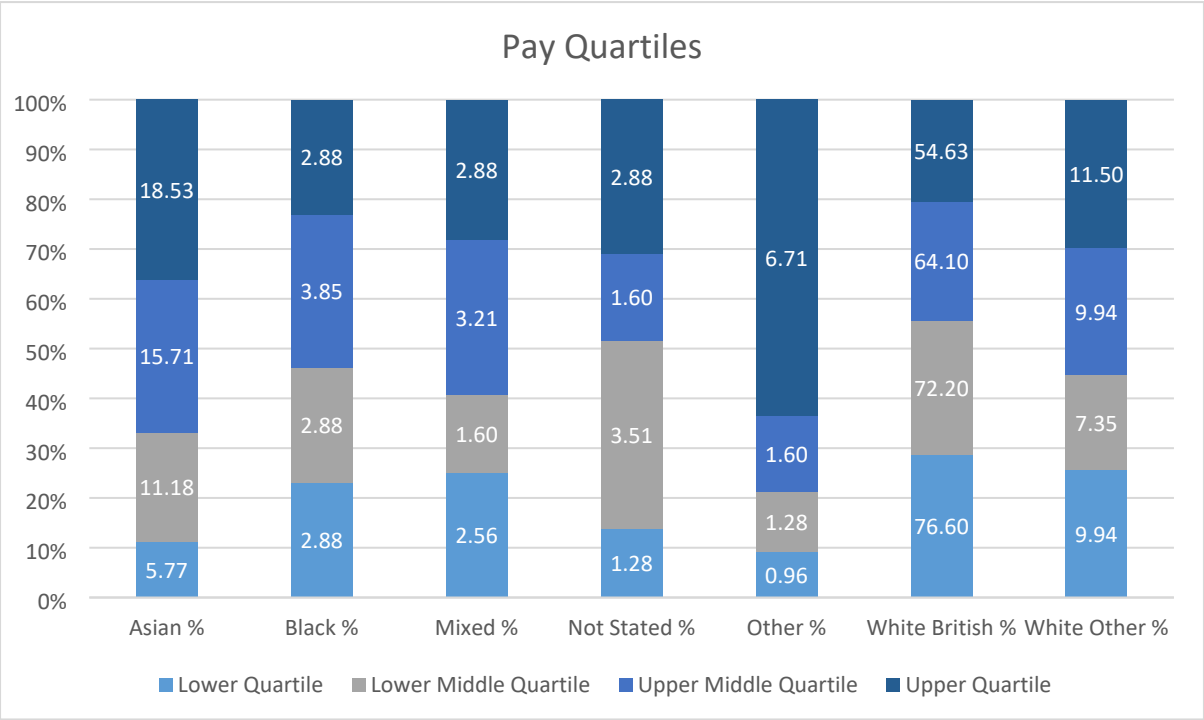
5. Data Analysis-Race

Colleagues from a multicultural background represent 21.98% of the workforce, with year-on-year increases being seen

	BME %	Non-BME %	Unknown %
2019	14.69%	83.07%	2.24%
2020	15.92%	81.14%	2.94%
2021	18.79%	79.38%	1.83%
2022	19.27%	78.73%	2.00%
2023	19.52%	78.53%	1.95%
2024	21.25%	77.48%	1.27%
2025	21.98%	75.99%	2.03%

5.1 Ethnicity Distribution Pay Quartiles

Quartile	Asian	Black	Mixed	Not Stated	Other	White British	White Other
1	18	9	8	4	3	239	31
2	35	9	5	11	4	226	23
3	49	12	10	5	5	200	31
4	58	9	9	9	21	171	36



The majority of BME staff are located in quartiles 3 and 4 (upper middle and upper quartiles), with less BME staff occupying the lower pay quartiles. The number of staff who have not stated or have an undeclared ethnicity increases with the pay quartiles.

5.2 Mean and Median Hourly Rate

The mean pay gap is the difference between the average earnings of two groups, in this case BME and White colleagues. This is widely considered the most suitable way to calculate the average as it incorporates all of data.

The median pay gap is the difference in hourly pay gap between the mid-point of the two groups when their salaries are listed by size. It therefore is not influenced by extremes in salaries and so the median would be more reflective of what the majority of individuals are paid.

Exploring the data from the 31st March 2025, it demonstrates that there is still a significant ethnicity pay gap in favour of BME colleagues. However the gap amongst staff who have not declared (51 out of 1221 staff) is over 20%

Overall Workforce

	2024 Mean Hourly Rate	2024 Median Hourly Rate	2025 Mean Hourly Rate	2025 Median Hourly Rate
BME	£27.01	£22.61	£29.13	£23.80
Not Known	£17.67	£14.40	£23.46	£19.21
White	£22.36	£17.44	£23.69	£18.66
Pay Gap - BME	**-20.79%**	**-29.67%**	**-22.95%**	**-27.53%**
Pay Gap - Not Known	**20.98%**	**17.41%**	**0.98%**	**-2.95**

Ethnicity pay gap – Agenda for Change (AfC) workforce

	2024 Mean Hourly Rate	2024 Median Hourly Rate	2025 Mean Hourly Rate	2025 Median Hourly Rate
BME	£18.97	£18.10	£20.50	£19.38
Not Known	£16.70	£14.01	£19.76	£15.68
White	£18.36	£14.20	£19.90	£16.33
Pay Gap - BME	**-3.32%**	**-27.46%**	**-2.99%**	**-18.71%**
Pay Gap - Not Known	**9.03%**	**1.34%**	**0.72%**	**3.98%**

In respect of Agenda for Change (AfC) staff (excluding Executives, Non-Executives and Medical & Dental), the mean pay gap was -2.99% a gap of £0.60 an hour in favour of BME staff. The median pay gap was -18.71% a gap of £3.05 an hour in favour of BME staff.

Ethnicity pay gap – Medical and Dental (M&D) workforce

	2024 Mean Hourly Rate	2024 Median Hourly Rate	2025 Mean Hourly Rate	2025 Median Hourly Rate
BME	£41.13	£36.08	£47.95	£46.43
Not Known	£30.07	£30.07	£37.64	£36.25
White	£45.14	£46.34	£53.50	£53.69
Pay Gap - BME	**8.89%**	**22.14%**	**10.37%**	**13.52%**
Pay Gap - Not Known	**33.39%**	**33.39%**	**29.64%**	**32.49%**

With regard to Medical and Dental (M&D) staff, the mean pay gap is 10.37%, a gap of £5.55 an hour in favour of White staff. The median pay gap was 13.52%, a gap of £7.26 an hour in favour of white staff. For context. QVH have 83 staff from a BME background and 108 from a White background

Staff Groups

The extent of the ethnicity pay gap varies considerably across the 8 different staff groups within the Trust.

Staff Group	2025 BME Mean Hourly Rate	2025 White Mean Hourly Rate	Difference per hour	Pay Gap	Gap difference between 2024 and 2025
Add Prof Scientific and Technic	£29.65	£25.23	£4.42	-17.52%	-8.32%
Additional Clinical Services	£13.99	£13.96	£0.03	-0.21%	-0.68%
Administrative and Clerical	£19.94	£18.72	£1.22	-6.52%	0.19%
Allied Health Professionals	£23.21	£24.75	-£1.54	6.22%	-4.52%
Estates and Ancillary	£13.90	£14.92	-£1.02	6.84%	-2.85%
Healthcare Scientists	£21.75	£30.12	-£8.37	27.79%	6.01%
Medical and Dental	£47.95	£53.50	-£5.55	10.37%	-1.48%
Nursing and Midwifery Registered	£23.35	£24.14	-£0.79	3.28%	0.32%

Reviewing the areas with the largest pay gaps in 2025, Healthcare Scientists see the highest pay gap at QVH with 27.79% in favour of White staff, the equivalent of £8.37 per hour. This gap has however reduced from 2024 where the gap was 33.8% (£10.37 per hour). This is in relation to a total of 39 staff in this area.

Staff in the Additional Professional, Scientific and Technical staff group who have 41 staff demonstrate a 17.52% pay gap in favour of BME staff, the equivalent of £4.42 per hour. (Psychotherapies, Optical, Pharmacy, Orthodontic staff). This gap has however reduced from 2024 where the gap was 25.84% (£8.32 per hour)

6. Bonus Pay

Bonus payments - overall workforce

In 2025, QVH made bonus payments in respect of the national and local Clinical Excellence Awards (CEAs) for medical and dental consultants, and new starter premium for Agenda for Change staff.

Of the 1250 relevant employees, 52 received bonus payments which equates to 2.48% of white staff and 1.6% of BME staff of the overall workforce.

The bonus payments totalled £289,734.03; of which 60.7% was awarded to white staff and 39.2% to BME staff. In 2025 the mean bonus ethnicity pay gap for the entire workforce was -14.84% and the median bonus ethnicity pay gap was 0%. The main contributor to this was the historic distribution of CEA awards within the Medical Consultant body.

Pro-rata bonuses received by part-time employees are not adjusted for the purpose of the ethnicity bonus gap calculations.

Ethnicity	2024 Mean Total Bonus	2024 Median Total Bonus	2025 Mean Total Bonus	2025 Median Total Bonus
BME	£5,615.35	£3,167.00	£6,617.23	£1,500.00
Not Known	£3,167.00	£3,167.00	£1,500.00	£1,500.00
White	£4,221.73	£3,167.00	£5,205.23	£1,500.00
Pay Gap - BME	**-33.01%**	**0.00%**	**-14.84%**	**0.00%**

Consultant Workforce

There are 98 consultants in the workforce at QVH; of which 32 (32.65% of the consultant workforce) are BME and 57 (58.16%) are White. More white staff (n=13) compared to BME (n=9) received bonus payments in the form of Clinical Excellence Awards (CEA's) awarded by the Trust prior to 2018.

CEA payments totalled £257,234.03. The **mean** (-17.71%) was in favour of BME staff who on average received £1,926.12 more in bonuses than white staff. The **median** was 33.53% which can be attributed to the Local CEA payments being applied eligible consultants in prior to 2018.

Ethnicity	Mean Total Bonus	Median Total Bonus
BME	£12,800.14	£7,868.34
Not Known	£670.54	£3,167.00
White	£10,874.02	£11,837.76
Pay Gap - BME	**-17.71%**	**33.53%**

Agenda for Change Workforce

In the year 2024-5 the Trust offered a new starter premium payment to AfC staff who referred a candidate subsequently employed. The value of this bonus totalled £32,000; of which 60.71% was awarded to white staff (n=17) and 35.71% to BME staff (n=10). These payments were paid to a total of 28 individuals.

Ethnicity	Mean Total Bonus	Median Total Bonus
BME	£1,055.56	£1,000.00
Not Known	£1,500	£1,500.00
White	£1,147.06	£1,500.00
Pay Gap - BME	**7.98%**	**33.33%**

7. Priorities for 2024/2025

Action	By When	Lead
A module on EDI and inclusive management will be added to the line manager's training offer in 2025-26	Q3 2025-26	Wellbeing & Inclusion Manager
Encourage, promote and role-model healthy work-life balance and family-friendly options, such as flexible working hours and patterns, hybrid working and disconnecting after work	Q2 2025-26	Wellbeing & Inclusion Manager
Triangulate Employee Relations case work, Freedom to Speak Up reports, Occupational Health data, Staff Survey and Pulse Survey results and Wellbeing & Inclusion insights to capture and act on themes highlighted on a quarterly basis	Q3 2025-26	Wellbeing & Inclusion Manager
Apply an EDI lens through lived experience to an end-to-end review of our current internal and external recruitment processes, with an EDI representative available for interview panels to support the de-biasing of the recruitment process	Q3 2025-26	DCPO
Conduct an EDI audit of all applications for career development, including apprenticeships and external learning, to establish how our disabled colleagues can be better supported to develop their careers and tackle any potential barriers	Q4 2025-26	DCPO
Ongoing review of the structures and roles across departments specifically looking at succession planning and talent management from Band 8a to VSM.	Ongoing through 2025-26	CPO, supported by Head of OD&L
Exploration of a reverse mentoring programme, using our networks to determine areas of initial focus to support career progression.	Ongoing through 2025-26	CPO, supported by Head of OD&L
Development and implementation of a shadow board programme to develop future leaders, build board level experience and confidence to support succession planning and talent management	Ongoing through 2025-26	CPO

Conclusion

The overall ethnicity pay gap across the organisation has increased across the Trust from 2024 to 2025 in favour of BME staff. When analysed more closely, pay gaps specifically within Additional Professional, Scientific and Technic roles and Allied Health Professional have grown in 2024-25 in favour of BME staff

and within Healthcare Scientists and Medical and Dental staff in favour of white staff. Work continues to support flexible working, de-biasing of job descriptions and adverts and supporting learning and development to attract a more diverse staff group at all levels.

Recommendation
To note the content of the report and approve the report for publication on the Trust's website.

Queen Victoria Hospital
NHS Foundation Trust

Ethnicity Pay Report 2025

Executive Summary

Queen Victoria Hospital NHS Foundation Trust's mean ethnicity pay gap has increased from -20.79% in 2024 to -22.95% in 2025 in favour of BME staff. The median gap has decreased from -29.67% to -27.53%.

The AfC ethnicity pay gap for 2025 is -2.99%% (Mean) and -18.71% (Median) in favour of BME staff. The M&D ethnicity pay gap for 2025 is 10.37% (Mean) and 13.52% (Median) in favour of white staff. Our ethnicity pay gap continues to be driven in part by a disproportionate number of BME colleagues in more senior clinical posts among our Agenda for Change (AfC) workforce and senior white clinicians earning top of grade and bonus payments relative to our total workforce.

In relation to the bonus pay gap, BME employees received a higher amount of bonus pay compared to white employees. The pay gap for bonus pay is -14.84% which has reduced significantly since 2024 where the gap was -33.01% This is mainly attributed to Consultant medical staff receiving historical Clinical Excellence Awards which ceased to be awarded in 2018.

Our workforce profile is 21.98% BME staff as at 31 March 2025, which represents a 0.73% increase against our 2024 data.

Reporting Requirements

There are six key indicators against which an employer must publish its calculations

1. **Mean gender pay gap** – The difference between the mean hourly rate of pay of male full-pay relevant employees and that of female full-pay relevant employees.
2. **Median gender pay gap** – The difference between median hourly rate of pay of male full-pay relevant employees and that of female full-pay relevant employees.
3. **Mean bonus gender pay gap** – The difference between the mean bonus pay paid to male relevant employees and that paid to female relevant employees.
4. **Median bonus gender pay gap** – The difference between the median bonus pay paid to male relevant employees and that paid to female relevant employees.
5. **Bonus proportions** – The proportion of males and females receiving a bonus payment.
6. **Quartile pay bands** – The proportion of males and females in each of the four pay quartiles

"Pay" includes;

- basic pay
- full paid leave including annual, sick, maternity, paternity, adoption or parental leave,
- bonus pay received in the pay period in which the snapshot date falls (bonus pay should be pro-rated where it relates to a period longer than the pay period) area, on-call and other allowances such as recruitment and retention allowances shift premium pay
- pay for piecework.

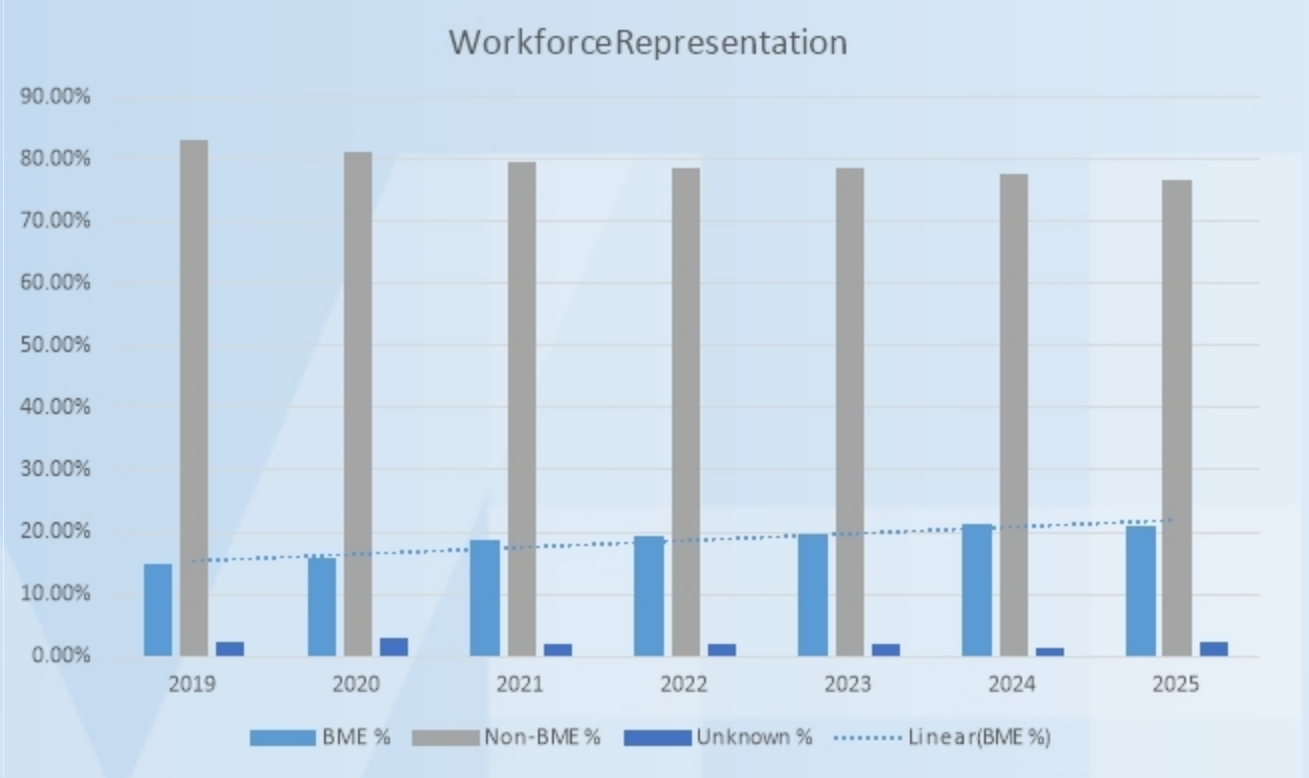
It does not include;

- overtime pay
- expenses (payments made to reimburse expenditure wholly and necessarily incurred in the course of employment, for example, mileage for use of vehicle)
- remuneration in lieu of leave
- benefits in kind (for example, child care vouchers)
- redundancy pay and tax credits.

Our Workforce Profile

Snapshot Date-31st March 2025

This chart provides details of the Trust ethnicity profile. There were a total of 1250 employees who fell under the requirements to report the ethnicity pay gap. 957 were from a White background, 264 from a BME background and 29 had not disclosed their ethnic origin to the Trust



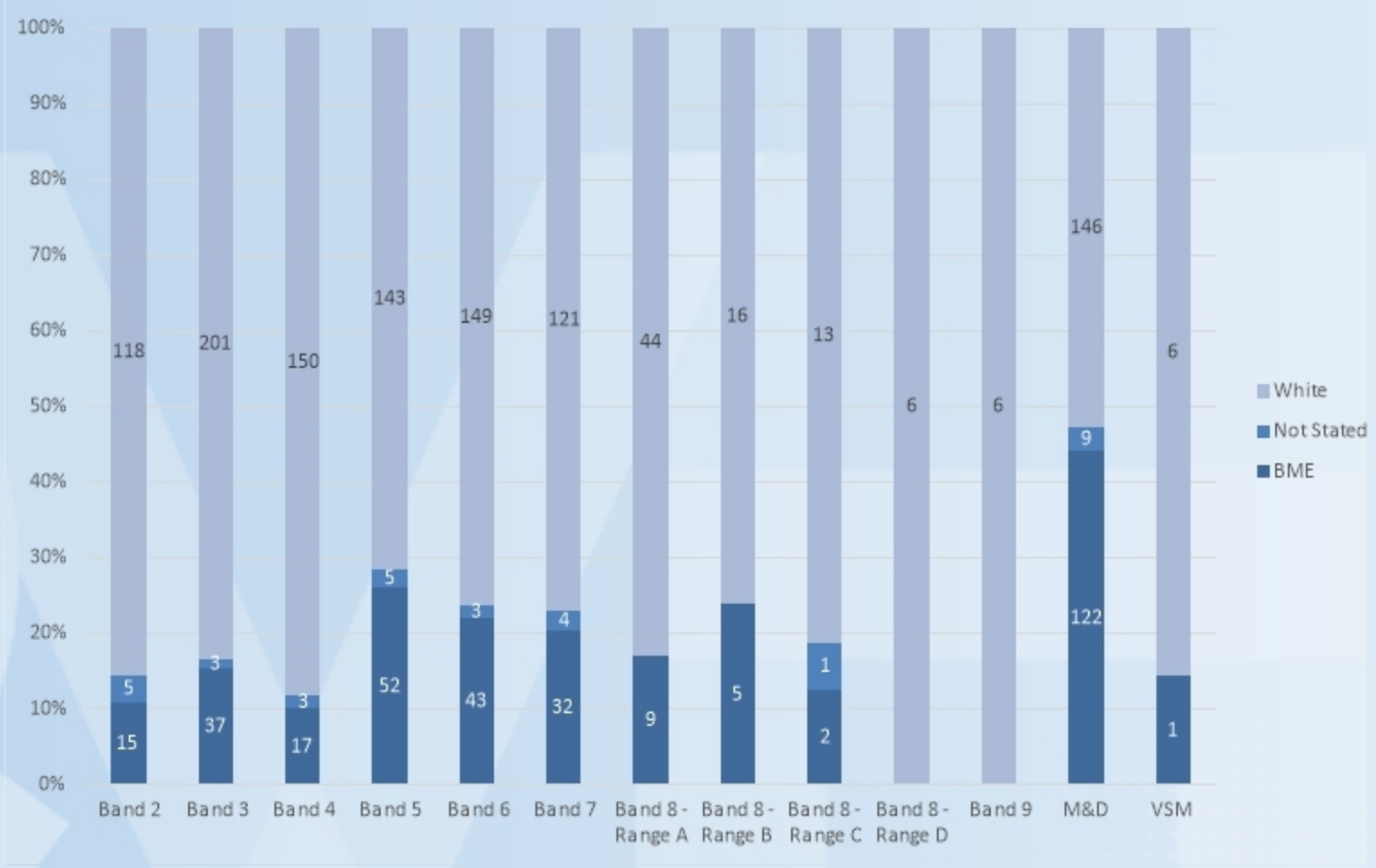
Our Ethnicity Profile by Staff Group

Pay structure

All QVH staff, except for medical and dental staff (M&D) and Trust Executive Managers (VSM) are paid on the National Agenda for Change (AfC) pay, terms and conditions of service. The terms and conditions set out band structures and pay for all employees to ensure transparency, fairness and equal treatment for all.

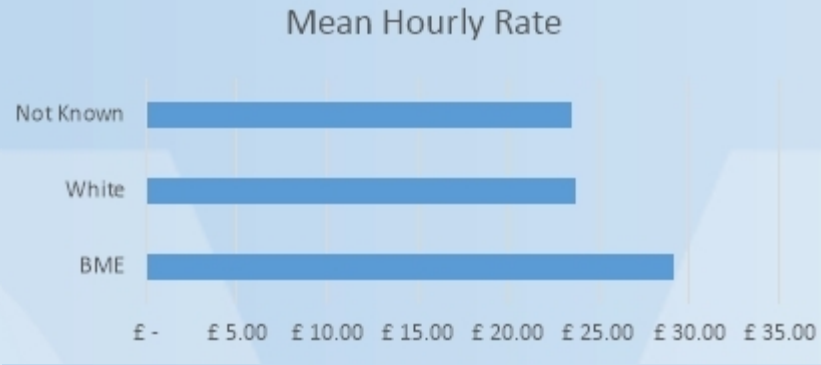
Profile across bands

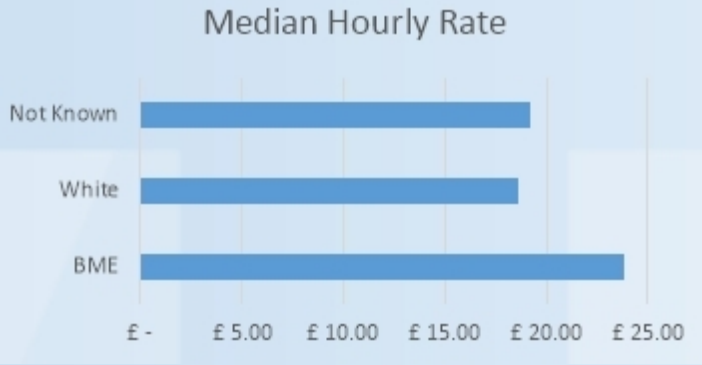
This chart details the number and percentage of BME staff within each pay bands as of 31 March 2025. While bands 2 to 8b are largely reflective of the organisation's profile, there is proportionality less BME staff at bands 8C and above, particularly at Band 8D and 9.Pay bands 8D & 9 are representative of just 6 individuals. Our M&D workforce show a greater ethnic diversity amongst their workforce



Our Ethnicity Pay Gap Data

Ordinary Pay	
Mean Ethnicity Pay Gap	-22.95%
Median Ethnicity Pay Gap	-27.53%





Bonus Pay	
Mean Ethnicity Pay Gap	-14.84%
Median Ethnicity Pay Gap	0%

Proportion of staff paid a bonus		
BME	White	Not Stated
38.50%	59.60%	1.90%

	Asian %	Black %	Mixed %	Not Stated %	Other %	White British %	White Other %
Lower Quartile	5.77	2.88	2.56	1.28	0.96	76.60	9.94
Lower Middle Quartile	11.18	2.88	1.60	3.51	1.28	72.20	7.35
Upper Middle Quartile	15.71	3.85	3.21	1.60	1.60	64.10	9.94
Upper Quartile	18.53	2.88	2.88	2.88	6.71	54.63	11.50

Our Ethnicity Pay Gap Data by Staff Group

Add prof & Tech			
Ethnic Origin Grouping Summary	Mean Hourly Rate	Median Hourly Rate	Total Full Pay Relevant Employees
BME	£29.65	£27.49	7
Not Known	£25.18	£25.18	1
White	£25.23	£25.77	33
% Diff White - BME	-17.52	-6.67	79
% Diff White - Not Known	0.19	2.29	97

AHP			
Ethnic Origin Grouping Summary	Mean Hourly Rate	Median Hourly Rate	Total Full Pay Relevant Employees
BME	£23.21	£23.06	9
Not Known	£20.51	£19.21	3
White	£24.75	£24.82	83
% Diff White - BME	6.22	7.09	89
% Diff White - Not Known	17.13	22.60	96

M&D			
Ethnic Origin Grouping Summary	Mean Hourly Rate	Median Hourly Rate	Total Full Pay Relevant Employees
BME	£47.95	£46.43	83
Not Known	£37.64	£36.25	6
White	£53.50	£53.69	108
% Diff White - BME	10.37	13.52	23
% Diff White - Not Known	29.64	32.49	94

Additional Clinical Services			
Ethnic Origin Grouping Summary	Mean Hourly Rate	Median Hourly Rate	Total Full Pay Relevant Employees
BME	£13.99	£13.52	33
Not Known	£15.55	£16.14	4
White	£13.96	£13.13	138
% Diff White - BME	-0.21	-2.97	76
% Diff White - Not Known	-11.39	-22.92	97

Estates & Ancillary			
Ethnic Origin Grouping Summary	Mean Hourly Rate	Median Hourly Rate	Total Full Pay Relevant Employees
BME	£13.90	£14.67	10
Not Known	£14.56	£14.56	1
White	£14.92	£14.15	48
% Diff White - BME	6.84	-3.67	79
% Diff White - Not Known	2.41	-2.90	98

N&M			
Ethnic Origin Grouping Summary	Mean Hourly Rate	Median Hourly Rate	Total Full Pay Relevant Employees
BME	£23.35	£21.90	75
Not Known	£19.22	£19.22	2
White	£24.14	£23.70	160
% Diff White - BME	3.28	7.59	53
% Diff White - Not Known	20.38	18.90	99

Admin & Clerical			
Ethnic Origin Grouping Summary	Mean Hourly Rate	Median Hourly Rate	Total Full Pay Relevant Employees
BME	£19.94	£15.92	36
Not Known	£21.56	£15.63	11
White	£18.72	£14.89	345
% Diff White - BME	-6.52	-6.92	90
% Diff White - Not Known	-15.17	-4.97	97

Healthcare Scientists			
Ethnic Origin Grouping Summary	Mean Hourly Rate	Median Hourly Rate	Total Full Pay Relevant Employees
BME	£21.75	£20.41	9
Not Known	£15.33	£15.33	1
White	£30.12	£25.38	29
% Diff White - BME	27.79	19.58	69
% Diff White - Not Known	49.10	39.60	97

Impacts upon our Ethnic Pay Gap

Higher proportion of White consultants at top of band and CEA's

We have a total of 98 consultants in the workforce at QVH, of which 57 (58.16% of the consultant workforce) are white and 32 (32.65%) are BME. More white consultants compared to BME consultants received bonus payments in the form of Clinical Excellence Awards (CEA's) which were historically awarded prior to 2018

We have a higher proportion of AFC senior clinical roles at QVH filled by BME staff

As a small specialist NHS Trust, we have a higher proportion of higher banded clinical roles (Additional Professional, Scientific and Technical along with Healthcare Scientists) as a proportion of our staff compared to larger Trusts who will have a higher number of admin and clerical and nursing roles. This significantly impacts upon the Trust's pay gap as there are fewer lower banded roles across both clinical and non-clinical roles to help reduce the average pay overall and the gaps we see between White staff and BME staff.

Female staff are more likely to resign due to pay and reward than male counterparts, representing 80% of all resignations due to pay. Promotion opportunities and work-life balance were also key reasons given by our female leavers. Additionally, 33% of our staff who left to undertake further education or training were BME, and all were female, suggesting that internal career development options may be beneficial.

29% of staff who left due to work life balance declared an ethnicity within the BME group, suggesting that efforts to support a healthy work-life balance and family-friendly work options may support retention of our BME colleagues.

Our Commitment

Our People and Culture strategy, published in 2024 identifies activities and programmes that QVH continues to drive forward to promote pay balance in the workplace. Some of these activities that can support closing the gender pay gap include:

- promotion of agile, flexible and part-time working
- wider implementation of the apprenticeship programmes.
- Encourage, promote and role-model healthy work-life balance
- Applying an EDI lens through lived experience to an end-to-end review of our current internal and external recruitment processes,
- Conducting an exercise to understand the experience of women at QVH

In addition to the above activities, QVH recognises the importance of minimising the barriers for individuals from all backgrounds right from the start of their journey with the Trust. As such the People and Culture Strategy outlines a key milestone for pay equity.

To achieve this, we seek to Educate and embed strong governance across the organisation to ensure equality of opportunity with a focus on pay equity amongst our workforce. Working actively with senior managers to understand the importance of equality, whilst taking active steps to reduce disparities amongst key areas of our workforce. Active promotion of development opportunities, flexible working initiatives and recruitment of candidates are key to our delivery in this area.

Our Actions

Action	By When	Lead
A module on EDI and inclusive management will be added to the line manager's training offer in 2025-26.	Q3 2025-26	Wellbeing & Inclusion Manager
Encourage, promote and role-model healthy work-life balance and family-friendly options, such as flexible working hours and patterns, hybrid working and disconnecting after work.	Q2 2025-26	Wellbeing & Inclusion Manager
Triangulate Employee Relations case work, Freedom to Speak Up reports, Occupational Health data, Staff Survey and Pulse Survey results and Wellbeing & Inclusion insights to capture and act on themes highlighted on a quarterly basis.	Q3 2025-26	Wellbeing & Inclusion Manager
Apply an EDI lens through lived experience to an end-to-end review of our current internal and external recruitment processes, with an EDI representative available for interview panels to support the de-biasing of the recruitment process.	Q3 2025-26	DCPO
Conduct an EDI audit of all applications for career development, including apprenticeships and external learning, to establish how our disabled colleagues can be better supported to develop their careers and tackle any potential barriers.	Q4 2025-26	DCPO
Ongoing review of the structures and roles across departments specifically looking at succession planning and talent management from Band 8a to VSM.	Ongoing through 2025/26	CPO, supported by Head of OD&L
Exploration of a reverse mentoring programme, using our networks to determine areas of initial focus to support career progression.	Ongoing through 2025/26	CPO, supported by Head of OD&L
Development and implementation of a shadow board programme to develop future leaders, build board level experience and confidence to support succession planning and talent management	Ongoing through	CPO

Report cover-page					
References					
Meeting title:	Board of Directors				
Meeting date:	11/09/2025		**Agenda reference:**	**70-25**	
Report title:	Audit & risk committee assurance report				
Sponsor:	Paul Dillon-Robinson, committee Chair				
Author:	Paul Dillon-Robinson, committee Chair Ellie Simpkin, Governance Manager				
Appendices:	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 external auditor's annual report will go to the AGM on 23 September. There is an unqualified opinion, but they identified a weakness in their Value for Money (VFM) assessment, that the committee and Trust were aware of. The committee was assured on the progress and assurance that these issues have been addressed and are not continuing. - Cyber security risk was discussed, in the context of the Trust's Cyber Assessment Framework and an internal audit review of it. An action plan is place to address the areas which require further development, but is an area acknowledged as complex and changing. - Security risks are being better mitigated through renewed contracts, however, there is dependence on the availability of digital resource to deliver some of the key capital works. The Trust needs to ensure that it is clear on the level of risk it holds and that there are appropriate mitigations in place. - There is sustained progress being made across all areas to address the financial control and governance issues and assurance that they are embedded across the Trust. - Assurance has been received on the Trust's Business Continuity arrangements - Progress is being made with embedding the Trust's Risk management framework across the organisation and the revised BAFs are due shortly.				
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:	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:	70-25
Date of meeting:	11 September 2025
Report from:	Paul Dillon-Robinson, committee Chair
Report author:	Paul Dillon-Robinson, committee Chair Ellie Simpkin, Governance Manager
Date of report:	03 September 2025
Appendices:	None

Sub-committee assurance report
Audit & risk committee – 1 September 2025

Key agenda items

- **Financial assurance**
- **Auditor's annual report 2024/25**
- **Internal audit progress report**
- **Local Counter Fraud progress report**
- **Assurance on KSO4**
- **Assurance on risk management framework**
- **Operational & management governance structure**
- **Cyber/information management security effectiveness & assurance**
- **Business continuity assurance**
- **Security management effectiveness & assurance**

Alert

- Cyber security risk, which was also discussed by the Finance & performance committee, is a significant risk for all organisations and recognised as complex. Whilst the committee received assurances on the measures being taken to mitigate this risk, its focus was on an internal audit independent assessment of the Trust's own evaluation under the Cyber Assessment Framework. The committee accepted that the auditor's review was undertaken early in the Trust's internal processes and there are a number of additional national requirements for the 2024/25. An action plan is in place to address the gaps, which require further development, by end of December 2025.
- The committee received an update regarding the mitigations in place to provide assurance relating to the delivery of Key Strategic Objective 4 (to deliver sustainable services), with a focus on the short-term financial measures. It also noted the development of the Trust's Board Assurance Framework is underway, its importance and that assurances on the Key Strategic Objectives will needed to be tested further.
- Security management services are being delivered in line with their annual plan, with new contracts in place, however 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.

Assure

- There is sustained progress being made across all areas to address the financial control and governance issues which were reported to the committee back in November 2024, and resulted in the external audit Value for Money (VFM) assessment (see below). 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. The committee was particularly pleased to note the progress which has now been made to improve contract management, as demonstrated by the internal audit report on procurement compliance which received a reasonable assurance outcome.

- The committee reviewed a report on the Trust's Business Continuity arrangements which provided assurance that QVH has appropriate processes in place to deal with unexpected incidents and to react proportionately when events occur.
- Progress is being made with embedding the Trust's Risk management framework across the organisation. The recent internal audit on risk management concluded with a partial assurance outcome and progress is being made on the management actions. The committee stressed the importance of a focus on the effectiveness of mitigations and managing to risk appetite.

Advise

- The external auditor's annual report 2024/25 will be presented at the Trust's Annual General Meeting that is taking place on 23 September 2025. The report summarises the key findings from the audit which resulted in an unqualified opinion on the 2024/25 financial statements. As reported previously to the Board, there was one significant weakness identified in the 2024/25 VFM assessment relating to governance arrangements, which the committee has been monitoring (see the bullet point on financial controls in the Assure section above), and a recommendation on the monitoring financial sustainability, which is being taken forward by the Finance & performance committee.
- The revised operational and management governance structure is now in place. It is important that the Board continues to ensure that there is effective oversight and escalation of the issues and risks.
- 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 use reports to help inform 'continuous improvement'.
- Although the committee has received positive assurance on the financial control, there remains a need to be mindful of the direct award of contracts without any mini-competition.
- Implementation of management actions from internal audits is generally good, but this remains an area for ongoing focus, on both their implementation and on a timely basis. The committee stressed that management can challenge audit recommendations but, if they are accepted, they should be implemented promptly to mitigate the underlying risk.

Risks discussed and new risks identified

- There was discussion on the importance of robust management of the Trust's cyber and the security management risks.

Recommendation

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

Report cover-page					
References					
Meeting title:	Board of Directors				
Meeting date:	11/09/2025		**Agenda reference:**	**71-25**	
Report title:	Quality & safety committee assurance report				
Sponsor:	Shaun O'Leary, committee Chair				
Author:	Shaun O'Leary, committee Chair Ellie Simpkin, Governance Manager				
Appendices:	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 implementation of the Trust's Electro-Bio Medical Engineering contract is progressing well, however, the committee noted a potential financial risk for the Trust due to the actual scope of the asset base being larger than anticipated. - The committee has received assurance that the current challenges with the estates infrastructure are being managed appropriately to ensure mitigations are in place to avoid patient harm caused or impact on the quality of patient care. - The Trust has received positive results in the GMC National training survey 2025. Detailed analysis of the results has been carried out and action plans for areas requiring further attention have been developed in conjunction with the clinical/surgical tutor for each speciality. - The committee has taken assurance from a report on the findings from recent safeguarding reviews in which QVH has been a contributing organisation. - Progress is being made to improve the timely investigation, completion and closing of incidents. This will continue to be monitored over the forthcoming months to ensure that progress is sustained. The committee has requested that future patient safety reports include further analysis of the highest reported incident categories. - The committee has undertaken a deep dive review on risk 117 – medical devices and was assured on the action being taken to mitigate the risk.				
Recommendation:	The Board is asked to **note** the contents of the report.				
Action required	Approval	Information	Discussion	**Assurance**	Review
Link to key strategic objectives (KSOs):	**KSO1:**	**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:	71-25
Date of meeting:	11 September 2025
Report from:	Shaun O'Leary, committee Chair
Report author:	Shaun O'Leary, committee Chair Ellie Simpkin, Governance Manager
Date of report:	02 September 2025
Appendices:	None

Sub-committee assurance report
Quality & safety committee – 2 September 2025

Key agenda items

- **Executive Committee for Quality & Risk assurance**
- **Integrated Quality & Performance Report – month three**
- **Quality Priorities – Quarter 1 2025/26**
- **Estates update – assurance on matters relevant to quality & safety**
- **GMC National training survey 2025**
- **Update on implementation of Electro-Bio Medical Engineering contract**
- **Organisational risk register**
- **Committee effectiveness review**
- **Burns service review**
- **Clinical audit programme update**
- **Annual assessment of addressing Health Inequalities**
- **Patient safety overview & update – learning from incidents & effectiveness of response**
- **Safeguarding update**

Alert

- Although there has been progress, policy management remains an area for improvement. The committee has requested a further update on the action being taken to ensure that clinical policies are being reviewed within the specified timeframe.
- The implementation of the Trust's Electro-Bio Medical Engineering contract is progressing well, however, the committee noted a potential financial risk for the Trust due to the actual scope of the asset base being larger than anticipated.

Assure

- The committee reviewed the Integrated Quality & Performance Report (IQPR) for the month three. The Trust has maintained a high Friends and Family Test recommendation rate and improved data capture for patient ethnicity. There was one reportable patient safety incident which is being comprehensively reviewed and declared as required.
- The Patient Safety overview report for the quarter one 2025/26 – and subsequent discussion in the meeting, provided the committee with assurance on the management of risk and patient safety at QVH. Progress is being made on improving the timely investigation, completion and closing of incidents. This will continue to be monitored over the forthcoming months to ensure that the progress is sustained. The committee has requested that future patient safety reports include further analysis of the highest reported incident categories.

- The committee has taken assurance from a report on the findings from recent safeguarding reviews in which QVH has been a contributing organisation. Common themes across the cases includes the critical role of clear inter/multi- agency communication and the importance of embedding professional curiosity in clinical encounters.
- The committee has also received 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. Progress has been made to support compliance and resilience. The committee will be receiving a further update on the planned fire evacuation exercises at its next meeting.
- The Trust has received positive results in the GMC National training survey 2025, with 18 'green flags' - an increase of six from 2024. Detailed analysis of the results has been carried out and action plans for areas requiring further attention have been developed in conjunction with the clinical/surgical tutor for each speciality.

Advise

- The Trust has received the outcome of the review of the Burns service review undertaken by the NHS England South-East Regional Specialised Commissioning Team. Overall, the service is recognised for delivering high quality, compassionate care with consistently positive patient feedback and a strong, motivated workforce, however, there are challenges. QVH has established a task & finish group to oversee the delivery of an improvement plan to explore what further compliance with national standards can be achieved and outline realistic long-term solutions for the service.
- The committee has undertaken its annual effectiveness review. The overall outcome was positive. Although the quality of reports has improved, this is recognised as an area for further development in order to ensure that tangible assurance is provided to the committee.
- Good progress is being made on the delivery of the Trust's Health Inequalities Programme for 2025/26. The committee was pleased to note that there is good engagement from staff and that ethnicity data capture has improved from 79.6% to 85.5% since April 2025.
- Delivery of the Trust's clinical audit plan 2025/26 is on track.
- Progress is being made to deliver the Trust's Quality Priorities 2025/26. One project for improvement for quarter 1 has been completed and all other projects for improvement are in progress with named project leads in place. The committee will continue to receive updates on the progress and impact of the work throughout the year.

Risks discussed and new risks identified

- The committee has undertaken a deep dive review on risk 117 – medical devices and was assured on the action being taken to mitigate the risk.
- Discussion was had on the mitigating action being taken to reduce the score of risk 176 which relates to the storage temperature of medicines. The need to prioritise a long term solution is recognised.

Recommendation

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

Report cover-page					
References					
Meeting title:	Board of Directors				
Meeting date:	11/09/2025		**Agenda reference:**	**72-25**	
Report title:	Finance & performance committee assurance report				
Sponsor:	Peter O'Donnell, committee Chair				
Author:	Peter O'Donnell, committee Chair Ellie Simpkin, Governance Manager				
Appendices:	None				
Executive summary					
Purpose of report:	To alert, assure and advise the Board regarding matters considered at the last committee meeting.				
Summary of key issues	- Operational and financial performance at month 4 is broadly in line with plan - Estate management remains very challenging. Infrastructure improvements are being progressed in line with plans but there are complexities (for example fire safety) and new issues arising (for example theatre roofing). There is limited capital available, with alternative funding sources being explored. The committee has stressed the importance of ensuring that the residual estate risks for staff and patients are clear and acceptable. - Work has commenced on developing the Trust's Medium Term Financial Planning (MTFP) in line with national guidance. - Although good progress has been made, the delivery of the full year Cost Improvement Programme remains a significant challenge and risk for the Trust. - Cancer performance continues to be challenged due to the increase in the number of skin cancer referrals. - There was an update on local security management progress and future actions and the committee asked for further assurance on areas including ensuring compliance with new Terrorism Act. - Delivery of the East Grinstead Community Diagnostic Centre build remains on track with groundworks expected to commence on site in September 2025. - The committee received assurance on Electronic Patient Record go live plan which included the timeline of critical path key milestones for staff engagement, system build, testing, training and organisational readiness. - The committee receive an update on cyber security and actions to ensure we remain in line with NHS guidelines				
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: 72-25
Date of meeting: 11 September 2025
Report from: Peter O'Donnell, committee Chair
Report author: Peter O'Donnell, committee Chair
Ellie Simpkin, Governance Manager
Date of report: 02 September 2025
Appendices: None

Sub-committee assurance report
Finance & performance committee – 1 September 2025

Key agenda items

- **Integrated Quality and Performance Report (month three)**
- **Operational and financial update (month four) and outlook**
- **Cost Improvement Programme update**
- **Major project updates**
- **Five year plan update**
- **Update on estates infrastructure delivery**
- **Local Security Management Specialist work plan 2025/26**
- **Apprenticeship Levy annual report 2024/25**
- **Organisational Risk Register**
- **Reinforced Autoclaved Aerated Concrete (RAAC) business case – next steps**
- **Relocatable MRI Contract Renewal**

Alert

- Work has commenced on developing the Trust's Medium Term Financial Planning (MTFP) in line with national guidance. Organisations are required to submit plans to NHS England in December 2025. The committee will receive further updates as work progresses.
- The delivery of the full year Cost Improvement Programme remains a significant challenge and risk for the Trust.
- Cancer performance continues to be challenged due to the increase in the number of skin cancer referrals. The Trust is part of an NHS Sussex task and finish which is reviewing pathways and options to address the increase in the demand for services.
- The Trust continues to have patients waiting in excess of 65 weeks, largely within breast reconstruction. Action is being taken to provide more capacity to reduce the long waiting position, however, it is likely that this will remain a challenge going forward.
- Although there has been some significant progress on the Bognor Community Diagnostic Centre (CDC) the project is rated red/amber due to risks relating to finances, resourcing, and external stakeholder influences.
- The committee received an update on work being undertaken to progress the Trust's Local Security Management Strategic Work Plan 2025/26. Security

reviews have been undertaken to inform action plans and priorities and address security weaknesses, taking into account the nature of the buildings and hospital site. The committee asked for further assurance on areas including ensuring compliance with new Terrorism Act.
- Work continues to deliver the estates infrastructure improvements. There is limited capital available, with alternative funding sources being explored. 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.

Assure
- Despite the challenges, the Trust met its planned month three and month four performance against the 2025/26 operational targets for Referral to Treatment for first appointments and 18 week performance, and the Cancer Faster Diagnosis Standard.
- The overall CDC activity plan was achieved in month four. Action plans are in place for the underperforming modalities.
- The reported year to date financial position at month was a deficit of £0.5m which is in line with plan. Discussion was had on the best and worst case scenario forecasting and the measures which can be taken to manage the Trust's cash flow.
- Delivery of the East Grinstead CDC build remains on track with groundworks expected to commence on site in September 2025.
- The committee received assurance on Electronic Patient Record go live plan which included the timeline of critical path key milestones for staff engagement, system build, testing, training and organisational readiness. The plan to maintain hospital activity during the go live phase was noted. And discussion was had on the implementation of the new Patient Administration System (PAS) which will be key in delivering the benefits realisation from the EPR.

Advise
- In 2024/25 QVH supported 55 apprentices across 22 different apprenticeship standards. 76% of annual levy income was spent against a target of 75%, an increase from 70% in 2023/24. The action plan for 2025/26 includes the promotion of apprenticeship uptake amongst underrepresented groups and will be monitored by the Executive Leadership Team.
- The committee supports the Executive Leadership Team's approach to developing a business case for the rebuilding of the medical photography site which has now been demolished to remove Reinforced Autoclaved Aerated Concrete (RAAC). The Trust will now proceed to engage design consultancy services to develop the business case which will come to the Board for approval. The award of the build contract will follow due process once the business case has been agreed. This approach means that the programme will slip into 2026/27 which creates a potential risk to the availability of capital funding. This risk is acknowledged and will be managed by the Executive Leadership Team.
- The contract renewal for the Trust's relocatable MRI scanner was approved.
- The committee received an update on the delivery of the Trust's Cyber Assurance Framework – Data Security and Protection Toolkit (CAF-DSPT) action plan and the mitigations which are in place to manage the current risks. The committee will receive further updates as work progresses.

Risks discussed and new risks identified

- The committee has queried whether a risk relating the constraints on the capital funding available to address the aging estate should be added to the organisational risk register.

Recommendation

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