Bundle Public Board 12 February 2026

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116.26 Welcome, apologies and declarations of interest

Angela McNab, interim Trust Chair

117.26 Draft minutes of the public meetings held on 13 November 2025 and 16 December 2025

Angela McNab, interim Trust Chair
Approval

Minutes- PUBLIC Board meeting- 13 November 2025 DRAFT V1
Minutes- PUBLIC Board meeting- 16 December 2025 DRAFT V1

118.26 Matters arising and actions pending from previous meeting

Angela McNab, interim Trust Chair
Review

118-26 PUBLIC Matters arising

119.26 Patient story

Liz Blackburn, acting Chief nursing officer
Discussion

120.26 Senior independent director's report

Shaun O'Leary, Senior independent director
Assurance

120-26 Senior independent director's report

121.26 Chief executive's report

Abigail Jago, acting Chief executive officer
Assurance

121-26 CEO's report January 2026 V2

122.26 Integrated quality and performance report

Kirsten Timmins, Chief operating officer
Assurance
Digital update (Helen Edmunds, Chief people officer)

122-26 (FC) IQPR M7
122-26.1 IQPR M7
122-26.2 Bi-annual digital report for Trust Board V2

123.26 Freedom to Speak Up Guardian report

Jackie Doherty, Freedom to Speak Up Guardian
Assurance

123-26 (FC) FTSU Guardian report
123-26.1 FTSU Guardian report January 2026

124.26 Annual review of raising concerns

Liz Blackburn, acting Chief nursing officer
Helen Edmunds, Chief people officer
Assurance

124-26 Annual review of raising concerns February 2026

125.26 Board Assurance Framework

Leonora May, Company secretary
All executive directors
Assurance

125-26 Board Assurance Framework (BAF) Board January 2026 V2

125-26.1 BAF summary updated 4 February 2026
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125-26.8 BAF template QUALITY V8
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125-26.10 BAF template SUSTAINABILITY AND STRATEGY V6

126.26 Six monthly safe staffing review

Liz Blackburn, acting Chief nursing officer
Assurance

126-26 Bi-annual safe staffing and workforce review February 2026

127.26 Annual equality, diversity and inclusion (EDI) annual report 2024/25

Helen Edmunds, Chief people officer
Approval

127-26 (FC) Annual equality diversity and inclusion annual report 2024-25
127-26.1 Annual Equalities Report 2024-25 V2 FINAL

128.26 Audit and risk assurance

Jagjit Dosanjh-Elton, non-executive director and committee Chair
Assurance

128-26 ARC assurance report January 2026 FINAL

129.26 Quality and safety assurance

Resident doctors: ten point plan actions update
Jo Emmanuel, non-executive director and committee Chair
Assurance

129-26 QSC assurance report January 2026 FINAL
129-26.1 Resident Dr 10 point plan action update to QSC

130.26 Strategy and culture assurance

Shaun O'Leary, Senior independent director
Assurance

130-26 SCC assurance report January 2026 FINAL

131.26 Financial, workforce and operational performance assurance

Russell Hobby, Non-Executive Director
Assurance

131-26 FPC assurance report January 2026 FINAL

132.26 Any other business (by application to the Chair)

Angela McNab, interim Trust Chair
Discussion

134.26 Questions from members of the public

We welcome relevant, written questions on any agenda item from our staff, our members or the public. To ensure that we can give a considered and comprehensive response, written questions must be submitted in advance of the meeting (at least three clear working days). Please forward questions to 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.
Angela McNab, interim Trust Chair

Queen Victoria Hospital
NHS Foundation Trust

Business Meeting of the Board of Directors

Thursday 12 February 2026

Session in PUBLIC
12.00-14.00
Education centre (location 40), QVH

MEMBERSHIP
BOARD OF DIRECTORS
February 2026

Members (voting):

Interim Trust Chair	-	Angela McNab
Senior Independent Director	-	Shaun O'Leary
Non-Executive Directors	-	Jagjit Dosanjh-Elton
	-	Peter O'Donnell
	-	Russell Hobby
	-	Jo Emmanuel
Acting Chief Executive Officer	-	Abigail Jago
Chief Medical Officer	-	Tamara Everington
Acting Chief Nursing Officer	-	Liz Blackburn
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)								
Angela McNab Interim Trust Chair	Non executive director / Vice Chair of Kent and Medway Integrated Care Board Non executive of Dimensions UK Ltd	Shareholder (less than 5%) in Rapid Health	Nil	Nil	Nil	Nil	Nil	Nil
Jagjit Dosanjh-Elton Non-Executive Director	Non-executive director for Social Investment Business Foundation Non-executive director for The Social Investment Business Limited Non-executive director for Public Relations Communications Association Limited Director 100% Shareholder of Ingenious Exec Limited	Nil	Nil	Trustee for TB Alert	Nil	Nil	Sister works as Chief Nurse at Guys and St Thomas Trust. Brother in law works as a Cardiac Consultant at Pembury Hospital Kent	
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
Liz Blackburn Acting Chief Nursing Officer	Nil	Nil	Nil	Nil	Nil	Nil	Nil	Nil
Helen Edmunds Chief People Officer	Nil	Nil	Nil	Nil	Nil	Nil	Nil	Nil

Kirsten Timmins Chief Operating Officer	Nil	Nil	Nil	Nil	Nil	Nil	Nil	Nil
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							
Angela McNab Interim Trust Chair	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Jagjit Donsanjh-Elton Non-Executive Director	N/A	N/A	N/A	N/A	N/A	N/A	N/A
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
Liz Blackburn Acting Chief Nursing Officer	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Abigail Jago Acting Chief Executive Officer	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Helen Edmunds Chief People Officer	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Kirsten Timmins Chief Operating Officer	N/A	N/A	N/A	N/A	N/A	N/A	N/A
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 12 February 2026
12.00-14.00

Agenda: session held in public		
WELCOME		
116-26	**Welcome, apologies and declarations of interest** *Angela McNab, interim Trust Chair*	
STANDING ITEMS		**Purpose**
117-26	**Draft minutes of the public meetings held on 13 November 2025 and 16 December 2025** *Angela McNab, interim Trust Chair*	*Approval*
118-26	**Matters arising and actions pending from previous meetings** *Angela McNab, interim Trust Chair*	*Review*
119-26	**Patient story** *Liz Blackburn, acting Chief nursing officer*	*Discussion*
120-26	**Senior independent director's report** *Shaun O'Leary, Senior independent director*	*Assurance*
121-26	**Chief Executive's report** *Abigail Jago, acting Chief executive officer*	*Assurance*
PERFORMANCE		
122-26	**Integrated quality and performance report** *Kirsten Timmins, Chief operating officer* • **Digital update (Helen Edmunds, Chief people officer)**	*Assurance*
GOVERNANCE, STRATEGY & RISK		
123-26	**Freedom to Speak Up Guardian report** *Jackie Doherty, Freedom to Speak Up Guardian*	*Assurance*
124-26	**Annual review of raising concerns** *Liz Blackburn, acting Chief nursing officer* *Helen Edmunds, Chief people officer*	*Assurance*
125-26	**Board Assurance Framework** *Leonora May, Company secretary* *All executive directors*	*Assurance*
ANNUAL REPORTS		
126-26	**Six monthly safe staffing review** *Liz Blackburn, acting Chief nursing officer*	*Assurance*

127-26	**Annual equality, diversity and inclusion (EDI) annual report 2024/25** *Helen Edmunds, Chief people officer*	*Approval*
COMMITTEE ASSURANCE REPORTS		
128-26	**Audit and risk assurance** *Jagjit Dosanjh-Elton, Non-executive director and committee Chair*	*Assurance*
129-26	**Quality and safety assurance** • **Resident doctors: ten point plan actions update** *Jo Emmanuel, Non-executive director and committee Chair*	*Assurance*
130-26	**Strategy and culture assurance** *Shaun O'Leary, Senior independent director*	*Assurance*
131-26	**Financial, workforce and operational performance assurance** *Russell Hobby, Non-Executive Director*	*Assurance*
MEETING CLOSURE		
132-26	**Any other business (by application to the Chair)** *Angela McNab, interim Trust Chair*	*Discussion*
MEMBERS OF PUBLIC		
133-26	**Questions from members of the public** *We welcome relevant, written questions on any agenda item from our staff, our members or the public. To ensure that we can give a considered and comprehensive response, written questions must be submitted in advance of the meeting (at least three clear working days). Please forward questions to 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.* *Angela McNab, interim Trust Chair*	

	Minutes (DRAFT)	
Meeting:	**Board of Directors (session in public)** **10.00-12 noon 13 November 2025** **Education Centre, QVH**	
Present:	Jackie Smith (JS)	Trust Chair (voting)
	Jagjit Dosanjh-Elton (JDE)	Non-executive director (voting)
	Peter O'Donnell (POD)	Non-executive director (voting) [MS Teams] [from item 85-25]
	Shaun O'Leary (SOL)	Non-executive director (voting)
	Russell Hobby (RH)	Non-executive director (voting) [MS Teams]
	Jo Emmanuel (JE)	Non-executive director (voting)
	Abigail Jago (AJ)	Acting Chief executive officer (voting)
	Simon Marshall (SM)	Interim Chief finance officer (voting)
	Tamara Everington (TE)	Chief medical officer (voting)
	Kirsten Timmins (KT)	Chief operating officer (voting)
	Jane Dickson (JD)	Interim deputy Chief executive officer (non-voting)
	Helen Edmunds (HE)	Chief people officer (non-voting)
	Liz Blackburn (LB)	Deputy Chief nursing officer (Deputising for ET) (voting)
	Vivek Chaudhri (VC)	Associate Non-executive director (non-voting)
In attendance:	Leonora May (LM)	Company Secretary
Apologies:	Aleema Shivji (AS)	Associate Non-executive director (non-voting)
	Edmund Tabay (ET)	Chief nursing officer (voting)
Members of the public:	4 members of staff, 10 governors	

79-25 **Welcome, apologies and declarations of interest**

The Chair opened the meeting welcoming members of the Board and those observing the meeting. The Chair welcomed JDE to her first Board meeting as a newly appointed Non-executive director.

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 AS and ET and the meeting was declared as quorate. LB was deputising for ET.

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

80-25 **Draft minutes of the public meeting held on 11 September 2025**

The Board **agreed** that the minutes of the public Board meeting held on 11 September 2025 are a true and accurate record of that meeting and **approved** them on that basis.

81-25 **Matters arising and actions pending from previous meetings**

LM provided an update on action 3 (compliance). She reported that training is being rolled out to budget holders including policies and governing documents. The governance handbook is in development.

HE provided a written update on equalities to address action 8 (workforce annual reports). She presented the update, highlighting that: the experience of the Trust's diverse staff is typically poorer than their comparators; presenteeism has seen an increase for staff with long term health conditions; bullying, harassment and discrimination is experienced disproportionately by the Trust's disabled and BME staff. She explained that the priority actions set out within the report seek to address these particular issues.

	The Board **noted** the written updates for the actions.
82-25	**Patient story** [This item was deferred to the next meeting]
83-25	**Chair's report** JS presented the report to the Board, highlighting the following: - The main item of business for the Board currently is the strategic partnership. Work is progressing and the Board will take its decision at the public Board meeting on 16 December 2025 - There have been some changes to Non-executive director roles. SOL has been appointed as the senior independent director. POD will take over as Chair of the Strategy and culture committee and JE will take over as Chair of the Quality and safety committee - Kokila Ramalingam has joined the Council of Governors as a staff governor - JS finishes her term at the end of December 2025. There will be an opportunity at the December Board meeting for reflections The Board **noted** the updates.
84-25	**Chief Executive's report** AJ presented her report to the Board, highlighting the following: - The Trust is facing risks related to finance, its ageing estate, performance and industrial action - The Trust's financial position remains fragile but is controlled. Good progress has been made to deliver the plan, however, further work is needed to meet the breakeven year end position - QVH has been ranked the highest nationally for patient experience in the adults inpatient survey and performance well in the cancer experience survey - The electronic patient record (EPR) went live on 4 November 2025 as planned which marks a key phase in QVH's digital transformation, with further optimisation to follow. This has been a significant amount of work led by TE. AJ thanked everyone involved AJ handed over to TE who provided a more detailed update on EPR. TE reported that she took on the leadership of this project from KT who had made good progress. The system went live on 4 November at 7am as planned. Throughout go live, no appointments were cancelled and performance was maintained within the minor injuries unit. The system has been very popular and efficient. There are over 120 digital champions and the Trust's Chief digital information officer has done outstanding work. The support from NHSE has been good. The command centre will continue through the industrial action and then the project will move into the early life support phase. In response to a question, TE stated that she expected there to be central funding for the EPR optimisation although this has not materialised yet. A Board member asked how benefits of the EPR system will be tracked. In response, TE explained that baseline assessment are coming through in date streaming to the leadership team and this will be built into business as usual. The Board commended TE and the team for the success for the success of the EPR go live and thanked everyone involved for their work to get to this point. The Board agreed that the Trust must focus on broader digital transformation in the next year.

	Discussion was had about the Provider capability assessment. In response to a question, AJ confirmed that a process of moderation is taking place nationally and that she expected the Trust would hear about the outcome of the assessment within the next two weeks. Discussion was had about the Sussex acute provider collaborative. In response to a question, AJ explained that the commissioning intentions indicate that the provider collaborative is a priority. Currently there are two alliances across Surrey and Sussex and the long term intention is to align these. The Board **noted** the contents of the report.
85-25	**Integrated quality and performance report** KT presented the report to Board and provided an update on operational performance. She reported that the teams have worked hard to ensure that there have been no cancellations throughout the EPR roll out. There is industrial action starting this week and the Trust is meeting the national requirement to maintain activity of over 95%. The Trust is meeting two out of three referral to treatment (RTT) targets. The Trust is off target for the percentage of patients waiting more than 52 weeks. This has been impacted by increased cancer referrals. In month five, the Trust missed the faster diagnostic standard internal trajectory due to consultant and capacity constraints. The Trust continues to provide mutual aid where it can. [POD joined the meeting] In response to a question, KT said that she thought the embedding of QVH's continuous improvement methodology had helped with response times, with teams considering and implementing improvements to processes. A Board member asked about the performance trajectory for year end. KT confirmed that the Trust will not meet its performance target for the community diagnostic centre (CDC) and that the team will need to focus on driving further demand. KT confirmed that within the next report, the Board will see how QVH ranks against others for access standards. LB provided an update on quality and safety. She reported that there are no concerns. Ethnicity recording is continuing to improve and recommendation rates remain high. The complaints response is below target and there have been no never events. TE confirmed that Mental Capacity Act processes have been embedded into the new EPR system and she was hopeful that this would drive further improvement with compliance. A Board member noted the importance of GP engagement with the Trust's CDC work. They asked how this will be measured. In response, TE confirmed that there is a secondary care interface meeting each month and that there are positive relationships being formed. There is technical detail to work through so that GPs can engage with the Trust's systems. JD confirmed that there are GP members on the CDC programme Board and that there is an engagement plan. She agreed to bring an update back to the Board. **ACTION JD** HE provided an update on workforce. She reported that the managers training programme has launched and that focussed culture work continues with specific target areas identified. The staff survey for 2025 has launched. The Trust has a 43.2% completion rate to date. Sickness is 4% and this is driven by long term sickness in some areas. In response to a question, HE confirmed that the Trust is on track to have everything in place to meet the violence prevention and reduction standards before the end of March 2026. A Board member asked when the Trust will see the output of the sexual safety work. HE stated that there will shortly be a report available. She confirmed that there are few reports on violence

	which demonstrates that it either does not exist or that it is not being reported. She thought that the continued focus should be to encourage people to speak up. The Board agreed that conversation and soft intelligence in these areas is important. The Board asked HE to report back on soft intelligence on sexual safety and violence. **ACTION HE** In response to a question, HE confirmed that reducing time to hire remains a priority. She confirmed that delays were due to awaiting visas or occupational health clearances. SM provided an update on finance. There was a £200k deficit in month five which brought the cumulative deficit to £700k. This has been recovered in months six and seven. Currently the Trust is breaking even financially with no deficit and a stronger cash position than previously reported. There is a need to drive further cost improvement initiatives in order to meet the year end breakeven target. In response to a question, SM confirmed that a £750k-£1m deficit at year end is the worst case position and that he thought the Trust could meet breakeven. SM confirmed that this does not take into account strike action which is shown as a financial risk. SM highlighted to the Board that there is a need for the Trust to do more activity in order to meet the plan. The Trust is doing the amount of activity expected, however, the case mix is lower and the ability to recover is more challenged. KT thought that there were opportunities for increased activity within theatres and outpatients. Discussion was had related to quality impact assessments for the cost improvement initiatives. SM confirmed that there have been no quality concerns raised to date. The Board requested increased visibility of the quality impact assessments through the quality and safety committee. **ACTION LB** SM confirmed that the Trust has been awarded £2.8m of estates safety funding which will help with some critical infrastructure challenges. <u>Electronic patient record (EPR) update</u> [This item was taken with item 84-25] <u>Business planning and commissioning intentions for 2026/27</u> SM presented the report to the Board, confirming that the report was based on early briefings from national teams about the business planning guidance for 2026/27, and that further guidance is expected to be received. He thought that the cost reduction requirement for the Trust for 2026/27 would be in the region of £6.5m-£8.3m. SM thought the ask is most likely to be at the higher end, with shifts to block contracting. A Board member asked how much of next years cost saving initiatives will be attributed to the partnership. In response, SM confirmed that it will depend on which partner, the pace the Trust and the partner are able to drive savings forward and the extent to which the benefits are shared. SM thought that up to £2m might be reasonable but that this is subject to discussions with the chosen partner The Board **noted** the contents of the reports.
86-25	**National inpatient survey and Cancer patient experience survey results 2024** LB presented the report to the Board, confirming that teams are very proud of these excellent survey results and that the Trust is looking at further improvement areas. Improvement areas include improving accessibility across the site and access to services. The Board congratulated all on these positive results. The Board **noted** the contents of the report.

87-25	**Guardian of safe working report** JON was unable to attend the meeting and TE presented the report to the Board on her behalf. TE confirmed that the Trust is in a good position broadly. Rota gaps are always a risk and must continue to be monitored. There has been a slight increase in claims which will be monitored. SOL confirmed that this report has been presented to the Quality and safety committee who were assured by the noticable incremental improvement. TE confirmed that NHSE have published the ten point plan to improve resident doctors working lives. The Trust completed a self assessment and the result was very good compliance with further improvements to be made including the appointment of Chief residents which is complete and the reimbursement of study leave. The Board **noted** the contents of the report.
88-25	**Board assurance framework (BAF)** LM presented the report to the Board, confirming that the BAF has been updated in line with the current position. The report sets out the current BAF risks for closure and the new BAF risks for approval by the Board. LM confirmed that the new BAF risks indicate that the biggest risks to the Trust achieving its key strategic objectives are finance, the Trust's ageing estate, sustainability challenges and leadership and digital capacity. Discussion was had regarding the BAF and the Board agreed that the new BAF risks reflect the strategic risks which may have an impact on the Trust achieving its key strategic objectives. The Board recognised the risks and agreed that the BAF included the right level of detail for the document to be a useful and meaningful tool. Discussion was had regarding the risk score for the quality risk and whether this should be lowered given assurance available. It was agreed that the Quality and safety committee should review this at its next meeting. The Board: - **Approved** the closure of the current BAF risks as set out within the report - **Approved** the new BAF risks as set out within the report
89-25	**Organisational culture assessment** HE presented the report which was welcomed by the Board. She confirmed that data from 2024/25 with over 1000 inputs has been used for the diagnostic. The data demonstrates that the Trust largely has a 'clan culture' with a hierarchical overlay. HE highlighted that Michael West's definition of culture has been used which addresses the outstanding action in the matters arising report. The Board thanked HE for this report. A Board member acknowledged that some of the recent actions completed and shifts in leadership behaviours are already beginning to tackle some challenges that the diagnostic identifies. They highlighted the importance of not completing actions which may be reversed during an upcoming period of significant change and suggested that focus should be on creating foundations of trust and leadership visibility. The Board agreed that the culture of the organisation will be the most complex thing to manage as the Trust transitions into partnership and that this report will support the Trust in moving forward and bringing staff on the journey.

	The Board **noted** the contents of the report.
90-25	**Quality and safety committee assurance** SOL presented the report to Board, sharing that the committee were pleased to receive the national survey results which were very positive. The committee has continued oversight of complaints and were pleased that the team have reduced the complaints response time target from 40 to 30 days. SOL confirmed that the committee were assured that there has been significant improvement in the Trust's compliance with the Mental Capacity Act which has been a longstanding issue. The committee completed a deep dive on the Trust's paediatric estates issues and was satisfied that staff on the ward work hard to ensure that the experience of paediatric patients is as good as it can be, recognising the limitation of the estate. The Board **noted** the contents of the report.
91-25	**Financial, workforce and operational performance assurance** POD presented the committee assurance report to the Board, reporting that the committee are content with the progress being made on the cost improvement programme, however, there is currently no certainty about a year end breakeven position. The team have done good work in this area. Some of the savings have been non recurrent which the committee have noted cannot be repeated next year. The committee has welcomed a three year financial plan. The committee remain focussed on long waiting patients and increased pressure in this area is expected. The Board **noted** the contents of the report.
92-25	**Any other business (by application to the Chair)** There was no further business and the meeting closed.
93-25	**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 made the following comments. - The Lead governor thanked JS for her dedication and expertise as Chair, noting that she will complete her term at the end of this year - The Council of Governors have confidence that the Board will choose the right strategic partner for QVH - Governors have welcomed the culture diagnostic report

	Minutes (DRAFT)	
Meeting:	**Board of Directors (session in public)** **14.00-14.45 16 December 2025** **Education Centre, QVH/ Microsoft Teams**	
Present:	Jackie Smith (JS)	Trust Chair (voting)
	Jagjit Dosanjh-Elton (JDE)	Non-executive director (voting)
	Peter O'Donnell (POD)	Non-executive director (voting)
	Shaun O'Leary (SOL)	Non-executive director (voting)
	Russell Hobby (RH)	Non-executive director (voting) [MS Teams]
	Jo Emmanuel (JE)	Non-executive director (voting)
	Abigail Jago (AJ)	Acting Chief executive officer (voting)
	Simon Marshall (SM)	Interim Chief finance officer (voting)
	Tamara Everington (TE)	Chief medical officer (voting)
	Kirsten Timmins (KT)	Chief operating officer (voting)
	Helen Edmunds (HE)	Chief people officer (non-voting)
	Liz Blackburn (LB)	Acting Chief nursing officer (voting)
	Vivek Chaudhri (VC)	Associate Non-executive director (non-voting)
	Aleema Shivji (AS)	Associate Non-executive director (non-voting)
In attendance:	Leonora May (LM)	Company Secretary
Apologies:	Jane Dickson (JD)	Interim deputy Chief executive officer (non-voting)
Members of the public:	18 members of staff, 16 governors	

109-25 **Welcome, apologies and declarations of interest**

The Chair opened the meeting welcoming members of the Board and those observing the meeting. The Chair welcomed LB to her first Board meeting as acting Chief nursing officer.

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 about the partnership.

Apologies were received from JD and the meeting was declared as quorate. RH was joining the meeting on MS Teams.

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

JS highlighted that this was her last Board meeting as she is finishing her tenure at the end of the year. There would be an opportunity at the end of the meeting to share some reflections.

110-25 **Option appraisal- strategic partnership**

AJ presented the report to the Board which sought approval for the QVH proceeding with a strategic partnership with Royal Surrey and Ashford & St Peter's NHS Foundation Trusts (RSASP).

AJ explained that the option appraisal presented to the Board is the product of a process which started in April 2025. There has been extensive engagement with staff, clinicians, the Council of Governors and key external stakeholders including NHSE and the ICB. The option appraisal sets out the two options considered from a shortlist; a partnership between QVH and RSASP or a partnership with Surrey and Sussex Healthcare Trust (SASH). Proposals were received from both RSASP and SASH and these have been evaluated by 21 members of senior staff, over half of which were clinicians. AJ recommended that the Board progresses a partnership with RSASP based on the outcome of the evaluation which sets out a compelling opportunity to meet the Trust's long term case for change and deliver

meaningful benefits to patients. AJ highlighted that the evaluation also indicates opportunities to collaborate with SASH.

JS invited each Board member to share their views on the recommendation within the report. All Board members supported the proposal for QVH to proceed with a strategic partnership with RSASP, whilst acknowledging that there are also opportunities to collaborate with SASH. Board members shared their views as follows:

- TE acknowledged that RSASP share the Trust's vision for excellence in care and commitment to community as well as common values. TE shared that she and other clinical leaders feel that a partnership with RSASP will strengthen QVH's future and consolidate clinical collaborations, as well as enabling new collaborations with other partners such as SASH
- POD expressed thanks to both RSASP and SASH for well thought out proposals which were both credible. He commended AJ the team for what he described as a very robust process. POD thought that a partnership with RSASP would be beneficial for patients, staff and also financially. He was content that there is capacity to deliver and noted the benefits of partnering with two foundation trusts with the experience of working as a group
- SM noted that both proposals scored similarly from a financial perspective. Overall, RSASP offered a more rounded set of potential solutions, however there remain financial opportunities with SASH
- SOL thanked AJ and the team for the rigor around this process. He acknowledged the potential opportunities with SASH due to geography and supported the proposal based on the outcome of the evaluation, referencing RSASP's financial position and stable leadership
- JE supported the proposal, acknowledging synergies in specialist services with RSASP and their experience of operating within a group model
- LB commented on the alignment between QVH and RSASP regarding the importance of clinical quality for patients. She thought that RSASP's patient safety culture is strong
- VC supported the proposal, stating that he believes a partnership with RSASP will benefit patients and staff
- RH thanked the executive team for the credible work and proposal. He stated that the credibility and capacity of the RSASP leadership team stood out as well as cultural alignment, relative financial stability and their experience of working as a group. He thought that the group model enables identity of individual entities to thrive and thought that the things which QVH does well will flourish
- HE emphasised the importance of the cultural alignment between QVH and RSASP which is evident
- AS highlighted the importance of the engagement process which has been key in involving stakeholders who support this proposal
- KT thought that a partnership with RSASP will strengthen clinical service delivery and cancer services. She acknowledged leadership and cultural alignment between QVH and RSASP
- JDE supported the recommendation, stating that the evaluation of the proposals is compelling

The Board thanked AJ, the executive team and the deputy Chief strategy officer for their all of the work which has supported the Board in making this important decision about the future of the Trust, supported by extensive and meaningful engagement.

The Board acknowledged that whilst the preferred option for a strategic partnership is with RSASP, there must be continued consideration about collaboration opportunities with SASH as the Trust's closest geographic partner.

	Discussion was had regarding next steps and the Board noted that a public Council of Governors meeting will be held after this meeting to seek governor support for the Board's decision. AJ confirmed that there will now be a period of transition and planning with RSASP, NHSE and the ICB. The intention is for the partnership to be in place in the autumn of 2026. The team will be working at pace to mobilise collaboration opportunities with RSASP and SASH. The Board unanimously **approved** QVH proceeding with a strategic partnership with RSASP whilst continuing to explore collaboration opportunities with SASH and **endorsed** the next steps as outlined within the report, supporting the principle of the appointment of a shared Chair and Chief executive officer, acknowledging that there will be a process. The Chair invited the Lead governor to ask questions about the partnership on behalf of the Council of Governors. The Lead governor commented that governors support the Board's decision. She asked how the partnership with RSASP will strengthen research and innovation. TE responded to the question, stating that RSASP have a strong track record of meaningful research and have created innovative opportunities which will help QVH moving forwards. RSASP host the regional research delivery network.
111-25	**Any other business (by application to the Chair)** AJ expressed thanks to JS on behalf of the Board for all that she had done for QVH during her tenure as Trust Chair. She highlighted the poignancy of the timing; this being JS's last Board meeting and the Board agreeing a clear path to secure the long term sustainability of QVH services. She stated that the Trust would not be in this position if were not for JS. AJ acknowledged and thanked JS particularly for: • Leading with exceptional commitment, deep expertise and an unwavering sense of purpose, consistently going above and beyond • Creating an environment where people feel heard, respected and able to speak up and a culture that has strengthened the Board and supported better decision making • Remaining calm, steady and principled throughout significant challenges faced • Integrity and values driven leadership and consistency in doing the right thing The lead governor and former lead governor concurred with AJ's reflections, sharing that JS has significantly strengthened the relationship between the Board and Council of Governors, and citing their appreciation for JS consistently listening to governors and putting mechanisms in place to support governors in their role. JS reflected on her time at QVH. She stated that QVH is an exceptional organisation that cares passionately about patients and that she is pleased that QVH now has a clear future. She acknowledged the progress made to address the additional licence conditions and the positive relationship built with governors. JS expressed thanks to AJ and the executive team, the Non-executive directors, the Council of Governors and the Company secretary for their exceptional support and work during her time in the role. There was no further business and the meeting closed.
112-25	**Questions from members of the public** There were no questions received from members of public.

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	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. November 2025: Training is being rolled out to budget holders which incl. policies and governing documents. The Governance handbook is in development January 2026: Assurance report Re compliance presented to the Audit and risk committee at its meeting in January 2026. All actions set out within the Annual governance statement completed with strengthened controls. Awaiting completion of the Governance handbook before the end of 2025/26	**PENDING**
2	September 2025	67-25 68-25 69-25	Workforce annual reports	Review of findings and actions to be undertaken and an update on key concerns and prioritised actions brought to the November 2025 meeting.	**HE**	**November 2025**	November 2025: This has been included as an appendix to the matters arising report January 2026: Report presented to the Board at its meeting on 13 November 2025. Action closed	**CLOSED**
3	November 2025	85-25	Community Diagnostic Centre (CDC)	Provide an update on the engagement of GP's with East Grinstead CDC work	**JD**	**March 2026***	January 2026: Update to be included with the major projects update to FPC in March 2026	**NOT YET DUE**
4	November 2025	85-25	Sexual safety and violence prevention and reduction (VPR)	Provide an update on progress with sexual safety and VPR including soft intelligence	**HE**	**March 2026***	January 2026: Update to be provided to the Strategy and culture committee at its meeting in March 2026	**NOT YET DUE**
5	November 2025	85-25	Quality impact assessments	Provide continuous updates on quality impact assessments related to the cost improvement programme through the Quality and safety committee	**LB**	**March 2026***	January 2026: Update to be provided to the Quality and safety committee at its meeting in March 2026 and bi-monthly thereafter	**NOT YET DUE**

Report cover-page					
References					
Meeting title:	Board of Directors				
Meeting date:	12/02/2026		**Agenda reference:**	**120-26**	
Report title:	Senior Independent Director's report				
Sponsor:	Shaun O'Leary, Senior Independent Director				
Author:	Shaun O'Leary, Senior Independent Director				
Appendices:	None				
Executive summary					
Purpose of report:	To provide the Board with an update on Trust Chair arrangements.				
Summary of key issues	At its private meeting on 16 December 2025, the Council of Governors agreed to appoint Angela McNab as the Trust's interim Chair from January- September 2026. This followed a robust recruitment process lead by the Council of Governors Appointments committee. The interview panel was made of up majority governors, the Senior Independent Director, a QVH Non-executive director, a representative from NHSE and a representative from Surrey and Sussex integrated care Board's. Angela will be focusing on helping us drive forward the implementation of the strategic partnership and will support us as we move to a shared Chair and Chief Executive with the Royal Surrey NHS Foundation Trust and Ashford and St Peter's Hospitals NHS Foundation Trust group. I would like to take this opportunity to welcome Angela to the Board. At its meeting on 16 December 2025, the Council of Governors confirmed its support for the partnership with the Royal Surrey NHS Foundation Trust and Ashford and St Peter's Hospitals NHS Foundation Trust group as well as support to appoint a shared Chair and Chief executive officer as a key pillar of the partnership. Jackie Smith finished her tenure as Trust Chair on 16 January 2026. At Jackie's final Board meeting in December, we agreed a clear and shared path to secure the long-term sustainability of our services. I would like to thank Jackie once again for all that she has done during her tenure as our Trust Chair.				
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:	BAF risk related to leadership capacity				
Organisational risk register:	None				
Regulation:	None				
Legal:	Council of Governors statutory duty to appoint the Trust Chair				
Resources:	None				
Assurance route					
Previously considered by:	NA				
Next steps:	NA				

Report cover-page					
References					
Meeting title:	Board of Directors				
Meeting date:	12/02/2026	**Agenda reference:**	**121-26**		
Report title:	Chief Executive Officer report				
Sponsor:	Abigail Jago, Acting Chief Executive Officer				
Author:	Kathy Brasier, Deputy Chief Strategy Officer Allison Hunter, Strategy Support Officer				
Appendices:	None				
Executive summary					
Purpose of report:	This report outlines the main developments to be brought to the Board's attention since the last public Board meeting.				
Summary of key issues	• QVH has delivered the month 8 financial plan. Continuing to accelerate progress in the Better Value programme and increased elective patient activity delivery is essential to achieve the planned year-end break-even position. • QVH is behind plan in delivery of the trajectory for zero patients waiting greater than 65 weeks by December 2025, outside of breast reconstruction services. Although the aggregate trajectory is on track, delivering zero patients other than breast reconstruction by December 2025 is behind plan. Challenges also remain in regard to 62 day cancer performance. Recovery plans are being further developed to strengthen management, oversight and assurance. Harm review processes continue in line with routine process. • There remains considerable financial challenge as we plan for 2026/27 and beyond. • East Grinstead Community Diagnostic Centre build is in progress. There is a risk of delay to the build which may have financial impact. Work is underway to mitigate the risk. • Key risks for the organisation relate to the financial position, estates challenges, delivery of performance standards and managing the impact of industrial action.				
Recommendation	The Board is asked to **note** the contents of the report.				
Action required	Approval	**Information**	Discussion	Assurance	Review
Link to key strategic objectives (KSOs):	**KSO1:**	**KSO2:**	**KSO3:**	**KSO4:**	**KSO5:**
	To deliver outstanding care	***To innovate and improve***	***To be an excellent employer***	***To deliver sustainable services***	***To collaborate with others***
Implications					
Board assurance framework:	All				
Organisational risk register:	None				
Regulation:	None				
Legal:	None				
Resources:	Resource impact as identified within the report.				
Assurance route					
Previously considered by:	NA				
Next steps:	NA				

Report to:	Board of Directors
Agenda item:	121-26
Date of meeting:	12 February 2026
Report from:	Abigail Jago, Acting Chief Executive Officer
Report author:	Abigail Jago, Acting Chief Executive Officer Allison Hunter, Strategy Support Officer Kathy Brasier, Deputy Chief Strategy Officer
Date of report:	08 January 2026
Appendices:	None

Chief Executive Officer (CEO) report

Alert

- QVH has delivered the month 8 financial plan. Continuing to accelerate progress in the Better Value programme and increased elective patient activity delivery is essential to achieve the planned year-end break-even position.
- QVH is behind plan in delivery of the trajectory for zero patients waiting greater than 65 weeks by December 2025, outside of breast reconstruction services. Although the aggregate trajectory is on track, delivering zero patients other than breast reconstruction by December 2025 is behind plan. Challenges also remain in regard to 62 day cancer performance. Recovery plans are being further developed to strengthen management, oversight and assurance. Harm review processes continue for long waiters in line with routine process.
- There remains considerable financial challenge as we plan for 2026/27 and beyond.
- East Grinstead Community Diagnostic Centre build is in progress. There is a risk of delay to the build which may have financial impact. Work is underway to mitigate the risk.
- Key risks for the organisation relate to the financial position, estates challenges, delivery of performance standards and managing the impact of industrial action.

Assure

- The Trust continues to deliver its planned capital improvements within the financial envelope available. £2.8m of additional Estates Safety capital funding and £0.75m of digital capital funding was confirmed during November and December which will allow us to reduce many of our immediate high-level estate risks and accelerate the next stage of our digital programme.
- Following the launch of the Electronic Patient Record (EPR) programme as planned on 4 November, go live support with a command centre was maintained throughout November Industrial Action. Potential Clinical Safety risks identified prior to go live are being closed down and optimisation is underway. Digital transformation priorities have been agreed for the coming year including replacement of the Patient Administration System (PAS) in 2026/27.
- Work is now focused on progressing the strategic partnership with Royal Surrey NHS Foundation Trust and Ashford and St Peter's Hospitals NHS Foundation Trust Group (RSFT & ASPH). This includes developing clear timelines, governance arrangements, and engagement plans to support effective implementation and optimise the benefits for patients and staff.

Advise

- The Trust submitted its first business plan on the 17 December in line with the national timetable. The Trust continues to develop and refine this plan further for the second submission which is due on the 12 February. Full contract offers have still to be received from our commissioners who continue to work through the national allocations. Whilst these are outstanding there remains a risk that the assumed activity levels, performance

requirements and financial envelopes, including our better value programme, may not fully align.

- Under the new national requirement within the National Oversight Framework (NOF), the Trust is currently ranked 30th nationally (previously 29th). This slight decrease reflects improvements made by other trusts. However, QVH's position could not increase further due to restrictions linked to the financial override.
- The Trust experienced an increase in staff sickness due to colds and flu and many hospitals were reporting increased patient attendance because of these symptoms. Combined with reports locally and nationally of a surge in flu cases, in early December, the Trust took the decision to introduce face masks in all clinical areas. This was stood down at the beginning of January. As of 21 January our staff uptake of the flu vaccine was 52.2%, which has exceeded the national requirement of a greater than 5% improvement to last year.
- Work continues in partnership with the University of Chichester to plan the refit of an existing building to develop the Bognor CDC and to work with the Integrated Care Board and partners re long term management.
- From Saturday 10 to Monday 19 January QVH was in Business Continuity due to an ongoing water supply situation in East Grinstead and the surrounding areas. During that time water was fed to the site via tankers by South East Water operating in a shuttle system. On the afternoon of Monday 19 January, QVH was returned to the mains water supply once South East Water and QVH were assured the supply to the Trust could be maintained. Changes to some outpatient service delivery locations were implemented to mitigate patient impact. 4 patients had their outpatient appointments cancelled due to the incident. Thanks to all staff for the effective team working in managing this incident.

National and Local Updates

Integrated Care Board Leadership

As part of the Surrey and Sussex ICB transition, a new Joint Executive Team has been appointed. The confirmed roles for the Joint Executive Team sit alongside Karen McDowell, Chief Executive NHS Surrey Heartlands and NHS Sussex Integrated Care Boards and Mark Smith, Deputy Chief Executive and Transition Director. The new Joint Executive Team came into effect from the 1 December 2025, with a gradual period of transition.

Ian Smith, the newly appointed joint Chair of the NHS Surrey and NHS Sussex Integrated Care Boards (ICB), recently visited QVH. During his visit, Ian met with our staff in Theatres, Prosthetics, Sleep, Corneoplastic Outpatients and the Local Anaesthetic Unit (LAU) to find out more about our role as a leading specialist centre for reconstruction and sleep, and the essential healthcare services we provide for local people. We would like to thank everyone involved in the visit. Ian provided us with some positive feedback reflecting the hard work and dedication of our teams.

Provider Collaboratives

Over the past year, the Provider Collaborative has strengthened its position with a shared vision for improving outcomes across Surrey and Sussex. It has also actively learned from other NHS collaboratives, refining its approach to ensure greater efficiency, sustainability, and impact. The 2026 plan will be shared in the coming months and will focus upon streamlining governance, enhancing collaboration with NHS partners to improve services and formalising a joint approach through the Neighbourhood Alliance.

Finance and Performance

For Month 8 the Trust reported a surplus of £48k, which increased year-to-date surplus position to £94k in line with plan. Whilst our position at Month 8 remains positive and on plan, there will need to be an acceleration in both the delivery of our Better Value programme and

elective activity levels to assure the planned break-even position for the year. To date £7.6m of Better Value schemes have been identified and are in progress. Actual delivery to month 8 was £4.8m in line with plan.

From an operational performance perspective for Month 8, the Trust met all three of the Referral to Treatment (RTT) elective care targets: time to first appointment, 18 week wait performance, and 52 week wait performance. QVH reported 52 patients waiting over 65 weeks in Month 8, meeting the aggregate trajectory for 65 week waits submitted to the Integrated Care Board (ICB) and NHS England (NHSE), however the reduction of patients that are not in the breast reconstruction cohort is behind plan. Insourcing and outsourcing continues to be used to provide additional capacity to treat long waiters.

Urgent Emergency Care (UEC) performance achieved 99% meeting national standard and internal trajectory. Diagnostic Waiting time (DM01) performance continued to demonstrate improvement delivering 91.73%, with recovery in both CT scan and sleep performance.

Quality and Safety
Edmund Tabay stepped down from his position as Chief Nursing Officer at QVH, effective 1 December 2025. Liz Blackburn, Deputy Chief Nursing Officer is now Acting Chief Nursing Officer.

Quality and safety in care was maintained throughout Industrial Action. One Never Event occurred in November, 'wrong site surgery' with no harm noted. A patient safety internal investigation is underway, with immediate learning identified and further learning to be shared.

Work is underway to improve the position regarding out of date policies. This includes risk stratification and increased executive oversight.

Strategic Partnership Development
The approval by the Board on Tuesday 16 December, endorsed by the Council of Governors, to progress a strategic partnership with Royal Surrey NHS Foundation Trust and Ashford and St Peter’s Hospitals NHS Foundation Trust Group (RSFT & ASPH), marks an important milestone for QVH. Forming this partnership will help strengthen our specialist services and support our long-term sustainability for the benefit of both patients and staff, while ensuring we continue to retain our identity.

Although the appraisal process clearly recommended a strategic partnership with RSFT & ASPH, QVH remains committed to continued collaboration with Surrey and Sussex Healthcare NHS Trust (SASH) and our wider system partners. Our intention is to maintain a system-wide approach that delivers the best possible care for patients and local communities.

We would like to thank everyone who participated throughout this process including the extensive internal and external partnership engagement sessions. Insights from these discussions played a key role in shaping the partnership assessment criteria, informing the development of strategic options and enhancing transparency, inclusivity, and clarity throughout the process.

Since the Board decision work is underway to commence planning. This includes:

- Continued Chair and Chief Executive conversations
- Virtual meeting between Clinical Directors
- Formation of a working group with strategy, governance and communication leads
- Commencing drafting of workstreams, project plans and risk register
- Sharing of information such as previous reviews and planning further review requirements.

Next steps will include defined corporate governance and programme of work to take forward the agreed workstreams, updated engagement and communication approach and confirmation of immediate priorities.

Celebrating our QVH Team

Values in Practice (VIP) Award Winners

The monthly Values in Practice (VIP) awards continues to highlight the exceptional contributions of individuals who make a significant impact across the Trust, often behind the scenes. Our October winner was Susan Haines, Staff Nurse in Outpatients, for being supportive and challenging (over staying comfortable) in her commitment to continuous improvement and professional development, shared learning and support of colleagues in her role as education lead.

Our November winner was Amy Hinz, Quality and Compliance Lead for Theatres, for listening to improve (over always knowing best) and being supportive and challenging (over staying comfortable). Amy was nominated for ensuring colleagues in theatres were prepared and advocated for ahead of the go-live of Archie Electronic Patient Record (EPR). She continues to proactively offer guidance and provide additional support which is both appreciated and impactful.

Prestigious national award recognises support for veterans

Miss Tania Cubison, Consultant Plastic Surgeon, has been awarded the prestigious Veterans Covenant Healthcare Alliance (VCHA) Merit Coin, in recognition of her outstanding leadership and long-standing commitment to improving care for veterans. Alongside her exemplary clinical practice, Tania has served as a Lieutenant Colonel in the Royal Army Medical Corps. This award reflects both her expertise and her dedication to the Armed Forces community.

QVH has a proud military heritage, and our accreditation with the VCHA, together with our involvement in national Ministry of Defence employer schemes, underlines our ongoing commitment to supporting veterans and their families. Tania specialises in burns care and the surgical management of amputees, including pioneering surgical techniques to improve outcome for our patients.

On behalf of the Trust, I would like to thank Tania for her exceptional service to her patients and the veteran community, as well as exemplifying our Trust values.

Recommendation

The Board is asked to:

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

Report cover-page			
References			
Meeting title:	Board of Directors		
Meeting date:	12/02/2026	**Agenda reference:**	122-26
Report title:	Integrated Quality and Performance Report Month 7		
Sponsor:	Kirsten Timmins, Chief Operating Officer		
Author:	Allison Hunter, Strategy and Partnership Project Support Officer		
Appendices:	Appendix – Integrated Quality and Performance Report (IQ&PR) M7 slide pack		
Executive summary			
Purpose of report:	To discuss the Month 7 Integrated Quality and Performance Report 2025/26 with key updates from M8 and M9 data where available.		
Summary of key issues	**KSO1** - RTT- The trust has achieved the RTT 18 week performance trajectory for M7-M9. The RTT first appointment trajectory was achieved in M7 and M8, however missed the M9 trajectory by 1% meaning more people waited longer than 18 weeks for their first appointment than forecast. The 52ww trajectory was achieved in terms of patient numbers vs plan in M7-M9 (but missed the % target by 0.1% in M7). While the trust is meeting the 65ww trajectory submitted to the ICB and NHSE in overall patient numbers, the trust is behind plan for 65ww in having a cohort of patients waiting in excess of 65ww outside breast reconstruction. The agreed trajectory agreed with NHSE and the ICB is to have zero patients waiting greater than 65 weeks with the exception of breast reconstruction due to regional and national capacity challenges. The trust is focussed on bringing forward treatment times for these patients wherever possible. Cancer- The Trust was challenged in terms of meeting the Faster Diagnosis standard trajectory in M6 and M7. Performance has shown improvement and in M8 (the latest reporting month) the trust delivered both the national standard and trust trajectory. 62 day performance deteriorated in M7 and M8 and the trust did not meet the planned trajectories and is likely to remain below trajectory in M9 and M10. This is in part driven by a significant increase in urgent suspected cancer referrals during the summer and autumn of 2025, and the need to ensure the trust internal pathways are as efficient as possible. Action plans are being developed focussed on increasing use of teledermatology, strengthening oversight of the PTL, continued additional weekend sessions, and pathway improvement work supported by the Surrey and Sussex Cancer Alliance. UEC performance has met trust plan and the national standard for M7-M9. YTD at M9 the trust has delivered CDC activity (88% plan) and income (83% plan). CDC activity vs plan YTD at M9 was 88% and CDC income vs plan was 83% YTD. There is ongoing collaboration with the ICB and other Sussex providers to offer imaging mutual aid. CDC pathways are also planned to move to eRS in M11, facilitating a greater number of GP practices to access the services. Ethnicity data recording has reduced for the second month in Month 7, the drop in compliance is noted in both Plastics and OMFS directorates. Work on the Children's Model Task & Finish group continues, with work focussed on children requiring overnight stays **KSO 2** – Progress is being made against the pillars of the strategic plan and National Institute for Health and Care Research (NIHR) funded research programmes. NIHR final funding allocation for 2026 is awaited but will focus on study set up key performance indicators (KPIs).		

	Clinical effectiveness workstreams are being targeted to ensure service outcomes metrics are collected. Digital capture remains dependent on Lime Survey until IT capacity for developing apps is available. The first cohort of experience based co-design has been agreed for delivery in November. Continuous improvement (CI) training at induction is in place and discussions progress regarding aligning CI to strategic priorities. Strong (87%) compliance with Resident Doctor 10 point plan and continued progress including appointment of Resident Doctor Peer Leads. **KSO 3** – Compliance with the Violence Prevention Reduction standards has increased to 93% in M7, with full compliance targeted by March 2026 through collaboration, peer learning, and improved incident reporting and victim support. Temporary staffing remains well-managed, with bank usage at 62 whole time equivalent (WTE) in M7, at 62.5 in M8 and reducing to 56.21 in M9 and agency at 7.6 WTE at M7, reducing 6.3 in M8 and reducing to 4.36 in M9. Sickness absence is stable at 4.0% in M7 driven by long-term cases, increasing marginally to 4.1% in M8 and staying at 4.1% in M9, with increases in seasonal cough, cold and flu absences. The Trust's time to hire has improved to 47.7 days (below KPI) in M7, reducing to 33.9 days in M8 and increasing slightly in M9 to 35.18 (ranging between 8 and 51 days); Managers' Essentials and change workshops launched with further roll-out continuing into 2026. Staff survey response rate for 2025 ended at 56.02% for substantive staff; mandatory and statutory (MAST) training rates continue to improve into M8 and M9, while appraisal completion requires continued focus, with marginal improvements in completion rates in M8 and M9. **KSO 4** – At the close of October 2025, the Trust reported an Income and Expenditure position in line with planned breakeven and had a cash balance of £11.3m. Whilst an on-plan position for the year to date (YTD) remains positive, the in-month position was supported by £0.2m of non-recurrent benefits. The Trust continues to report a forecast breakeven position which assumes that income and pay will be maintained at current levels, and some planned non-recurrent benefits will be required. As at month 9 we remained on plan and forecasting to breakeven. Archie Electronic Patient Record (EPR) went live successfully as planned on Tuesday 4th November. Freedom of Information (FOIs) requests responded to within 20 days has decreased in M7 to 71.8%, as older FOIs are being responded to. There was a further decrease in M8 to 67.2% and an improvement in M9 to 71.7%. This continues to be an area of focus through the Information Governance Group and Digital Steering Group, with a follow up sent to managers and Executive Directors for responses to be agreed and sent back to the requestor in a timely manner.				
Recommendation:	The Trust Board is requested to review the Month 7 IQ&PR position				
Action required	Approval	Information	**Discussion**	Assurance	Review
Link to key strategic objectives (KSOs):	**KSO1:**	**KSO2:**	**KSO3:**	**KSO4:**	**KSO5:**
	To deliver outstanding care	***To innovate and improve***	***To be an excellent employer***	***To deliver sustainable services***	***To collaborate with others***
Implications					
Board assurance framework:	BAF 1 – Outstanding patient Care. BAF 4- long term sustainability (the IAF supports the delivery of the Trust's strategy BAF5- compliance				
Corporate risk register:	The IQPR reflects the risks on the organisational risk register.				
Regulation:	ICS, NHS England, CQC				
Legal:	None				
Resources:	None				

Assurance route				
Previously considered by:	Finance & performance committee Quality & safety committee			
	Date:	20.01.26	Decision:	
Next steps:				

Queen Victoria Hospital
NHS Foundation Trust

Queen Victoria Hospital

Integrated Quality and Performance Report

Month 7: November 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	Oct-25	£0.0m (surplus)	£0.0m (surplus)	£0.5m (surplus)	The Trust's Income and Expenditure position was in line with the planned in month surplus	
RTT> 52 weeks as a proportion of waiting list	1%	Oct-25	1.50%	1.6%	1.96%	Not achieving target in month.	
Cancer 62 days	75%	Sep-25	81.8%	77.4%	77.4%	Achieving target. Common cause - no significant change.	
% Overall FFT Recommendation Rate	90%	Oct-25	90%	95.1%	94.9%	Achieving target. Common cause - no significant change.	
Trust vacancy rate (excluding bank and agency)	8%	Oct-25	7%	4.6%	4.5%	Achieving target. Special cause – improving variation.	

Major Project	This Month	Overall Status	Last Month	Summary
To deliver the Community Diagnostic Centre (CDC) programme at East Grinstead and Bognor (respectively)		On track (East Grinstead) On track (Bognor)		Works commenced on 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 for revised timescales		Full re-evaluation of programme across the Sussex system given complexity and scale of programme, with revision of QVH LiMS/ICE go live to 2027.
To implement year one of the Electronic Records Programme (EPR)		On track		We went live successfully on Tuesday 4th November as planned and are transitioning to a BAU state.

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 continues to have a challenging financial outlook for the year ahead with risks around the full delivery of savings and the expected levels of activity in order to achieve the breakeven plan in 2025/26. Additional mitigating actions are being put in place to support the required trajectory to the year end.
- The strategic partnership options appraisal is in progress to ensure long-term sustainability for the organisation. Timeline remains on track for Board decision and approval in December 2025.
- The Trust has seen a significant increase in skin cancer referrals, which mirrors the national position, and consultant capacity at spoke sites has impacted the Trust's cancer performance in the second quarter of the year. Looking forward, the trust is at risk of missing the trust 62 day cancer trajectory in M7 and M8 given the significant increase in cancer referrals over the summer months. The trust is actively engaged in improvement work supported by the Surrey and Sussex Cancer Alliance and the ICB.
- CDC activity continues to be behind plan in M7 at 96% (93% of income vs plan), driven by a requirement to increase demand from GPs or other trusts. The trust is seeking opportunities to increase demand including offering mutual aid to other trusts. Income vs plan (excluding CDC activity) was 101% of plan in M7.

Assure

- The Trust achieved the planned performance metrics for RTT 18-weeks, time to first appointment, 52 week waits (in terms of patient numbers), cancer 62 days and Urgent and Emergency Care performance in our Minor Injuries Unit.
- Archie EPR went live successfully as planned on Tuesday 4th November.
- The Trust submitted its self-assessment against the Resident Doctor 10-point plan with positive feedback. An action plan is in place including appointment of Resident Doctor Peer Leads

Advise

- The Trust's Income and Expenditure YTD position was in line with the planned breakeven and had a cash balance of £11.3m. The main risks remain the delivery of best value schemes of £7.5m (6%) for the year and the required activity levels.
- Organisational culture remains a key priority for the Trust, with a culture diagnostic presented to the Board. Culture reviews are underway across a number of departments. The annual staff survey was released on 6 October and remains open until 28 November 2025 - ongoing communications / walkarounds / executive leadership continues to encourage staff survey completion.
- Negotiations continue with University of Chichester on Heads of Terms for the Bognor CDC programme. Preparations for the ground works have commenced on the East Grinstead CDC including several surveys, erection of hoarding and reduction of vegetation. . The new CDC building is due for completion in Summer 2026.

Abigail Jago
Acting Chief Executive Officer

KEY STRATEGIC OBJECTIVES – SUMMARY

Queen Victoria Hospital
NHS Foundation Trust

KSO1

- The Trust achieved the planned M7 performance targets for the three elective care Referral to Treatment (RTT) metrics (first appointment, 18 week wait, and 52 week wait performance). The Trust achieved the M6 internal cancer trajectory for 62-day standard but was challenged regarding FDS given the increase in cancer referrals compared to the previous year. The trust met the national standard for FDS of 75% but missed the internal trajectory. Urgent and Emergency Care (UEC) performance was 98%, exceeding the national standard and internal trajectory. DM01 performance improved in M7 and reported over 90% performance. CDC activity was under plan, driven by a requirement to increase demand, and equipment and space constraints. The Trust is proactively looking for opportunities to increase demand through GPs and providing mutual aid to other trusts. Trust income from all activities was 101% vs plan for M7.
- Ethnicity data recording has reduced for the second month in Month 7, the drop in compliance is noted in both Plastics and OMFS directorates.
- Work on the Children's Model Task & Finish group continues, with work focussed on children requiring overnight stays.

KSO2

- Progress against pillars of strategic plan and NIHR funded research programmes. NIHR final funding allocation for 2026 awaited but will focus on study set up KPIs.
- Clinical effectiveness workstreams targeted to ensuring service outcomes metrics collected. Digital capture remains dependent on Lime Survey until IT capacity for developing apps available.
- First cohort of experience based co-design agreed for delivery in November. CI training at induction in place. Discussions on alignment of CI to strategic priorities.
- Strong (87%) compliance with Resident Doctor 10 point plan and continued progress including appointment of Resident Doctor Peer Leads.

KSO3

- Compliance with the VPR standards has increased to 93% in M7 (from 88%), with full compliance targeted by March 2026 through collaboration, peer learning, and improved incident reporting and victim support.
- Temporary staffing remains well-managed, with bank usage at 62 WTE and agency at 7.6 WTE; sickness absence stable at 4.0%, driven by long-term cases.
- The Trust's time to hire has improved to 47.7 days (below KPI), aiming for 30 days by April 2026; Managers' Essentials and change workshops launched with further roll-out planned for 2026.
- Staff survey response at 46.2% for substantive staff @ 18 November; MAST training rates improved, while appraisal completion requires continued focus, with senior managers addressing hotspots.

KSO4

- At the close of October 2025, the Trust reported an Income and Expenditure position in line with planned breakeven and had a cash balance of £11.3m. Whilst an on-plan position for the year to date (YTD) remains positive, the in-month position was supported by £0.2m of non-recurrent benefits. The Trust continues to report a forecast breakeven position though at time of reporting, this now assumes that income will need to be at least maintained at current income per working day, that pay expenditure needs to be maintained at recent run rate levels, and some planned non-recurrent benefits will be required.
- Archie EPR went live successfully as planned on Tuesday 4th November.
- Freedom of Information (FOIs) requests responded to within 20 days has decreased in M7 to 71.8%, as older FOIs are being responded to. This continues to be an area of focus through the Information Governance Group and Digital Steering Group, with a follow up sent to 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 at the East Grinstead Community Diagnostic Centre (CDC) site, including several surveys, erection of hoarding and reduction of vegetation. CDC activity remains a key area of focus, as well as negotiations with University of Chichester on Heads of Terms for the Bognor programme.
- Two areas of transformation have been identified through the Major Services Review. This includes new models of care for Rehabilitation and Intermediate Care and Urgent and Emergency Care (UEC). These are identified as complex and cross cutting areas of transformation. Discussions regarding the leadership, governance and resourcing of the programmes are due to be further explored at the next Committee in Common (CiC) meeting.

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

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.

KSO1 EXECUTIVE SUMMARY

Queen Victoria Hospital
NHS Foundation Trust

Ethnicity data recording has fallen for the second consecutive month to 83.92%, the reductions noted in both plastics and Oral and Maxillofacial Surgery (OMFS) directorates. Smoking status compliance remained high at 99.62%. Two unwitnessed patient falls resulting in no harm.

Complaints response compliance was 77% against the target of 30-day completion for 24/25, this accounts for two complaints. Safe staffing levels were maintained across all inpatient areas, with a fill rate at 99%. No Never Events were reported. The Friends and Family Test recommendation rate remained strong at 95%, and Venous Thromboembolism (VTE) assessment compliance was recorded at 98%, above our target of 95%.

The Children's Model Task & Finish group will extend into Q4 as further work is required to ensure that provision for children requiring an overnight stay is fully understood.

From an operational performance perspective for October, the Trust met all three of the Referral to Treatment (RTT) elective care targets: time to first appointment, 18 week wait performance, and 52 week wait performance (in terms of patient numbers rather than % of waiting list which the Trust missed the target by 0.1%). While the Trust was on plan at M7 for the number of patients waiting in excess of 52 weeks, capacity to treat long waiting patients remains constrained by the significant increase in patients referred on a cancer pathway. QVH reported 54 patients waiting over 65 weeks in M6, meeting the trajectory for 65 week waits submitted to the Integrated Care Board (ICB) and NHS England (NHSE). Insourcing and outsourcing continues to be used to provide additional capacity to treat long waiters.

The Trust achieved the internal M6 trajectory for Cancer 62-day standard, despite a significant increase in urgent suspected cancer referrals. However, the Trust did not achieve the internal target for Cancer Faster Diagnostic Standard (FDS) performance in M6. Looking forward, this increased service demand is likely to impact Q2 cancer performance, particularly M7 and M8 where there is a risk the Trust will not meet the internal trajectories. Mitigation actions are underway with additional clinic and theatre lists scheduled, and collaborative transformation work with the Sussex system progressing, and support from the Surrey and Sussex Cancer Alliance around pathway improvement.

Urgent Emergency Care (UEC) performance achieved the national standard and trajectory. Diagnostic Waiting time (DM01) performance continued to demonstrated improvement, to over 90% performance, with recovery in both CT scan and sleep performance.

The Trust reported income vs plan (excluding CDC activity) of 101% in M7. CDC activity continues to be behind plan in M7 delivering 96% of activity and 93% of the monthly income vs plan. There was ongoing collaboration with the ICB and other Sussex providers to explore imaging mutual aid, and targeted communications have been distributed to GP practices.

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	Oct-25	95%			83.92%	84.60%	80.36%	77.45%	83.27%	Special Cause - improving variation
Smoking Status	Oct-25	95%			99.62%	98.95%	99.08%	97.84%	100.32%	Common cause - no signficant change
Falls per 1,000 Occupied Bed Days	Oct-25	7			2.3	1.4	4.08	-3.58	11.75	Common cause - no signficant change
Hospital Aquired PU Per 1,000 Occupied Bed Days	Oct-25	0			0.0	1.4	0.82	-2.00	3.64	Common cause - no signficant change
% Complaints Responded On Time	Oct-25	90%			77.78%	75.00%	92.85%	68.25%	117.44%	Common cause - no signficant change
Safer Staffing Compliance	Oct-25	90%			99.17%	100.00%	99.62%	98.47%	100.78%	Common cause - no signficant change
% Overall FFT Recommendation Rate	Oct-25	90%			95.08%	94.96%	95.38%	94.54%	96.22%	Common cause - no signficant change
Overall FFT Response Rate	Oct-25	25%			19.86%	22.04%	20.70%	17.30%	24.10%	Common cause - no signficant change
FFT Recommendation Rate - Inpatients	Oct-25	90%			99.19%	100.00%	99.68%	98.19%	101.16%	Common cause - no signficant change
FFT Response Rate - Inpatients	Oct-25	25%			32.89%	37.93%	38.61%	17.68%	59.55%	Common cause - no signficant change
FFT Recommendation Rate - Inpatients Children	Oct-25	90%			100.00%	99.01%	99.57%	97.96%	101.17%	Common cause - no signficant change
FFT Response Rate - Inpatients Children	Oct-25	25%			42.05%	56.11%	27.48%	-0.12%	55.08%	Special Cause - improving variation
FFT Recommendation Rate - MIU	Oct-25	90%			92.38%	91.53%	92.54%	87.74%	97.35%	Common cause - no signficant change
FFT Response Rate - MIU	Oct-25	25%			18.47%	20.26%	29.08%	-32.15%	90.31%	Common cause - no signficant change
FFT Recommendation Rate - Outpatients	Oct-25	90%			94.78%	94.78%	95.09%	94.06%	96.13%	Common cause - no signficant change
FFT Response Rate - Outpatients	Oct-25	25%			16.95%	18.82%	17.55%	15.11%	19.99%	Common cause - no signficant change
Readmissions< 30 Days	Oct-25	2%			1.83%	2.31%	2.18%	0.84%	3.52%	Common cause - no signficant change
VTE Risk Assessment	Oct-25	95%			97.90%	98.78%	97.64%	94.30%	100.98%	Common cause - no signficant change

KSO1 BALANCED SCORECARDS

Queen Victoria Hospital
NHS Foundation Trust

QUALITY & SAFETY METRICS

Metric	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25
Number of Complaints	7	4	5	8	7	4	6	7	6	9	9	9	9
Number of Open CAS Alerts	1	0	1	0	0	0	0	0	0	1	0	0	0
Number of Patient Falls Incidents	4	1	1	5	2	4	1	5	4	5	4	1	2
Number of QVH Acquired Pressure Ulcers Cat. 2 and above	0	2	0	0	0	4	2	0	2	1	1	1	0
Never Events declared	0	0	0	0	0	1	0	1	0	0	0	0	0
Medication Incidents (No and low harm)	33	18	7	4	8	12	9	6	10	15	12	12	4
Medication Incidents (Moderate harm or above)	0	0	0	0	0	0	0	0	0	0	1	0	0
Internal Investigation declared	0	0	0	0	1	0	0	0	0	0	1	0	0
Patient safety incident investigations declared	0	0	0	0	0	0	0	0	1	0	0	0	0
Mortalities	0	0	0	1	0	1	1	0	0	1	0	0	0
Hospital Acquired CDI, MRSA, E.Coli, MSSA	1	1	1	0	1	1	0	1	0	1	0	0	0
Occupied Bed Days	908	939	755	803	893	991	781	848	800	933	704	739	860
Oliver McGowan Training Compliance	92.2%	92.1%	92.2%	92.4%	92.3%	91.8%	91.9%	91.5%	91.8%	92.2%	92.4%	92.9%	92.4%

KSO1 BALANCED SCORECARDS

Queen Victoria Hospital
NHS Foundation Trust

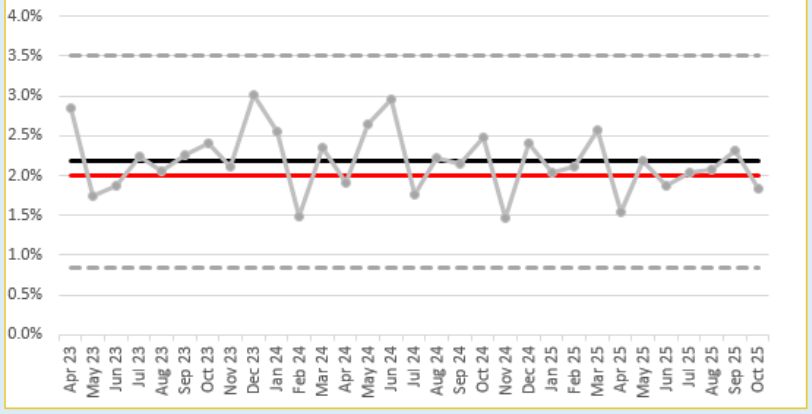
OPERATIONAL PERFORMANCE METRICS

Metric	Latest Month	Target	Variation	Assurance	Actual	Actual Previous Month	Mean	LCL	UCL	Summary
RTT 18 week wait performance - first appointment	Oct-25	75.32%			76.69%	76.45%	72.47%	68.93%	76.02%	Special Cause - improving variation
RTT 18 Week Wait Performance	Oct-25	62.35%			62.73%	64.50%	60.16%	57.25%	63.08%	Special Cause - improving variation
RTT Waiting List	Oct-25	-			19,811	19,776	18291.45	17543.64	19039.27	Special Cause - concerning variation
RTT >52 Weeks	Oct-25	-			329	387	409.16	330.96	487.37	Special Cause - improving variation
RTT >52 Weeks as a proportion of Waiting List	Oct-25	1.00%			1.66%	1.96%	2.24%	1.86%	2.62%	Special Cause - improving variation
CDC activity vs plan	Oct-25	100.00%			95.82%	91.28%	97.28%	45.99%	148.56%	Common cause - no signficant change
% Income Vs Plan	Oct-25	100.00%			101.22%	99.39%	99.71%	89.93%	109.50%	Common cause - no signficant change
Cancer 28 Day FDS	Sep-25	80.00%			77.54%	74.92%	82.07%	68.75%	95.38%	Common cause - no signficant change
Cancer 62 Days	Sep-25	75.00%			81.77%	77.37%	78.13%	65.62%	90.64%	Common cause - no signficant change
Outpatient Productivity - Patient Initiated Follow Ups (PIFU)	Oct-25	2.00%			1.80%	1.97%	1.83%	1.25%	2.42%	Common cause - no signficant change
Outpatient Productivity - Missed Appointment Rate	Oct-25	4.00%			5.30%	5.32%	5.29%	4.66%	5.91%	Common cause - no signficant change
Diagnostics 6 Week Wait Performance	Oct-25	95.00%			90.61%	88.91%	86.04%	77.69%	94.40%	Common cause - no signficant change
UEC 4 Hour Performance	Oct-25	98.00%			98.78%	98.17%	99.19%	97.63%	100.75%	Common cause - no signficant change
Theatre Productivity - % of Cancellations on the Day	Oct-25	5.00%			4.69%	5.59%	106.65%	22.59%	190.70%	Common cause - no signficant change
Theatre Elective Utilisation - QVH Site (Capped)	Oct-25	85.00%			81.99%	80.58%	82.60%	77.43%	87.77%	Common cause - no signficant change
NHS App appointments available	Oct-25	70.00%			84.45%	84.11%	84.53%	82.89%	86.17%	Common cause - no signficant change

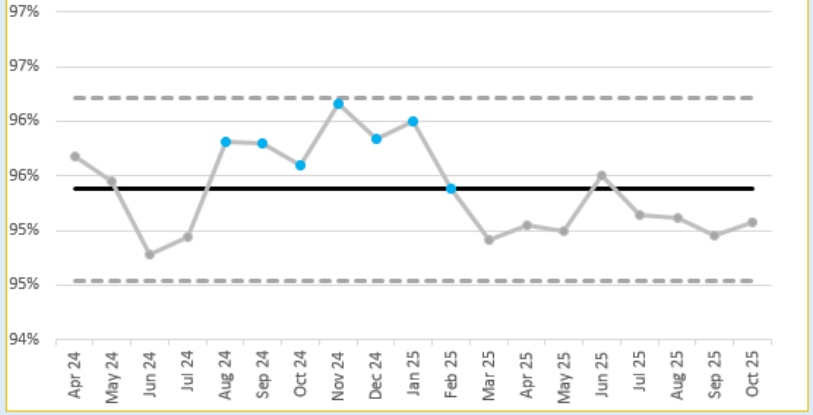
QUALITY & SAFETY METRICS

Queen Victoria Hospital
NHS Foundation Trust

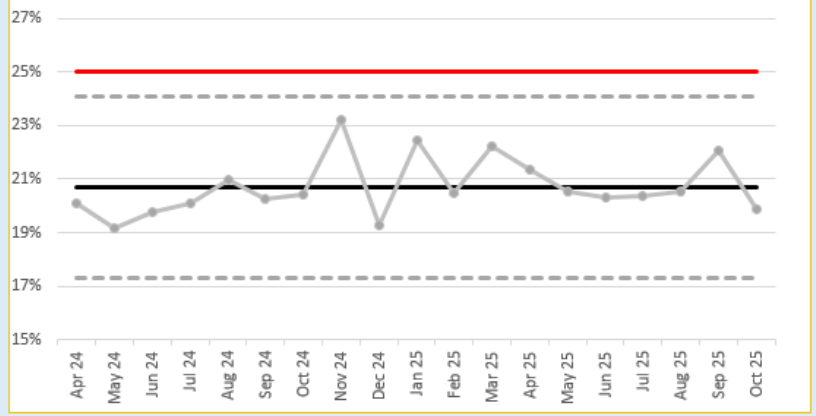
Readmissions< 30 Days



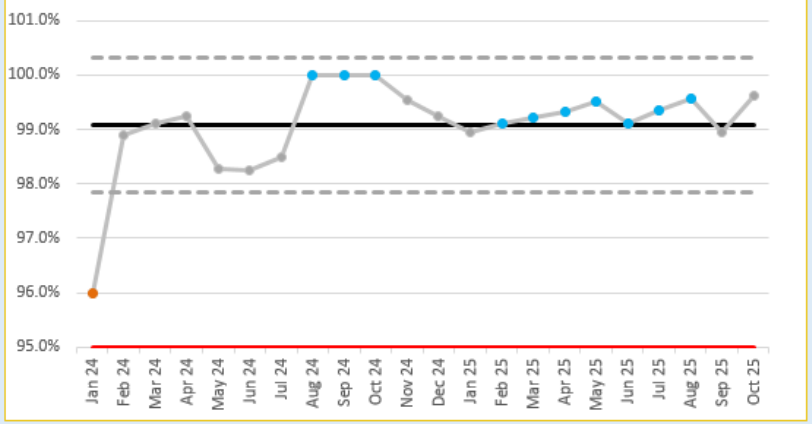
% Overall FFT Recommendation Rate



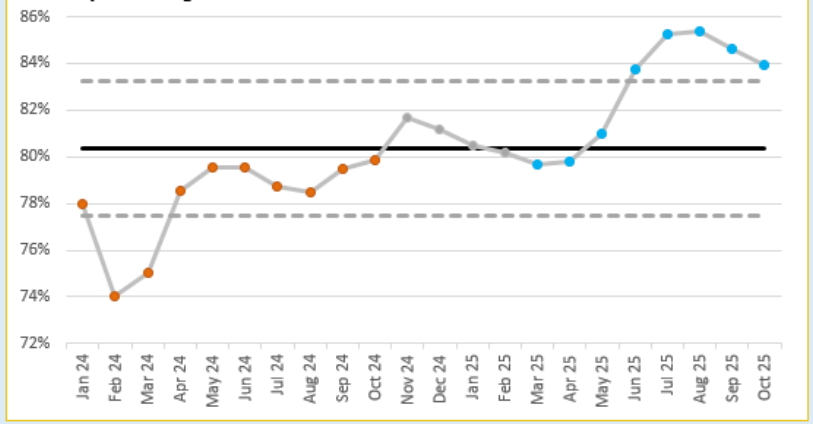
Overall FFT Response Rate



Smoking Status



Ethnicity Recording



Safer Staffing Compliance - Trust

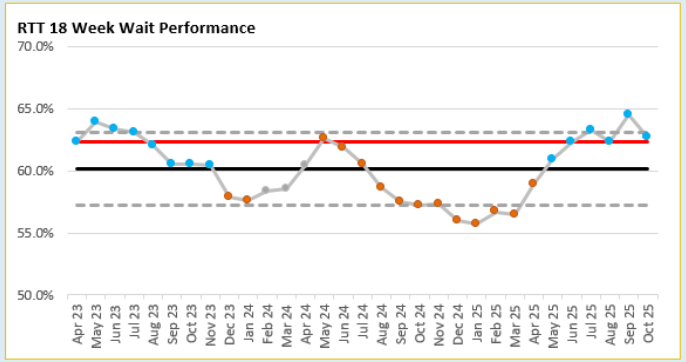
		Planned staff			Actual staff			October 2025
DAY		RN	NA	HCA	RN	NA	HCA	
		4,042.25	115.00	1,299.50	4,007.75	115.00	1,265.00	*Total Hrs Planned and Actual*
					99.1%	100.0%	97.3%	*% Planned Hrs Met*
				5,456.75			5,387.75	*Total Hrs Planned & Actual - Combined reg & support*
							98.74%	*% Planned Hrs Met - Combined reg & support*
NIGHT		Planned staff			Actual staff			
		RN	NA	HCA	RN	NA	HCA	
		3,358.00	57.50	782.00	3,358.00	57.50	770.50	*Total Hrs Planned and Actual*
					100.0%	100.0%	98.5%	*% Planned Hrs Met*
				4,197.50			4,186.00	*Total Hrs Planned & Actual - Combined reg & support*
							99.73%	*% Planned Hrs Met - Combined reg & support*
Combined		Planned staff			Actual staff			
		RN	NA	HCA	RN	NA	HCA	
		7,400.25	172.50	2,081.50	7,365.75	172.50	2,035.50	*Total Hrs Planned and Actual*
					99.5%	100.0%	97.8%	*% Planned Hrs Met*
				9,654.25			9,573.75	*Total Hrs Planned & Actual - Combined reg & support*
							99.17%	*% Planned Hrs Met - Combined reg & support*

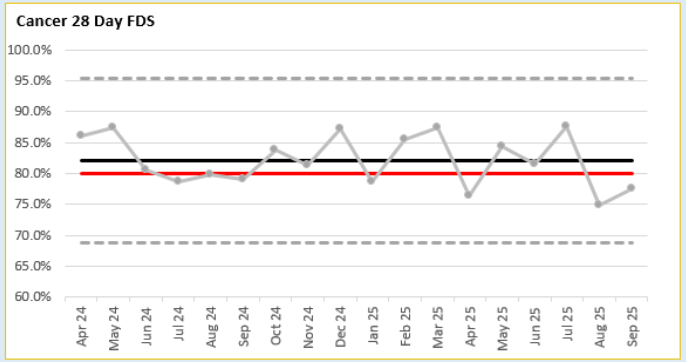
SPC Chart Key:

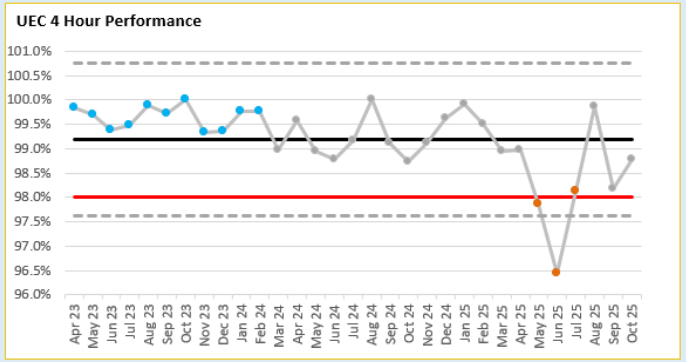
- Mean
- Target
- Process limits
- Special cause - concern
- Special cause - improvement

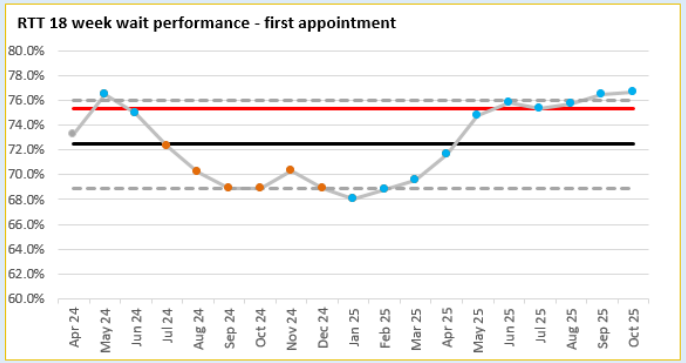
OPERATIONAL PERFORMANCE METRICS

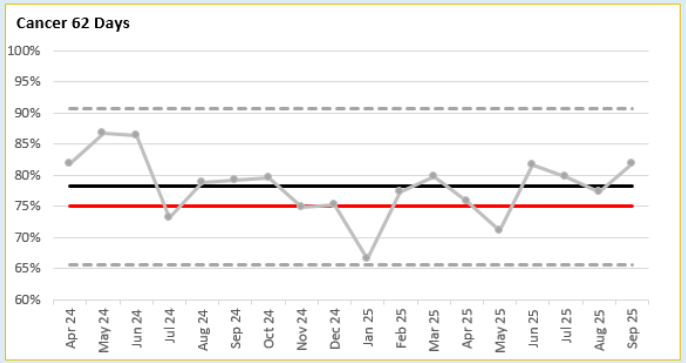
Queen Victoria Hospital
NHS Foundation Trust

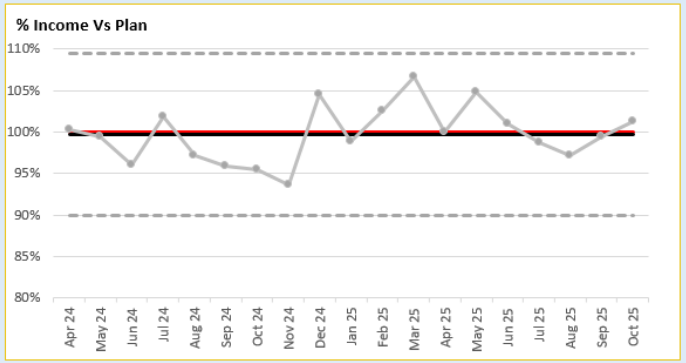


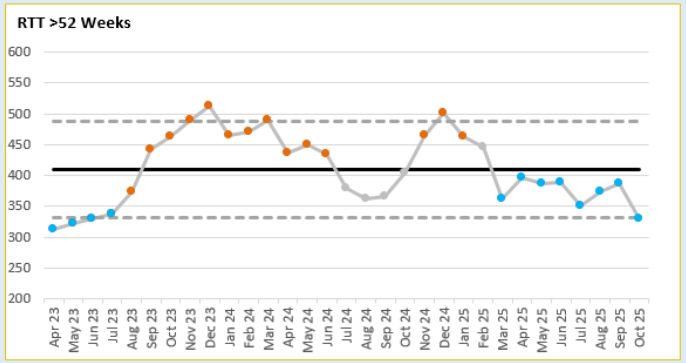


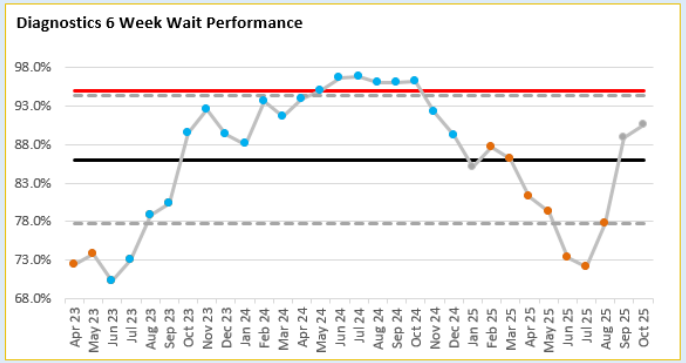


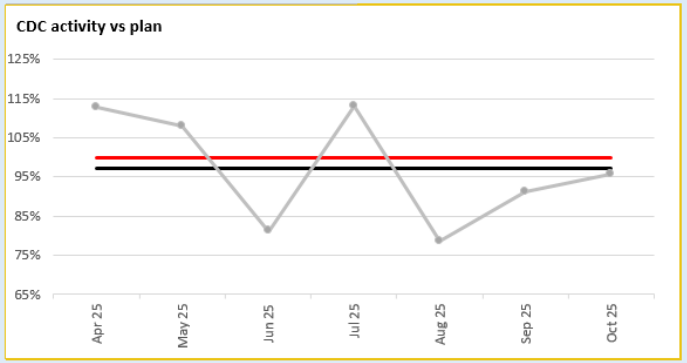












KSO1 AREAS OF FOCUS

Queen Victoria Hospital
NHS Foundation Trust

Area	Summary, impact and actions
Ethnicity Recording	A reduction in compliance was noted for a second month in M7. Improvements have been noted in Orthodontics and Sleep, this is offset by a decrease in compliance with Plastics and OMFS. Trust wide communication planned.
Smoking Status	Smoking status recording remains at 98% compliance.
Falls	Two unwitnessed falls were reported within the Trust, one within an inpatient ward, one within the therapies department, both reported as no harm.
Pressure ulcers	Zero pressure ulcers reported in M7.
% Complaints Responded On Time	Compliance with the complaints' response timeframe during the reporting period was 77%, below the target for 25/26 of 90% within 30 days. Two complaints missed the timeframe, one is a complex case requiring input from multiple sources within the directorate.
Safer Staffing Compliance	Safe staffing levels were maintained across all inpatient areas, with a fill rate at 99%.
Never Events	Zero never events were reported for this month.
Mortalities	None
% Overall FFT Recommendation Rate	The recommendation rate is 95%, a small increase from the previous month.
VTE Risk Assessment	Compliance at 97.9%, above our target of 95%.

KSO1 AREAS OF FOCUS

Queen Victoria Hospital
NHS Foundation Trust

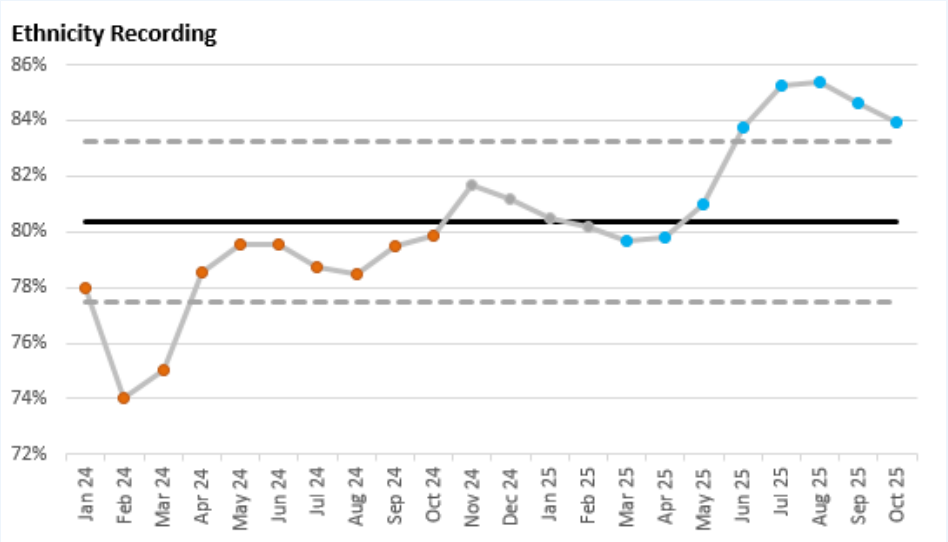
Area	Summary, impact and actions
RTT> 65 weeks	The Trust reported 54 patients waiting over 65 weeks in M7, meeting the trajectory submitted to the ICB and NHSE regarding the number of patients waiting in excess of 65 weeks. Insourcing and outsourcing continue to be used to provide additional capacity to treat long waiters.
RTT >52 Weeks %	The Trust reported 329 patients waiting in excess of 52 weeks in M7, a reduction of 58 from the previous month. While the Trust achieved its internal trajectory for M7 in terms of patient numbers, it missed the % trajectory by 0.1% given the reduced size of the overall waiting list. The Trust remains constrained by the priority to treat patients on a cancer pathway who are of higher clinical priority. The national expectation is for all Trusts to get back to plan for 52ww by December 2025.
RTT - 18 week wait - first appointment	The Trust achieved the planned trajectory for M7 and predicts to remain on plan in M8.
RTT 18 Week Wait Performance	The Trust achieved the planned trajectory for M7 and predicts to remain on plan in M8.
RTT Waiting List	The RTT Waiting List showed a marginal increase in month by 79 patients overall (from 19,776 to 19,855). While the trend is showing 'concerning variation' as the waiting list is increasing, this is in line with our operational plan. The Trust continues to participate in NHSE's 'Validation Sprint' exercise, which aims to maintain internal 12-week validation performance above 90% and ensure inactive pathways are removed from the waiting list during Q2. The Sprint will continue into Q3.
Cancer 28 Day FDS	The Trust reported 77.5% M6 performance achieving the national FDS standard of 75% yet did not achieve the Trust internal trajectory to deliver in excess of the national standard. The Trust has experienced a 12% increase in cancer referrals in 2025/26 compared to the previous year, constrained capacity at spoke sites, diagnostic delays, outpatient capacity, patient choice and late referrals continued to negatively impact on performance, which is predicted to remain challenged into M7.
Cancer 62 Days	The Trust reported 81.7% in M6, achieving the internal trajectory. The 12% increase in referrals year-to-date has significantly challenged services, and this is likely to be reflected in M7 and M8 performance which is at risk of missing the trajectory. To cope with the increased demand, the Skin service have scheduled additional clinics and theatre lists throughout the Summer months. The Trust is working with the Surrey and Sussex Cancer Alliance to review improvement opportunities within the 62 day cancer pathway, and the Trust is actively engaged in Sussex wide work to review the skin pathway opportunities in the medium to longer term.
Diagnostics 6 Week Wait Performance	DM01 performance improved in M7 to over 90%, primarily driven by the recovery of Sleep diagnostics and Cone Beam CT (CBCT) following equipment failure in M1. Overall DM01 performance is likely to remain over 90% going into Q4.
MIU 4 Hour Performance	The Trust performance (98.8%) exceeded the national standard (95%) and the internal trajectory.
% Income Vs Plan	The Trust reported 101% income vs plan for M7.
% CDC activity vs plan	The Trust reported 95.8% CDC activity vs plan in M7, an improvement of 4% from M6. This equated to 93% of CDC income vs plan. There was ongoing collaboration with the ICB and other Sussex providers to explore imaging mutual aid, and targeted communications have been distributed to GP practices. Ophthalmology (which was previously challenged by workforce, estates and equipment limitations) is forecasted to improve from M8, and Teledermatology improvements are expected from M10.

HEALTH INEQUALITIES PRIORITY PROGRESS

Queen Victoria Hospital
NHS Foundation Trust

Area	Summary and actions
Data Improvement	The Trust ethnicity data collection for October is **84.3%**, a small decrease since last month. A communication plan is in place throughout Q3 to reinforce the importance of ethnicity recording across the Trust, including patient poster, staff guidance leaflets, Connect communications and a 10-minute take-over is scheduled for Team Talk Monday 16 December Each Directorate has improving ethnicity recording as an annual goal for 2025/26, and communications are being sent to each directorate triumvirate to reiterate targets and processes.

Ethnicity data collection



Area	Summary and actions
Mental Capacity Act (MCA)	The Mental Capacity Act (MCA) task and finish group continues to oversee progress in every step of the patient pathway where adapted process can facilitate improvements in assessments and supported patient-centred decision making. Introduction of Archie EPR on 4th November shifted MCA assessment from paper forms to new MCA and best interests digital assessments.

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

Queen Victoria Hospital
NHS Foundation Trust

Research & Innovation (R&I):
The strategy for research and innovation was translated into a strategic operational plan and there has been continued achievement against this plan. This has included strengthening of governance including the implementation of a revised contract sign off process. The Associate Director of Research, Innovation and Improvement is now reporting into Chief Medical Officer to bring together the Improvement, Quality & Compliance and Medical & Dental education teams. The Health and Social Care research (NIHR) final funding allocation for 2026 has been presented in draft and a finalised version will be provided in Q4. Priority is now on key performance indicators (KPIs) relating to study set-up times to ensure optimisation of income. Strategic funded in-year projects continue with our Primary Care project and NHS Study Accelerator programmes progressing well in collaboration with partners within the local community.

Quality priority: Evidence through measurable outcomes
Clinical effectiveness workstreams have identified governance structures within each clinical directorate which are ensuring that all services have outcome projects established. Services have demonstrated clear understanding of the standards they need to deliver against. In some areas, such as orthodontics, nationally recognised outcome measurements are long established and evidence high quality delivery. The Quality & Compliance team are continually mapping against emerging standards to inform work with services. Due to IT focus on delivery of Archie EPR in Q3, the Trust has not yet progressed digital outcome applications beyond simple Lime Surveys, the ongoing digital transformation programme will evaluate the priority of Patient Knows Best and REDCaP platforms, which enable direct digital communication with patients, going forward. The Clinical Learning Forum for November has planned focussed on learning from safeguarding, antibiotic stewardship and introduction of Archie electronic prescribing.

Embed continuous improvement (CI):
The first Cohort of Experience Based Co-Design has been agreed and is due for delivery in mid-November with a further cohort planned for early 2026. A CI Mandatory Training video is now in place within the induction programme with feedback sought from first recipients. CI training remains a priority and the trust is identifying areas where CI trained resource could support delivery against strategic priorities. Three Nursing Associate Apprentices have been undertaking a five-week placement with the CI team and are being trained and supported to use 'The QVH Way' to undertake key improvement work.

Medical Education:
Assessment has shown 87% achievement against the Resident Doctors 10 Point plan with further progress since this assessment was performed: Resident doctor peer leads are now in post with two plastic surgery registrars sharing the role. At the latest Resident Doctors' Forum meeting there was generally positive feedback on training experience received. This is also being picked up via the 10 Point Plan work. October doctor's induction was well attended, and a revised process will be put in place for 2026 inductions to incorporate Archie EPR training requirements.

Tamara Everington
Chief Medical Officer

KSO3

To be an excellent employer

Ambition

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

Board Assurance Framework

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

Queen Victoria Hospital
NHS Foundation Trust

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

Queen Victoria Hospital
NHS Foundation Trust

Further work on national Violence Prevention and Reduction (VPR) standards increased the Trust compliance to 93% from 88% in M7. We continue to work towards 100% compliance by March 2026, through ongoing system collaboration / peer to peer meetings and sharing good practice. In order to reach full compliance, further work is being done to promote reporting of incidents and increasing welfare support for victims of incidents.

Temporary staffing has increased slightly in M7 with bank usage increasing from 60.04 in M6 to 62 WTE in M7, agency usage has reduced from 8 WTE in M6 to 7.6 in M7. We remain under plan for 2025-26 and one of the best performing Trusts in the South East Temporary Staffing Collaborative for our temporary staffing usage. Continued focus is through the temporary staffing reduction oversight groups and dedicated management by the Heads of Nursing.

There was 1 grievance raised in M7.

Overall sickness absence has remained at 4.0% in M7. Long-term sickness continues to drive the overall rate however it is anticipated that this will reduce in M8. Sickness absence in theatres is higher than other departments. Support for managers and from managers to staff is in place to help improve the position. The system target is 4% in the national operational planning guidance, and it remains an ambition for QVH to reduce sickness absence to 3%.

Time to hire has decreased further in M7 to 47.7 days from 51.2 days in M6 on average (below KPI of 53). Work continues to identify improvements to bring key performance indicator (KPI) down incrementally to 30 days from 1 April 2026.

The Organisational Development team and Employee Relations team launched the new Managers' Essentials programme on 20 October 2025. Two pilots are underway and feedback continues to be sought to make adjustments to the roll out planned for 2026. Leading Change and managing self through change workshops were launched in October and further sessions are being scheduled in 2026.

The Staff Survey launched on 6 October, with work underway with communications and staff survey champions to promote survey. Two staff survey walkabouts and monthly Team Talk sessions have been utilised to encourage completion of the survey and overall response rate as of 18 November is 46.2% (574/1242) for substantive staff and 19% (34/184) for bank workers.

Focussed work is ongoing for specific areas of mandatory and statutory training (MAST) compliance. Mandatory and Statutory Training (MAST) rates increased for clinical, non-clinical and bank workers in M7. Non-clinical appraisal completion saw a slight decrease in M7, however those outstanding by >3months decreased. There is an ongoing focus for managers to complete their staff appraisals. Hot spot areas are being followed up by senior managers for completion.

Helen Edmunds
Chief People Officer

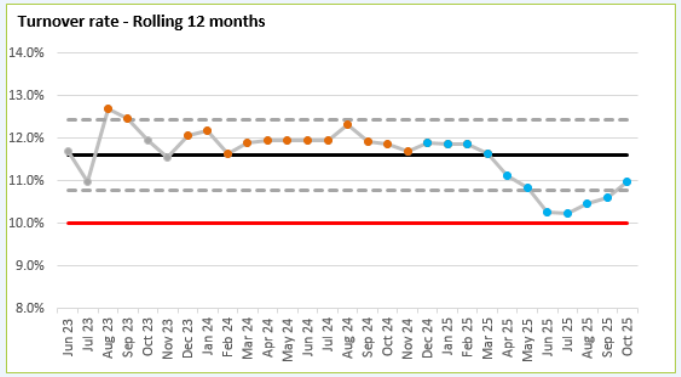
KSO3 BALANCED SCORECARD

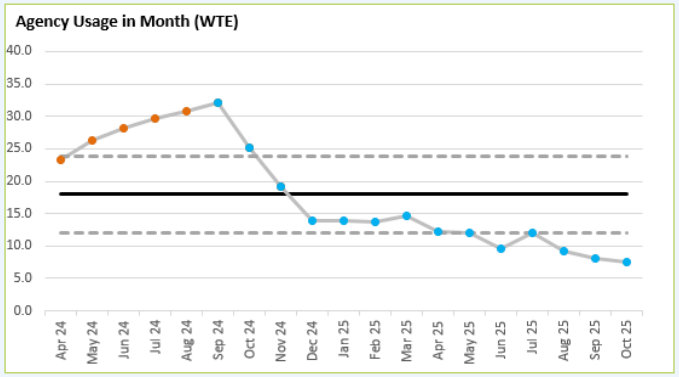
Queen Victoria Hospital
NHS Foundation Trust

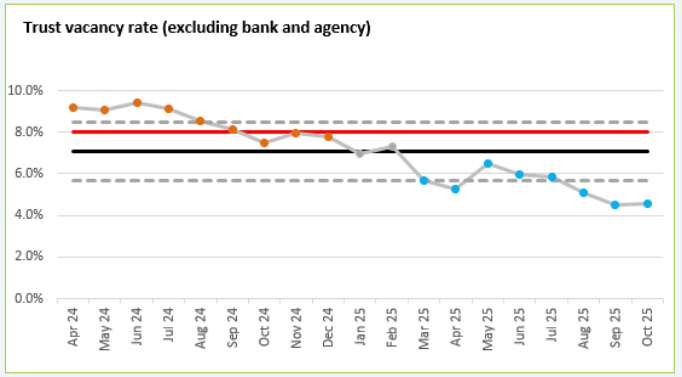
Metric	Latest Month	Target	Variation	Assurance	Actual	Actual Previous Month	Mean	LCL	UCL	Summary
Trust vacancy rate (excluding bank and agency)	Oct-25	8%			4.6%	4.5%	7.1%	5.7%	8.5%	Special Cause - improving variation
Vacancies - Incl Bank & Agency	Oct-25	8%			1.3%	1.3%	1.8%	-0.3%	3.9%	Common cause - no signficant change
Average Time to Hire - Days	Oct-25	53			47.7	51.2	60.57	24.29	96.86	Common cause - no signficant change
Turnover rate - Rolling 12 months	Oct-25	10%			11.0%	10.6%	11.6%	10.8%	12.4%	Special Cause - improving variation
Sickness absence rate - Rolling 12 months	Oct-25	3%			4.0%	4.0%	3.8%	3.7%	3.9%	Special Cause - concerning variation
Appraisal Rate	Oct-25	90%			83.2%	80.2%	83.9%	81.2%	86.6%	Special Cause - concerning variation
Statutory & Mandatory Training Compliance	Oct-25	90%			91.7%	91.4%	91.9%	90.8%	93.1%	Special Cause - concerning variation
Agency Usage in Month (WTE)	Oct-25	-			7.6	8.0	17.97	12.07	23.88	Special Cause - improving variation
Bank Usage in Month (WTE)	Oct-25	-			62.0	60.4	78.34	61.55	95.13	Special Cause - improving variation
Annual Leave Taken	Oct-25	-			56.1%	49.4%	33.9%	15.3%	52.5%	Special Cause - improving variation

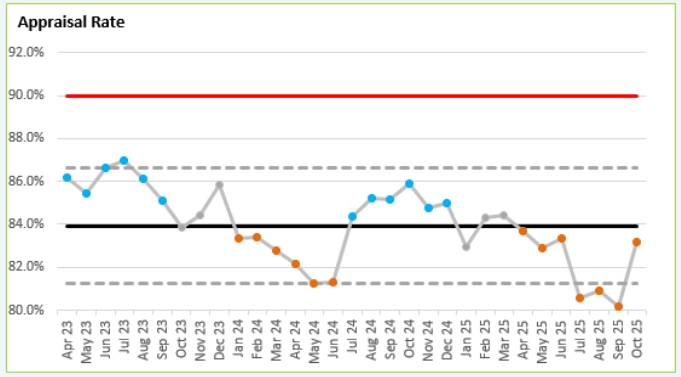
EXCELLENT EMPLOYER KEY METRICS

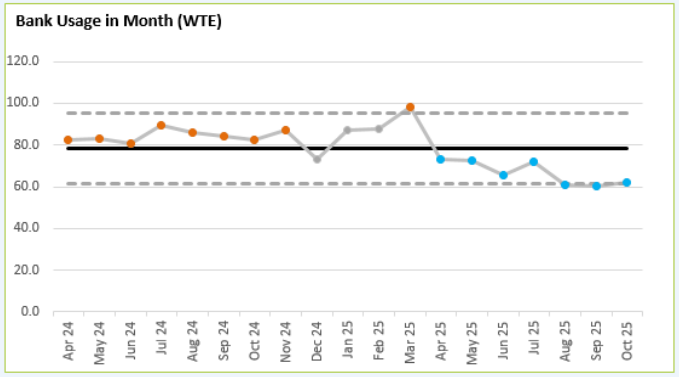
Queen Victoria Hospital
NHS Foundation Trust

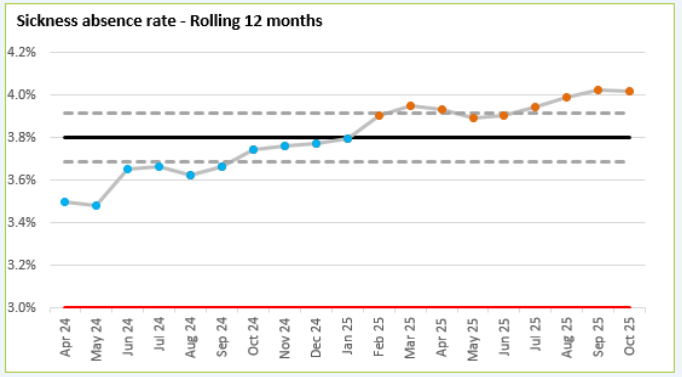












KSO3 AREAS OF FOCUS

Queen Victoria Hospital
NHS Foundation Trust

Area	Summary, impact and actions
Trust vacancy rate (excluding bank and agency)	M7 shows an increase in whole time equivalent (WTE) to 1077.94. This is 11 WTE above the plan, however, with the ongoing reduction in bank and agency the Trust are 13 WTE under the overall staffing plan. The increases in headcount are in CMO (research), CCCS (sleep, radiography, pharmacy, MIU), Operational Manager (Cancer Team), however these are small increases and are balanced by reductions in other areas to bring to 1 WTE increase in month. The vacancy rate has increased from 4.5% in M6 to 4.6% in M7.
Average Time to Hire - Days	Reduction from 51.24 to 47.7 in M7. Delays due to issues with Home Office not increasing our allocation of Certificate of Sponsorships which has led to candidates having to wait with all other clearances done but unable to start without a Right to Work in place. This has now been resolved, and the team are working through issuing Certificate of Sponsorships.
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 as last month. This measure is at 4% (which is the system target in the national operational planning guidance), and it remains an ambition for QVH to reduce sickness absence. Long-term absence is anticipated to reduce in M8 with individuals return to work or leaving the organisation, including for reasons of ill-health retirement. The Employee Relations and Wellbeing & Inclusion teams are conducting a deep-dive into reasons for absence and hot-spots, supporting managers with absence management.
Agency Usage In Month (WTE)	M7 has seen a further reduction in agency usage from 8.00 to 7.6. The highest agency usage is within nursing at 4.22 WTE. The highest agency usage area is Theatres with the other main usage areas of the Trust are CCCS and Estates.
Bank Usage In Month (WTE)	Bank has increased from 60.04 in M6 to 62 in M7. Peri-op shows highest use at 28.21 to cover weekend additional clinics / lists (increase from M6) with Nursing being the highest staff group at 21.90 followed by Admin at 17.41 (sleep and plastics highest admin bank use at 3.11 and 2.24 retrospectively).
Grievances raised	1 grievance raised in M7.
% Job plans complete	84% of job plans are currently agreed / signed off, with focussed work underway to continue to improve the completion rate.
Turnover rate	Turnover increased by 0.5% to 11% in M6. This takes us 1% over the 10% target, this is a minimal increase with a long-term continuing reduction since 24-25.
Statutory and mandatory training	M7 has shown an increase in mandatory and statutory training (MAST) compliance from 91.4% in M6 to 91.7% in M7. Fire evacuation, fire marshal and Resus L2 (Adult and children) has been highlighted as focus areas for improvement. A report is being produced for managers on fire compliance.
Appraisal rate	There is ongoing work to attain 90% appraisal completion rate, with continued focus with managers and highlighting outstanding areas. M7 had a small decrease from 80.20% in M6 to 80.18%. The number of appraisals outstanding >3 months saw a decrease from 103 to 92 in M7, with focused work underway with senior managers to follow up in areas where rates of completion are low.

KSO4

To deliver sustainable services

Ambition

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

Board Assurance Framework

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

Queen Victoria Hospital
NHS Foundation Trust

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

Queen Victoria Hospital
NHS Foundation Trust

At the close of October 2025, the Trust reported a YTD Income and Expenditure position in line with planned surplus (£46k) and had a cash balance of £11.3m. Whilst an on-plan position for the year to date (YTD) remains positive, the in-month position was supported by £0.2m of non-recurrent benefits. The Trust continues to report a forecast breakeven position and this assumes that income will need to be at least maintained at current income per working day, that pay expenditure needs to be maintained at current levels, and some non-recurrent benefits will be required.

Elective activity value is currently behind plan at M7 by £0.2m YTD, mainly due to £0.1m income loss from Industrial action (IA) and some under-performance in Sleep Outpatient activity . Additional Plastics weekend work is also supporting delivery of the plan by offsetting other areas of underperformance. There is also £0.1m commissioner income underperformance partly due to variance in agreed contract values from plan with a further £0.1m of other variable items such as devices recharges. There is further underperformance in CDC income YTD though this is offset by underspends in pay and non-pay. The trust is proactively managing this through dedicated actions plans to proactively address underperforming modalities and are seeking opportunities to increase demand.

Pay was c£0.1m favourable to plan in month and YTD with non-delivery of better value schemes (£0.5m), offset mainly by underspends relating to CDC. Worked WTE was reduced overall compared to the YTD and broadly in line with M6. Agency spend is within the 2% target of overall budget following the trend of the last 3 months. The pay expenditure trend in M5-M7 will need to be at least maintained to support delivery of the breakeven forecast. Non-pay was underspent for the YTD (£1m), mainly within corporate areas and the CDC. This trajectory will need to continue to support delivery of the forecast. In M7 non-pay was favourable to plan mainly in clinical supplies due to a YTD stock adjustment for Sleep respiratory medicine devices.

At the end of M7, the Trust reported YTD delivery of £4.1m efficiencies which is on plan. Pay related schemes are off plan (£0.5m) and are being offset by over-delivery of non-pay items, reflecting the Trust's financial performance. To meet the full year financial plan, these mitigating underspends will need to continue for the remainder of the year.

The Trust’s capital plan for the year was £26.4m of which £18.0m relates to the CDC. Spend remained low in M7 against plan but is expected to catch up in later months.

The Electronic Patient Record programme remained on track for a 4th November 2025 go live.

Freedom of Information (FOI) requests responded to within 20 days has decreased in M7 to 71% from 78% in M6, as older FOIs are responded to. This continues to be an area of focus through the Information Governance Group and Digital Steering Group, with a follow up sent to 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	Oct-25	£0.05m			£0.05m	-£0.50m	-0.51	-1.25	0.23	Common cause - no signficant change
Cash at Bank YTD	Oct-25	£1.90m			£11.30m	£10.80m	7.17	0.31	14.04	Common cause - no signficant change
Capital Spend YTD	Oct-25	£6.60m			£3.50m	£2.80m	3.25	-4.28	10.79	Special Cause - improving variation
Efficiencies YTD	Oct-25	£4.10m			£4.10m	£3.40m	3.34	0.20	6.47	Special Cause - improving variation
BPPC (NHS & Non NHS) - volume	Oct-25	95%			93.2%	92.6%	0.91	0.88	0.94	Common cause - no signficant change
BPPC (NHS & Non NHS) - value	Oct-25	95%			89.8%	88.8%	90.1%	85.7%	94.5%	Common cause - no signficant change
Agency spend <2% total pay bill	Oct-25	£0.90m			£0.50m	£0.44m	0.34	0.17	0.51	Special Cause - improving variation
Agency spend 40% less than 24/25 forecast	Oct-25	£0.90m			£0.50m	£0.44m	0.34	0.17	0.51	Special Cause - improving variation
Agency staff spend as % of total staff spend	Oct-25	2%			0.51%	0.41%	1.04%	0.37%	1.70%	Special Cause - improving variation
Bank spend reduction of 10% of Total Pay Bill	Oct-25	£2.60m			£1.90m	£1.68m	1.15	0.47	1.84	Special Cause - improving variation
Total Pay cost per Worked WTE	Oct-25				£5,645.32	£5,574.96	5696.26	5444.00	5948.53	Common cause - no signficant change
Subject Access Requests - Total Received	Oct-25				100	89	78.00	34.91	121.09	Common cause - no signficant change
Subject Access Requests - % Closed within 30 calendar days	Sep-25	100%			100.0%	100.0%	94.1%	76.1%	112.2%	Special Cause - improving variation
Freedom of Information requests – Total Received	Oct-25				58	39	50.52	15.67	85.36	Common cause - no signficant change
Freedom of Information requests – % Closed within 20 working days	Sep-25	80%			71.8%	78.2%	64.4%	37.6%	91.3%	Common cause - no signficant change

KSO4 EXECUTIVE SUMMARY

Queen Victoria Hospital
NHS Foundation Trust

Capital

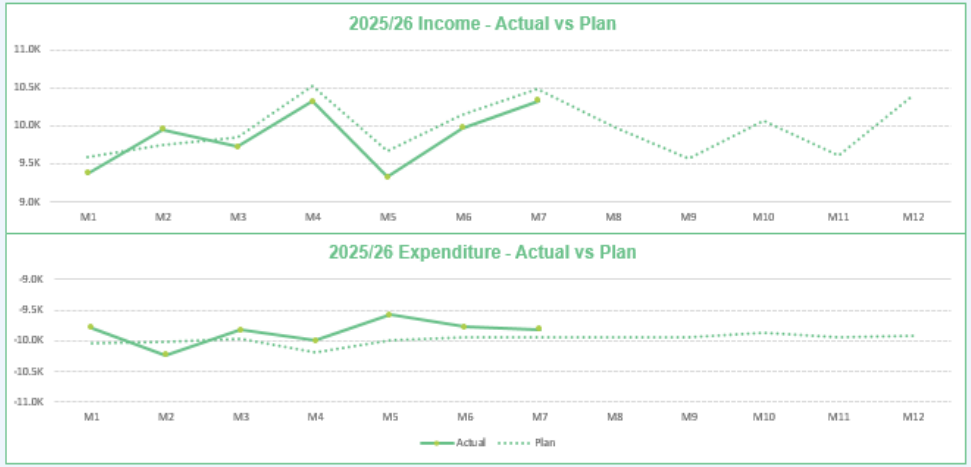
	In Month £'000			Year to Date £'000			Forecast Outturn £'000s		
	Plan	Actual	Variance	Plan	Actual	Variance	Plan	Actual	Variance
IT	0	31	31	131	142	11	131	142	11
Medical Equipment	83	12	(71)	249	12	(237)	1,000	989	(11)
Estates Maintainance	193	193	0	193	868	675	1,907	1,907	0
Estates Other	0	0	0	750	0	(750)	750	-	(750)
EPR	248	111	(137)	744	1343	599	2,983	2,983	0
CDC	1,495	300	(1,195)	4485	932	(3,553)	17,949	17,949	0
Other Capital	24	67	43	24	230	206	1,640	5,199	3,559
Total	2,043	714	(1,329)	6576	3527	(3,049)	26,360	29,169	2,809

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	10,134	9,978	(156)	67,577	66,541	(1,036)	114,691	114,691	0
Other Operating Income	352	352	-	2,458	2,471	13	4,226	4,226	0
Total Income	10,486	10,330	(156)	70,035	69,012	(1,023)	118,917	118,917	0
Pay									
Substantive	(5,864)	(6,017)	(153)	(41,360)	(42,358)	(998)	(69,910)	(69,910)	0
Bank	(342)	(235)	107	(2,539)	(1,911)	628	(4,228)	(4,228)	0
Agency	(134)	(33)	101	(938)	(469)	469	(1,599)	(1,599)	0
Total Pay	(6,340)	(6,285)	55	(44,837)	(44,738)	99	(75,737)	(75,737)	0
Total Non-Pay	(3,474)	(3,375)	99	(24,274)	(23,315)	959	(34,943)	(34,943)	0
Total Non Operational Expenditure	(148)	(153)	(5)	(1,039)	(1,073)	(34)	(8,511)	(8,511)	0
Total Expenditure	(9,962)	(9,813)	149	(70,150)	(69,126)	1,024	(119,191)	(119,191)	0
Surplus/(Deficit)	524	517	(7)	(115)	(114)	1	(274)	(274)	0
Technical Adjustments	23	23	0	161	160	(1)	274	274	0
Adjusted Surplus / (Deficit)	547	540	(7)	46	46	-	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	83	229	146	501	1,104	603	922	1,931	1,009
Pay - Corporate Service and Digital Transformation	175	72	(103)	1,125	295	(830)	2,000	912	(1,088)
Pay - Clincal Service Redesign	134	56	(78)	641	392	(249)	1,310	672	(638)
Pay - Agency	39	31	(8)	273	365	92	463	555	92
Non-Pay - Procurement	58	109	51	346	278	(69)	641	585	(57)
Non-Pay - Other	-	9	9	-	829	829	-	1,030	1,030
Non-Pay Corporate Service and Digital Transformation	137	103	(34)	889	390	(499)	1,584	926	(658)
Non-Pay Clinical Service Redesign	13	56	43	91	392	301	153	672	519
Income - Non-patient care	31	6	(25)	217	46	(171)	376	174	(202)
Income - Other	1	-	(1)	7	-	(7)	11	4	(7)
Total	671	671	0	4,090	4,090	0	7,460	7,460	0

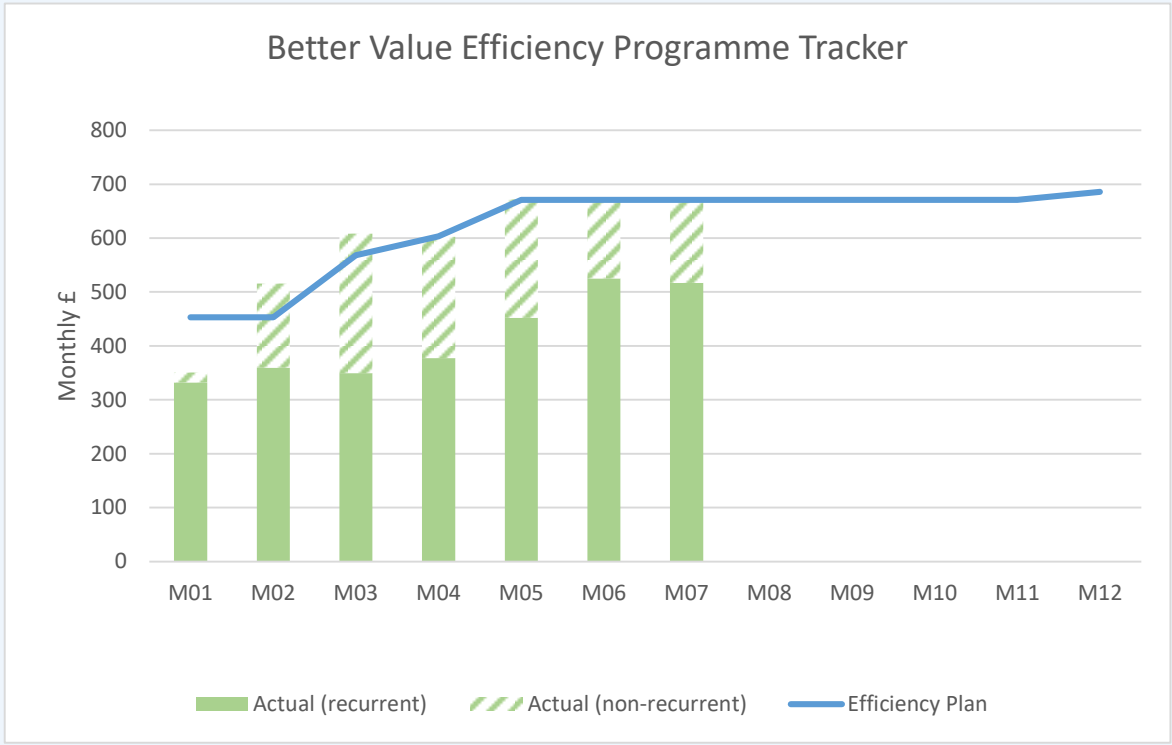


	Annual Target	Forecast Outturn
Income & Expenditure	£0.0m	£0.0m
Cash at bank	£1.9m	£1.9m
Capital Spend	£26.4m	£25.6m
Efficiencies	£7.46m	£7.46m
BPPC (NHS & Non-NHS)		
Volume	95.0%	91.9%
Value	95.0%	93.6%

Trust Best Value Efficiency Programme

Queen Victoria Hospital
NHS Foundation Trust

% Confidence	Financial Risk Rating	£000	M07 YTD	Current Forecast	Variance
100%	Blue	2,413	1,253	2,399	(15)
80%	Green	1,100	562	1,255	154
60%	Amber/Green	1,982	825	1,774	(208)
40%	Amber	832	145	393	(439)
20%	Amber/Red	222	0	9	(213)
10%	Red	994	0	33	(961)
	Mitigating items		1,305	1,600	1,600
	Total	**7,544**	**4,090**	**7,462**	**(81)**



KSO4 AREAS OF FOCUS

Queen Victoria Hospital
NHS Foundation Trust

Area	Summary, impact and actions
Breakeven YTD	In month position was on plan of a £0.5m surplus for M7 and the Trust remains on plan YTD (£0.05m surplus). Patient income is £1.0m off plan YTD, due to the impact of industrial action (£0.1m), underperformance in CDC (£0.5m), devices income £0.1m activity underperformance £0.3m, and a 25/26 contract issue (£0.1m) in part offset by £0.2m 24/25 contract impact. This is being offset by an underspend in non-pay. The Trust would be reporting a deficit of £0.8m without the inclusion of non-recurrent deficit support funding.
Cash at Bank YTD	Cash at M7 was £11.3m and cash levels remain supported by the slow start in capital spending
Capital Spend YTD	The Capital Plan for M7 included £10.5m for CDC and £0.8m for boiler lease (which was contracted in 2024/25). Excluding these items planned spend was £3.5m in M7 with an underspend of £0.9m due mainly to delays in spending for EPR & Estate Safety Fund programmes. We are working on delivering these plans and on contingencies and so are confident that the Trust will spend the capital and stay within the allocation.
Efficiencies (Cost Improvement Plans) YTD	Delivery of £4.1m vs plan of £4.1m. Includes elements of non-recurrent vacancy and slippage on non-pay expenditure. Pay CIP slippage is being offset by additional non-pay CIP. Whilst the high-risk schemes have not developed at the scale and pace that was anticipated, the mitigating underspends have enabled the Trust to stay within the financial plan. These underspends will need to continue in order for the Trust to deliver the full-year plan.
BPPC (NHS & Non-NHS) Volumes	BPPC is slightly below target at 93.2% slightly increased from previous month.
BPPC (NHS & Non-NHS) Values	BPPC is slightly below target at 89.8% 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	Pay is on plan YTD but there is slippage in better value schemes (£0.5m) offset by underspend in CDC. Pay will need to be maintained at the average of M5-M7 to support delivery of control total.
Non-Pay Spend	£1.0m underspent for the YTD due to underspends in Digital, CDC and other corporate areas. In addition, the underspend is also due to plan alignment between pay and non-pay.

KSO4 PROJECT REPORT

Queen Victoria Hospital
NHS Foundation Trust

Sussex Pathology Network

Exec Lead: CMO
Lead: PMO

Reporting Month: August-25

Overall Status: R / A / G
Amber

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

LIMS – The re-baseline plan has been agreed by the Pathology Programme Board this month. An external assessor report will be shared with SPN member organisations for review and sign off through Trust governance processes with a target for sign off by mid-December
Digital Histopathology (DHP) - Digital histopathology deployment remains a high priority for the department. The team are working through a number of technical issues relating to slide labelling with a target to commence digital reporting by December 2025.
Order Comms (ICE) - Delivery of ICE will align with the revised timescales for WinPath Enterprise. The delay allows exploration of a closed loop reporting solution compatible with cross-Trust ICE
Digital Infrastructure - Resourcing remains a risk across all digital projects.
Managed Service Contract (MSC) - The MSC procurement is currently in a pause state until the end of December 2025. SPN will then conduct a final round beginning January 2026 and running until November 2026. During the pause, the team will be conducting reviews of all procurement documentation to ensure it is fit for purpose, adds value to the procurement and aligns with the original intention to procure notice.
Network Formation and Laboratory Operating Model (LOM) - The Network Formation and Laboratory Operating Model projects are continuing with drafting the Outline Business Case. Assurance and milestone status has been amended to reflect the delay in completion of the procurement of services with TU. TU are continuing at risk until 24th November. The timeline for activities remains challenging in context of network workload and resource to support all competing projects.

Milestone	Start Date		Expected Completion Date	Commentary
LIMS - complete UAT Phase 1 Gap Analysis review for Cell Path	Oct 2025		TBC	Continued escalation to Clinisys about technical issues and lack of functionality
Completion of Network Formation OBC for approval	Sept 2025		Q4 2026	Additional resourcing has been added to assist delivery
Managed Service Contract documentation review to be completed	Nov 2025		Nov 2025	Governance approval to follow in Dec 2025
Commencement of digital histopathology reporting	April 2025		Dec 2025	Manual forms may be used to mitigate barcode solution issues preventing slide label print functionality

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. Resources in place for Pathology digital projects, along with DDCP funding for FY 25/26. Planning underway for FY 26/27
April 2025	Varying internal governance scheduling delays to programme timelines.	Assign Trust and Network SROs to manage issues, project boards and steering groups in place, early socialisation of business cases via SROs. No Current issues with governance schedules. Regular meetings with CMO ensuring Exec level ongoing awareness of progress, risks and issues

KSO4 PROJECT REPORT

Queen Victoria Hospital
NHS Foundation Trust

Electronic Patient Record (EPR)

Exec Lead: CMO
Lead: PMO/EPR team

Reporting Month: August-25

Overall Status: R **/ A / G**
Amber

Archie EPR successfully went live on Tuesday 4th November and the system has been well received. Patient Administration System (PAS) planned to go live in Q3/4 2026; however, funding still needs to be provided by 2025/26.

The go live was well supported by Trust staff including digital champions, IT/Clinical systems, our supplier Altera, 'Tiger Teams' (an NHS England initiative), external suppliers along with other NHS organisations including NHS England and Maidstone and Tunbridge Wells NHS Trust. To date, there have been no elective cancellations or MIU breaches attributable to the go live.

As of 23rd November, there have been:
- Over 13,000 clinical documents created
- 7,282 medicines prescribed and 13,010 administered
- Over 35,000 patient context links to systems such as Evolve, PACS etc.

The programme team stood down the command centre on Friday 21st November and staff have been advised to log issues on the service desk portal, Sysaid for the clinical systems and IT teams to resolve. Over 150 optimisation requests have been received to date and the programme team are reviewing these requests in terms of priority with the support of appropriate Trust staff. There are a number of elements to transitioning from the programme team to a business-as-usual state. Several of these have taken place including the command centre stand down and handing over business continuity processes and system to the relevant Trust teams and areas including theatres and site teams.

Funding has been agreed by Trust Chief Finance Officer to extend the programme team until end March 2026. This will help to support stabilisation, optimisation and the commencement of the PAS project.

Milestone	Start Date	Expected Completion Date	Commentary
Archie Go Live.	4th November 2025	21st November 2025	Complete
PAS Go Live.	Q3/4 2026	Q3/4 2026	Project planned for Q3/4 2026. At significant risk due to lack of funding. Additional monies have been requested with NHS England. Trust Chief Finance Officer has allocated some funds for 2026/27.

Date Raised	Risk Description	Mitigating Actions
May-25	There is currently no funding for programme team beyond the November 4th go live	Trust Chief Finance Officer has provided funding until end March 2026. Awaiting funding outcome from NHS England for 26/27 from the Digital Productivity funding. This will be for the programme team to continue PAS implementation.

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

Queen Victoria Hospital
NHS Foundation Trust

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

Queen Victoria Hospital
NHS Foundation Trust

Local Offer
This month work has centred on strengthening engagement with clinical teams to ensure smooth adoption of ongoing improvements outlined below. There has been collaborative work with dietetics and their administrative team to streamline referral pathways and follow-up processes, to improve efficiency. In parallel, the team has continued strategic involvement in the development of Integrated Neighbourhood Teams (INTs) as part of the Major Service Review. Significant progress has also been made in data optimisation, with all clinical codes successfully transitioned to enable reporting by team rather than profession from the new year (2026/27), improving accuracy and visibility. Correct coding for the Falls Group is now in place, supporting activity tracking. Finally, the final stages of implementing standardised templates across all teams is underway to maximise patient contact time and expand group interventions, improving clinical productivity.

Major Service Review
Two areas of transformation have been identified through the Major Services Review. This includes new models of care for Rehabilitation and Intermediate Care and Urgent and Emergency Care (UEC). These are identified as complex and cross cutting areas of transformation. Discussions regarding the leadership, governance and resourcing of the programmes are due to be further explored at the next Committee in Common (CiC) meeting.

Community Diagnostic Centre (CDC) – East Grinstead and Bognor
Preparations are underway, including set up of hoarding and reduction of vegetation on the site for the commencement of building works on the East Grinstead CDC site. Work is due to be completed by Summer 2026. 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 (CDC)	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 preparation for works started on site in East Grinstead including hoarding around the site and reduction of relevant vegetation within the area.
2. Engagement continues with University of Chichester regarding next steps for the Bognor site.
3. Activity against plan for East Grinstead was at 96% for October 2025 and income against plan (year to date) is 88%.
4. Redesign work planning continues for Bognor site. Long term operating model agreed in principle. More detailed work and formal agreements being undertaken.
5. Contract for current activity in Bognor being run by University Hospital Sussex (UHSx) elapses in Feb 2026. Arrangements post this time need to be agreed

Key areas for focus 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		30/11/25	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		01/10/25	Several surveys undertaken. Preparations for building works including hoarding and reduction of vegetation in progress.
Design of Bognor retro-fit	01/09/25		30/12/25	Contract awarded early October 2025. Work commenced on the design for completion by end of December 2025

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.	Continued remedial actions being taken to bring back to plan.

Benchmarking - Operational performance

Queen Victoria Hospital
NHS Foundation Trust

Group	Metric	Value	Latest Month	Specialist Rank	Specialist Rank (out of)	England Rank	England Rank (out of)
A&E / Minor Injury Unit	All 4 Hour Waits Performance	98.64%	Oct-25	1	3	7	140
Cancer Treatment	62 days Performance	81.77%	Sep-25	7	13	26	139
	FDS Performance	77.74%	Sep-25	11	12	52	134
Diagnostics (DM01)	Under 6 Weeks Performance	88.91%	Sep-25	11	13	54	156
Referral To Treatment	Within 18 Weeks Performance	64.52%	Sep-25	9	13	54	150

Source: *NHS England Statistical Work Areas website; NHS Trusts Only - 'Community and Mental Health', 'Acute' & 'Specialist'*

Trajectories- Operational performance

Queen Victoria Hospital NHS Foundation Trust

RTT	M1	M2	M3	M4	M5	M6	M7	M8	M9	M10	M11	M12
65ww							67	64	64	58	55	52
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

- In M7 the trust achieved the 52ww trajectory in terms of patient numbers, but missed the % trajectory by 0.1%

Interpretation of Summary Icons for Statistical Process Charts

Queen Victoria Hospital NHS Foundation Trust

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

SPC Chart Key:

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

GLOSSARY

Queen Victoria Hospital
NHS Foundation Trust

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

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

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

Report cover-page					
References					
Meeting title:	Board of Directors				
Meeting date:	12/02/2026	**Agenda reference:**	**122-26**		
Report title:	Bi-annual Digital Report				
Sponsor:	Helen Edmunds, Chief People Officer				
Author:	Bill Gordon, Chief Digital Information Officer				
Appendices:	None				
Executive summary					
Purpose of report:	Provide the Board with a bi-annual update report relating to Digital programmes of work				
Summary of key issues	• EPR Archie go-live; since the go-live of Archie we have had over 110,000 patient in-context links to other systems (Evolve, PatienTrack, PACS and Waba) • Windows 10 went end of life in Q4 2025 and our Windows 11 migration programme is almost completed (extended support from Microsoft in place where required) • Data Security Protection Toolkit (DSPT) – the improvement has 1 outstanding item (Board cyber training), with all other actions completed • Development and implementation of the new version of Trips Telemedicine System • Planned for 2026/27; The implementation of our new Patient Administration System (PAS), which is the next phase of our EPR				
Recommendation:	The Trust Board is asked to note the contents of the report and the ongoing programmes of digital transformation across QVH.				
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:	Digital BAF				
Corporate risk register:	None				
Regulation:	None				
Legal:	None				
Resources:	None				
Assurance route					
Previously considered by:	Executive Leadership Team				
	Date:	19/01/2026	Decision:	Present report to the Trust Board	
Next steps:	Continue with digital transformation programmes of work				

Report to:	Board of Directors
Agenda item:	122-26
Date of meeting:	12 February 2026
Report from:	Helen Edmunds, Chief People Officer
Report author:	Bill Gordon, Chief Digital Information Officer
Date of report:	7 January 2025
Appendices:	None

Bi-Annual Digital Report

1. Executive summary

This report provides a concise overview of Digital services at QVH for the last 6 months and an update on delivery of the current digital strategy and alignment to the NHS 10 Year Plan. It also highlights our progress on technology implementations, digital transformation progress, system reliability improvements and our Cyber current position / response.

Digital at QVH is comprised of three core teams – Clinical Systems Team (CST), Information Technology (IT) and the Business Intelligence Unit (BIU The internal teams are supported by external Third Parties for areas such as cyber, networking and infrastructure. All three teams provide support and resources for digital, operational and facilities projects as required.

Over the last 6 months there has been a substantial number of competing priorities for the Digital teams. These include regaining compliance with the Data Security Protection Toolkit (DSPT) / Cyber Assessment Framework (CAF), the successful go-live of our Archie EPR, improved communications with our patients (Patient Knows Best) and the introduction of innovative digital clinical workflows (Bleepa).

Whilst the core digital infrastructure at QVH is up to date there were gaps in key areas such as a Digital service desk, to enable measurement, monitoring and service performance. In July 2025 we implemented Sysaid, a cloud-based service desk solution with AI embedded for the benefit of staff and the digital teams. This, alongside the planned introduction of internal service level agreements for the provision of digital services will allow us to effectively provide key performance data for our IPQR's.

2. Digital Strategy Progress

QVH's Digital Strategy is closely aligned with the overall objectives of the Trust. Our strategic priorities for digital align to 5 objectives:

Patient Outcomes and Experience
Staff Experience
Interoperability
Operational Transparency
Efficient and Reliable

The introduction of the EPR was central to the success across all five of these objectives and was core to the delivery of the strategy.

For each of the pillars of the digital strategy we have mapped progress so far as follows:

- Patient Outcomes and experience
  - Actively participating in the Peoples panel and the implementation of the digital inclusion framework for Sussex to create an inclusive and accessible health and care system in Sussex that works for everyone, regardless of whether they use digital tools.

- Successful implementation of the Electronic Patient Record (Archie)
- We have continued to expand the work with Sussex Wide Shared Care Record (Plexus) and Sussex Wide Patient Portal (Patients Know Best – PKB)
- Completed the development and implementation of the new version of Trips Telemedicine System
- Progressed with our NHSE funded CDC clinical software deployment of Feedback Medicals' Bleepa solution.

- Staff Experience
  - As part of the Archie EPR we have engaged with staff and developed surveys to ascertain the need for additional digital skills
  - The Archie EPR programme identified over 150 digital champions who were key to our go-live
  - Training needs analysis was undertaken, and a number of learning modules were developed for Archie, successful completion was mandatory prior to gaining access to Archie
  - The work for digital training needs for staff is still in progress and will continue throughout 2026
  - The Chief Medical Officer (CMO) is now the senior responsible officer (SRO) for digital transformation at Board level to ensure sustained progress alongside the Chief Digital Information Officer as the lead

- Interoperability
  - Key to improving our interoperability was the implementation of the EPR, this now allows us to share more patient information with other organisations and patients
  - Since the go-live of Archie we have had over 110,000 patient in-context links to other systems (Evolve, Patientrack, PACS and Waba)
  - The next stage to build on, is the implementation of our Patient Administration System, which is scheduled to be delivered end of 2026. Data Migration analysis and design work is already underway to realise further benefits and functionality
  - We have identified resources to further exploit PKB, Plexus, and AI, and combining the digital transformation programme together for QVH. Our Archie EPR team will work with our Digital team to progress these at pace

- Operational Transparency
  - We have successfully replaced our Trust Intranet
  - Our out-of-date Telephony system is being migrated to modern infrastructure
  - We have started the migration to Microsoft Office365 for all staff and starting to promote the use of the NHSE provided Co-pilot Chat app
  - Windows 10 went end of life in Q4 2025 and our Windows 11 migration programme is almost completed. There are some devices that still require windows 10 and we have purchased extended support from Microsoft for these
  - Co-developed with procurement the digital and cyber requirements and included them in the procurement policy to ensure compliance in the supply chain to minimise risk to the organisation

- Efficient and Reliable
  - E-consenting is one of the priorities for the digital transformation programme
  - Paper has already been reduced as part of the EPR implementation and one of the priorities for digital is to become paper light – over 200,000 pieces of paper has been saved so far which equates to 26 trees and 1 tonne of CO2
  - Patient Check in and room optimisation procurement in progress
  - Ambient Voice extending the use of our G2 speech recognition tool
  - Educate and promote the use of Co-pilot Chat app provided by NHSE

As the strategy is a living document it needs to be continuously reviewed to ensure its appropriateness and reflects the changing priorities of the QVH, our patients, external partners, and the local / national landscape.

Following a review In December through the EPR Programme Board, chaired by the CMO we have agreed the next key digital transformation priorities for QVH.

There are 5 key themes:

Productivity
Patient Experience/safety
AI
Financial
Strategic

Within these themes there are a number of schemes which are being progressed and have been prioritised and agreed with stakeholders. Listed below are the agreed projects:

- The implementation of our new Patient Administration System (PAS), which is the next phase of our EPR
- Electronic Discharge Notifications (EDN) for the safe transfer of patient information to other organisations
- Increase the use of our Patient Portal (PKB) and Shared Care Record (Plexus) to share information with patients and clinicians
- Extend the use of our speech recognition software with the introduction of AI and Ambient Voice technology
- Additional EPR functionality for Theatres, CCU and Prescribing in Outpatients and Paediatrics
- eConsent
- Financial Saving
- Development of an Ophthalmology EPR business case
- Review the devices in use within the Trust by clinicians based on location and need

Additionally, we are reviewing the overall digital strategy to ensure alignment with the NHS 10 year plan in conjunction with NHS Sussex and our peers across Sussex. Work is already underway with key elements such as the Federated Data Platform and Sussex Patient Health Record (PHR) prioritisation with PKB and the NHS App.

3. Cyber security and compliance

The NHS England DSPT changed significantly for 2024/25 from assurance against the National Data Guardian's data security standards to assurance against the National Cyber Security Centre's (NCSC) Cyber Assessment Framework (CAF) as its basis for cyber security and information governance assurance. This reflects the significant importance for the Trust to be cyber resilient, through robust policies and procedures, to manage cyber risk and protect our organisation against cyber-attack. This is through prevention, detection and minimising impact. Key security elements of confidentiality, privacy and mandatory staff training in data security remain. CAF positively raises the bar for security practice but it is also a new way of thinking.

The Trust submitted its CAF-DSPT return on 30 June 2025, with an update on 30 July 2025, accompanied by an Improvement Plan.

- The Trust's current status is "Approaching Standards", indicating foundational controls are in place but further development is required to achieve full compliance.
- As of 31 December 2025:
  - 196 of the 197 Indicators of good practice actions are complete (99.5%)

- 1 indicator of good practice action is still outstanding (Board Leadership Cyber Training - scheduled for February 2026)

NHSE expects all organisations with Improvement Plans to have delivered these by 30 June 2026.

Cyber Security Operations Centre (CSOC) Alerts

The Cyber Security Operations Centre (CSOC) service - formerly known as CareCERT alert - is provided by NHS England. It issues broadcasts and alerts relating to known cyber-security threats, including high-severity issues that must be remediated within 14 days. The Trust is required to acknowledge each alert within 48 hours and confirm when remediation is complete.

Over the past six months:

- 28 critical security alerts were received
- 13 were applicable to the QVH IT Infrastructure and all have been completed
- 15 were not applicable
- 3 were not completed within the 14-day timeframe due to complexity; however, all have since been remediated, and the Senior Information Risk Owner (SIRO) was kept fully informed throughout

There are currently no open or outstanding alerts.

4. Business Intelligence (BI) and Data Quality

The BI team are maintaining business as usual tasks and continue to support new development projects where possible. They have consistently delivered all statutory submissions alongside the IPQR reports each month. The Trusts (Data Quality Maturity Index) DQMI continues to trend above 97% and has been maintained and is above England average of 79.8%.

There have been competing priorities for data, report changes, Archie EPR and additional IQPR workload since the external company supporting the IQPR data work ceased trading.

As part of the EPR Programme a new Data Warehouse has been provided to receive the Archie EPR data within a few minutes of its entry and an on-premise Microsoft Power BI (MS PBI) reporting service for the new Archie EPR. The team have been working with East Kent who have assisted with the provision of the initial reports. These can be made available to any QVH staff member that need them without further licensing costs. BIU are currently developing a work programme to migrate from the NHSE tenancy the existing Power BI reports into the new environment, standardising the development of new dashboards also reducing costs.

5. Clinical Systems

The Clinical Systems Team (CST) provide the day-to-day support of the Clinical applications in use within QVH. This includes upgrades and implementations of new Clinical applications within the Trust.

The clinical systems team provides system support to end users for 12 clinical systems. PAS/Patient Centre, G2 digital dictation, Enlighten Check in, SMS portal, Patientrack eOBs, eDN, Archie EPR, TRIPS trauma referrals, Bleepa, ICE ordercomms, Attend Anywhere, SaferSleep and PKB patient portal.

As part of the implementation of Archie the CST team worked closely with the EPR team and were provided with training and knowledge transfer to ensure they were able to provide business as usual support for the new EPR. Clinical Systems also now provide out of hours support for Tier 1 systems such as Archie.

6. IT

The Information Technology team provide 3 levels of IT support to the Trust.

- First Line support: logging tickets and resolving technical issues over the phone or using remote access.
- Second Line support: resolving hardware and software issues and complex technical issues.
- Third Line support: management of the 2 on-premise Data Centers and Data Network Infrastructure dealing with highly complex challenges to minimise service outages and protect against cyber security threats.

IT provides out-of-hours support for all Tier 1 infrastructure such as the Network and Disk Storage systems.

Summary

2025 saw the largest digital transformation programme that QVH has ever undertaken. We were able to deliver not just a successful go-live of our Archie EPR, but also a number of key core infrastructure projects and innovative digital clinical workflow applications successfully and safely.

Digital at QVH is more integrated with our peers across Sussex and is an active voice in shaping the direction of travel going forward. We have been working much more closely with NHSE garnering their support for not just additional funding but them also volunteering to act as part of the team for our Archie EPR go-live.

Given the dependency on digital and data, a resilient infrastructure to support digital system requirements will be imperative, with digital people support aligning to move resources from paper support to digital support.

Next Steps

- Continue building business cases for the future digital transformation programmes to enable application to NHSE for further funding for 2026/27.

- Work with NHS Sussex / Surrey to develop a system wide data strategy for publication in 2026/27.

- Implementation of our new Patient Administration System (PAS), which is the next phase of our EPR, giving the Trust the opportunity to work differently with how we manage patients / patient flow.

- Participate with the enterprise architecture work with NHS Sussex – working with an external company (Ethical) for the discovery phase completion by the end January 2026. The discovery report is planned to act as supporting evidence to underpin a shared system digital narrative, helping organisations make a consistent case at individual Board level for collective priorities and approaches.

- Work with the Trusts future partners for digital transformation opportunities and where possible alignment of digital systems.

Recommendation

The Trust Board are asked to note the contents of the report and the ongoing work undertaken by the Digital teams at QVH.

Report cover-page					
References					
Meeting title:	Board of Directors				
Meeting date:	12/02/2026		**Agenda reference:**	**123-26**	
Report title:	Freedom to Speak Up Guardian report				
Sponsor:	Jackie Doherty, Freedom to Speak Up Guardian				
Author:	Jackie Doherty, Freedom to Speak Up Guardian				
Appendices:	None				
Executive summary					
Purpose of report:	This report provides an overview of data relating to cases, themes, and issues raised through the Freedom to Speak Up (FTSU) Guardian between 1 April 2025 and 30 November 2025. It has been prepared in line with guidance from the National Guardian's Office (NGO).				

Summary of key issues	The Trust has demonstrated its commitment to fostering a healthy speaking-up culture through the FTSU service:
	• All concerns raised via the Guardian Service have been addressed within agreed timescales.
	• Between 1 April 2025 and 30 November 2025:
	  ○ 23 concerns were raised through the FTSU Guardian Service.
	  ○ 39% of staff used the service for impartial support.
	  ○ 39% of cases were from staff who had previously raised concerns but felt they had not been listened to.
	• The Trust recognises that all concerns represent opportunities for learning and improvement and should be managed fairly and promptly.
	Recommendations include:
	• Implement regular well-being checks and provide clear access to support for staff
	• Ensure leaders at all levels actively role-model speaking-up principles to foster a safe and open culture
	• Strengthen manager capability				

Recommendation:	The Board are asked to note the contents of the report and support the recommendations.				
Action required	Approval	Information	Discussion	**Assurance**	Review
Link to key strategic objectives (KSOs):	KSO1: *To deliver outstanding care*	**KSO2:** ***To innovate and improve***	**KSO3:** ***To be an excellent employer***	KSO4: *To deliver sustainable services*	KSO5: *To collaborate with others*
Implications					
Board assurance framework:	KSO1				
Organisational risk register:	None				
Regulation:	CQC				
Legal:	None				
Resources:	None				
Assurance route					
Previously considered by:					

	Date:		Decision:	
Next steps:				

Queen Victoria Hospital
NHS Foundation Trust

The Guardian Service
Here to listen

Annual Report
1 April -30 November 2025

Circulation:

Main point of contact

Liz Blackburn

Acting Chief Nursing Officer

Prepared by:

Jackie Doherty

Guardian

The Guardian Service Ltd.

Date: 05 January 2026

The Guardian Service
Here to listen

Contents

1. Executive summary

This is an interim report covering the period between 01st April to 30th November 2025.

The Trust has demonstrated its commitment to fostering a healthy speak up culture and has supported the introduction of The Guardian Service within Queen Victoria Hospital NHS Trust.

The Trust has responded within the agreed timescales to all concerns raised from the Guardian Service.

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

The service has been advertised on the staff intranet, with posters and postcards distributed throughout different sites.

In the period this report covers, there have been a total of 23 concerns raised via the Freedom to Speak Up Guardian service and 39% of staff advised they used the service for impartial support, and 39% of cases were from staff who advised they had raised a concern before but felt they had not been listened to.

It is important that all concerns raised are seen as opportunities for learning and improvement and dealt with in a fair and timely manner.

This will help staff to believe there is a benefit to Speaking Up and feel confident they will be listened to and appropriate action will be taken.

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

2. Purpose of the paper

The main purpose of this report is to give an insight into the data arising from cases, themes and issues raised through the Freedom to Speak Up Guardian from 01 April 2025 - 30 November 2025. The report follows the guidance from the National Guardian Office (NGO) on the content FTSU Guardians should include when reporting to their Board which include Assessment of cases, Action taken to improve speaking-up culture and Recommendations.

3. Background to Freedom to Speak Up

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

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

4. The Guardian Service

The Guardian Service Limited (GSL) is an independent and confidential staff liaison service. It was established in 2013 by the National NHS Patient Champion in response to The Francis Report. The Guardian Service provides staff with an independent, confidential 24/7 service to raise concerns, worries or risks in their workplace. It covers patient care and safety, whistleblowing, bullying, harassment, and work grievances. We work closely with the National Guardian Office (NGO) and attend the FTSU workshops, regional network meetings and FTSU conferences. The Guardian Service is advertised throughout the QVH Trust as an independent organisation. This encourages staff to speak up freely and without fear of reprisal. Freedom to Speak Up is part of the well led agenda of the CQC inspection regime. The Guardian Service supports the QVH Board to promote and comply with the NGO national reporting requirements.

The Guardian Service Ltd (GSL) was implemented in QVH on 01 May 2024.

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

5. Access and Independence

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

6. Categorisation of Calls and Agreed Escalation Timescales

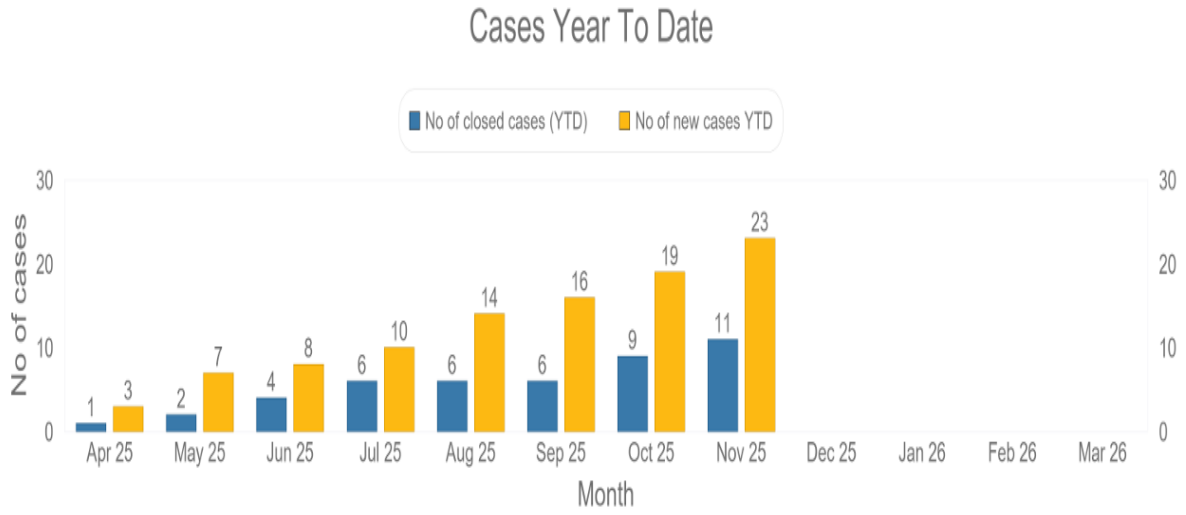
The following timescales have been agreed and form part of the Service Level Agreement.

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

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

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

7. Number of concerns raised



There have been a steady number of concerns raised with a total of 23 in the period 01 April 2025 to 30 November 2025, compared to 20 in the same period last year.

There will be detailed comparisons using data from clients of the Guardian Service Limited and National Guardian's Office data in the full Board report, to be presented in May 2026.

8. Confidentiality

Confidentiality	No. of concerns	Percentage
Keep it confidential within Guardian Service remit	10	44%
Permission to escalate with names	6	26%
Permission to escalate anonymously	7	30%
Total	**23**	**100%**

9. Themes

Concerns raised are broken down into the following categories;

Theme	Total
A Patient and Service User Safety / Quality	2
B Management Issue	8
C System Process	7
D Bullying and Harassment	4
E Discrimination / Inequality	0
F Behavioural / Relationship	2
G Other (Describe)	0
H Worker Safety	0
I Sexual Misconduct	0
Grand Total	**23**

10. Trends in Cases

There have been a total of 23 cases raised to the FTSU Guardian between 01 April 2025 and 30 November 2025. The months of May, August and November were the months with the highest number of 4 each. The highest number of cases came from job groups Nursing and Midwifery-8, Admin and Clerical-6 and Estates and Ancillary-4.

The latest data from the national Guardian's Office (April 2024-March 2025) shows that 28.3% of cases raised are by Nursing and Midwifery, in comparison to 34.78% at QVH and 21% raised by Admin and Clerical staff, in comparison to 26% at QVH.

11. Assessment of Cases

There have been 2 concerns regarding patient safety, raised in the timescale this report covers. One was in relation to lack of appointments available for patients, and this was escalated by the staff member themselves after a conversation with the FTSU Guardian The other one was a concern raised regarding possible drug errors and this was escalated to the Interim Chief Nurse for investigation and the Trust responded in line with the agreed RAG timescales to the Guardian Service, with the concern being dealt with at the service level.

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

Management issue

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

- Managers not dealing with issues within the team.
- Belief of favouritism in the team from the manager and staff feeling isolated as a result.
- Feeling of not being supported by manager.
- Managers passing responsibility of managing and tasks to other team members.

System and Process

The theme of system and process accounted for 30% and examples of this are:

- Number of senior posts in Trust when other areas being challenged with cost cutting.
- Communication not always transparent within the Trust.
- Policies not being followed correctly.
- Reasonable adjustments not being adhered to.

Bullying and Harassment

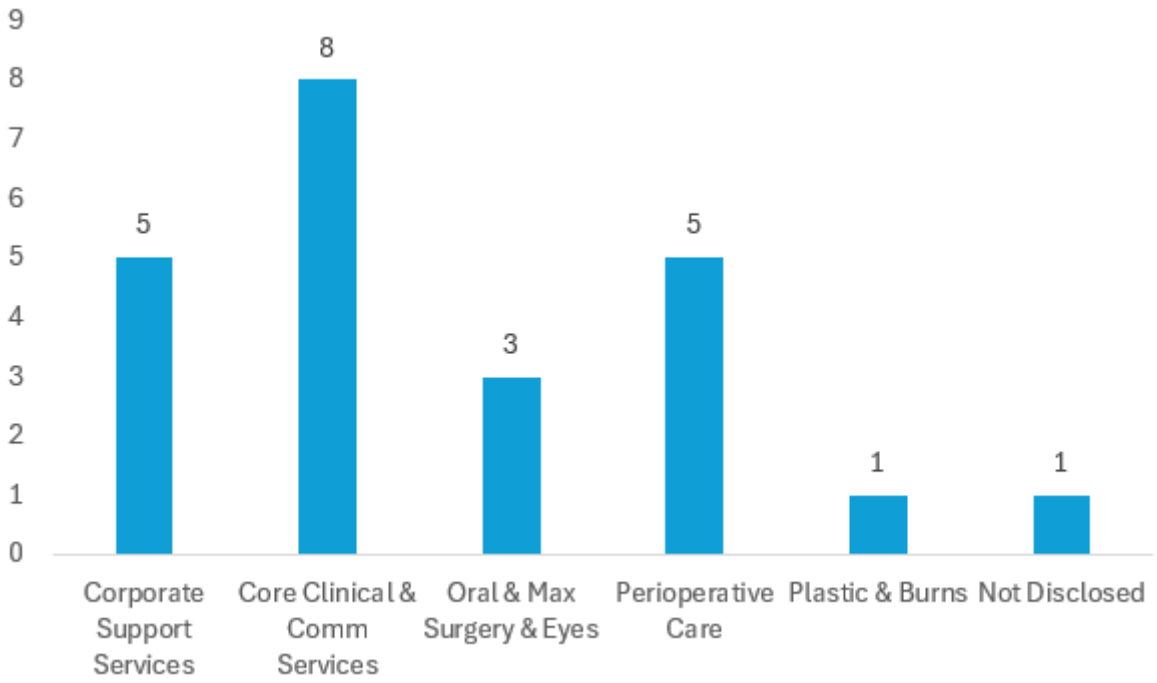
This theme accounted for 17% of cases and some examples of this are:

- Believe being bullied by a senior staff member and feeling discriminated against.
- Feeling bullied and harassed whilst off sick by their manager.
- Belief there is a toxic, bullying culture in the team.

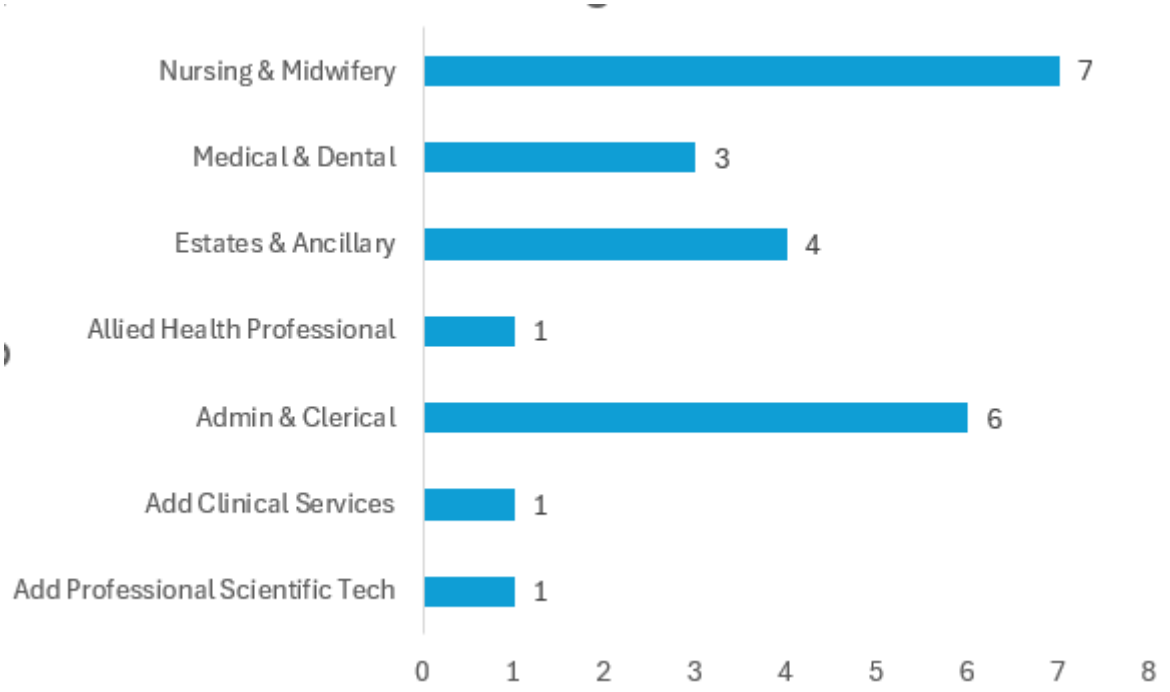
Other themes are Patient safety, which have been detailed above, and 9% of Behaviour/relationship regarding relationship with colleagues in a team.

12. Statistical Graphs

Concerns raised by Directorate



Concerns raised by Job Group



13. Why do staff use The Guardian Service?

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

Reason for using Guardian Service	Number	Percentage
Impartial Support	9	39%
Have raised concern before but not been listened to	9	39%
Believe they will not be listened to	2	9%
Fear of reprisal	3	13%
Total	23	100%

14. Detriment

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

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

- The FTSU Guardian promotes the service through briefings at staff meetings and group sessions, both in person and via MS Teams, as well as through unscheduled walkabouts across the Trust. In addition, the FTSU Guardian is a regular contributor to corporate induction programmes for newly appointed staff.
- Monthly meeting with Executive Director to discuss activity report which includes themes and outcomes of cases-no identifying details are shared, therefore maintaining staff members' confidentiality.
- Quarterly meeting held with Non-Executive Director to discuss activity, and any emerging themes and support required.
- Monthly meetings being held with the Chief Executive Officer to share any themes or concerns, particularly while Trust is undergoing restructuring due to cost savings and the transition towards a strategic partnership.
- Regular attendance on Team Talk by FTSUG to promote the service.
- Visibility of Executive team across all areas of the Trust promoting FTSU to encourage staff confidence in Speaking Up.

16. Learning and Improvements

- The FTSUG takes a coaching approach and supports staff to address their concerns, as much as possible, independently. Staff are encouraged, where appropriate, to raise their concerns initially with their line manager or another leader in their division. Exploring ideas on using existing tools, like team meetings and supervision, can also help an individual bring about a resolution. The FTSUG is an empathetic listener and often just providing a listening ear is all that is required to help staff address their concerns.

17. Comments & Recommendations

- Staff involved in the Trust's formal processes have expressed concerns about the negative impact on their mental health and well-being, both during and after the process.
- It is important to continually assess individual's well-being and make them aware of available support options. Additionally, aftercare should be considered, including regular check-ins with staff following the outcomes of formal processes, to ensure effective coping strategies are in place for all parties involved.
- Leaders at every level need to role-model the speaking-up principles. It helps workers feel safe, valued, and confident to speak up and workers are likely to emulate the values and behaviours they see in their more senior colleagues.
- It is important that the Trust is able to ensure that managers, primarily mid-level managers, receive the support they need to handle speaking-up concerns. This could include mandating The National Guardians Office Speaking Up, Listening Up, Follow Up training, soft skills training on listening,

emotional intelligence, improving empathy and self-awareness which are all behaviours that are crucial in the effective handling of concerns

Report cover-page					
References					
Meeting title:	Board of Directors				
Meeting date:	12/02/2026	**Agenda reference:**	**124-26**		
Report title:	Annual review of raising concerns November 2024 – November 2025				
Sponsor:	Liz Blackburn, Acting Chief Nursing Officer Helen Edmunds, Chief People Officer				
Author:	Karen Jackson, Head of Nursing.				
Appendices:	None				
Executive summary					
Purpose of report:	The purpose of this report is to provide assurance to the Board that staff have access to appropriate routes for raising concerns, that these mechanisms are effective, and to confirm that all concerns raised have been thoroughly and appropriately investigated.				
Summary of key issues	This report outlines the available channels for staff to raise concerns, provides an overview of the types of issues being reported, and highlights additional sources of information used to monitor the effectiveness of these processes. • Staff have used a variety of different routes to speak up/raise concerns. • The numbers of concerns raised are consistent with that of last year • A reduction is noted in the number of concerns reported to the Chief Nursing Officer by half – possibly due to the discontinuation of the anonymised form which commenced Aug 2024 • Bullying and harassment remains the most common theme across all concerns raised, followed by management issues and system processes				
Recommendation:	The Board is asked to **note** the contents of the report.				
Action required	Approval	Information	Discussion	**Assurance**	Review
Link to key strategic objectives (KSOs):	**KSO1:** ***To deliver outstanding care***	KSO2: *To innovate and improve*	**KSO3:** ***To be an excellent employer***	KSO4: *To deliver sustainable services*	KSO5**:** *To collaborate with others*
Implications					
Board assurance framework:	None				
Corporate risk register:	None				
Regulation:	None				
Legal:	None				
Resources:	None				
Assurance route					
Previously considered by:	Audit & risk committee				
	Date:	05/01/26	Decision:	Submit to	
Next steps:	Continued promotion of raising concerns and triangulation of those raised				

Report to:	Board of Directors
Agenda item:	124-26
Date of meeting:	12 February 2026
Report from:	Liz Blackburn, Acting Chief Nursing Officer Helen Edmunds, Chief People Officer
Report author:	Karen Jackson, Head of Nursing
Date of report:	8 December 2025
Appendices:	None

Annual review of raising concerns November 2024 - 2025

Introduction

This report provides an overview of the process and response to raising concerns from 1 November 2024 to 31 October 2025.

Issues/ concerns can be raised via:

- Email route via Qnet to Chief Nursing Officer (CNO)
- Email route via Qnet to Chief Executive Officer (CEO)
- Employee Relations team
- Via management route to the Executive Leadership Team
- Incident reporting (Datix)
- Freedom to speak up guardian service (contracted independent service)
- Via the Directorate Leadership Team.
- Menti-metre at Team Brief, anonymised opportunity to raise questions

Context

As an organisation, we are committed to fostering a culture where staff feel empowered to speak up, confident they will be listened to and assured that concerns will be followed up and acted upon. Promoting psychological safety and embedding a continuous learning culture are central to this commitment.

Assessing the effectiveness of our “Speak Up” arrangements requires both quantitative and qualitative evaluation to ensure processes are robust, concerns are addressed promptly, and the culture supports transparency and openness. This includes reviewing the routes available for raising concerns, the volume and themes of issues reported, and the timeliness of acknowledgement and resolution.

This paper presents the available data, its sources, and internal trends over previous years, alongside comparisons to national benchmarks where possible

A review of the available data and Information

As a Trust, we continue to improve and support a culture of speaking up across our entire workforce. To support this the trust has had a formal Cultural Transformation Steering Group in place since April 2025 with executive sponsorship and attendance from the CEO and CMO of the Trust. This group was formed to provide a formal setting to understand and transform the culture of the Trust against 4 key work streams; Cultural Events and Activities, Addressing Inequality, Embedding Inclusion and Re-Engaging and Connecting with the Workforce. This has provided a forum for the Trust's EDI champions to raise concerns and to introduce initiatives and amended practice in their own areas of influence.
Latterly this group has been going through a review, to better support our EDI champions, and to identify the key areas of workplace culture that can be targeted in 2026. This will have a direct impact upon staff feeling empowered to raise concerns and improve their psychological safety with the Trust as their employer.

QVH has an independent Freedom to Speak up Service, which is widely publicised through our induction programme, Team Talk, Connect and Screen Savers.

CNO route 'Tell Edmund, previously tell Jane'

Period	Total No. of Concerns Raised via Tell Jane / Tell Edmund
Jan to Dec 2020	23
Jan to Dec 2021	6
Jan to Dec 2022	12
Jan to 20 Nov 2023	31
Dec 2023 – Nov 2024*	31
Nov 2024 to Oct 2025	15
Trend from Last Year	⬇

Total number of concerns raised to the CNO via 'Tell Jane/Edmund' was 15 between 1 November 2024 to 31 October 2025. There was also one additional comment sent via this route that was a positive and not a concern.

It is noted that there has been a significant drop from last year in raising concerns via this route (31 to 15). The anonymous feature of the Tell CNO form was deactivated from Monday 5 August 2024. This route remained confidential but was no longer anonymous, the rationale for this change was to be able to respond and take action whilst reinforcing safety of speaking up. It is acknowledged that this could be a contributing factor to the reduction noted in concerns raised. This continues to be triangulated with all other routes of speaking up, which have not seen a reduction in reporting.

Themes of the concerns raised

Themes	Amount
Bullying and Harassment	4
Pay and fairness	2
Smoking	1
Unknown, requested to meet	1
Patient record keeping	1
Patient Meal times	1
Team structure	1
Posters in department	1
Injury at work	1
Fairness and transparency with leave	1
Fairness and transparency with recruitment	1
Total	**15**

The most frequently reported concern was bullying and harassment, accounting for 4 cases. Pay-related issues were raised twice. All remaining concerns were isolated and evenly distributed, with no identifiable themes.

14 staff left their name and contact details, only 1 was sent anonymously. All were responded to directly by the CNO, some required e-mail responses only and some were offered an opportunity to meet in person.

CEO Route 'Tell James' / 'Tell Abigail'
We also have a similar route to our CEO 'Tell Abigail' that follows the same process as the 'Tell CNO'

We have received 15 'Ask James/Abigail', these were all answered. Topics are variable and include concerns related to workforce/employee relations, Estates and IT. Some of the issues raised are then noted in Connect if appropriate, e.g. smoking on site, staff email signatures, car parking.

Employee relations/ Workforce relations cases
The table below indicates the total number of informal and formal employee relations cases related to grievance, dignity and respect, and whistleblowing in the period December 2024 to November 2025:

Issue	Informal	Formal	Total cases
Grievance	0	6	6
Dignity & Respect	0	11	11
Whistleblowing	0	0	0
Totals	**0**	**17**	**17**

The numbers of cases in progress / open as of November 2025 are:

Issue	Informal	Formal	Total cases
Grievance	0	3	3
Dignity & Respect	0	8	8
Whistleblowing	0	0	0
Totals	**0**	**11**	**11**

The highest reported were under Dignity and Respect with 11 received, there were no whistleblowing reports. Themes include bullying and harassment, working relationships, discrimination, investigation process, engagement/consultation process, fairness of learning opportunities/progression.

There has been an increase in employee relations cases from last year, current open cases this year are 11 compared to 7 the previous year and cases raised in total is 17 compared to 10 last year.

The increased cases through Employee Relations could reflect a positive cultural shift driven by greater awareness and communication initiatives such as the sexual safety charter. Staff feel more confident raising concerns as evidenced by survey results and are less tolerant of inappropriate behaviour leading to more challenges around language and conduct. The staff survey also notes an increase in Bullying and Harassment which also supports the increase in figures.

There are also counter-complaints where an individual has raised a complaint about a colleague and they have raised a counter complaint in response.

Incident reporting (Datix)
Between 1 Nov 2024 to 31 Oct 2025 there were 2408 incidents reported on Datix, (a slight increase from last year at 2261), of these 1206 were reported under the patient safety category. A preliminary review has been undertaken to identify incidents that might indicate lack of speaking up in the moment either in terms of patient or staff safety.

Incidents were searched using keywords in the ‘description / action taken / investigation / lessons learned’ fields for: “*speak up” “speak out” “confident to” “raise concerns” “escalate” “empowered*”.

On review of these incidents 7 were identified, the themes were:

- Confidence to speak up and challenge
- Escalation processes regarding care provision
- Escalation processes of staffing concerns
- Training issue and competence
- Professionalism and conduct

All incidents reported as ‘suboptimal care’ for that period were also searched for which identified 15 incidents, 9 were low or no harm, and 6 were reported as harm unknown.

Incidents raised concerning staff and not patients were identified, 7 Datix reports involved workforce/employee relations, which is equal to the previous year. On review of these incidents 2 were related to Information Governance and no others related to speaking up/raising concerns.

12 incidents were raised via Datix stating ‘staff to staff abuse’, 5 of these reports describe rude behaviour from fellow staff, 4 stated raised voices, 1 bullying and harassment and 1 inappropriate behaviour and harassment.

On reviewing the incidents during this period there were no specific reports alleging or referring to financial impropriety

All incidents were investigated, actions completed and learning identified.

On review of the themes from our Datix’s raised, many of these are related to our trust Values and Behaviours

Freedom to Speak Up Guardian
Whilst QVH has always had a Freedom to Speak up service, from April 2024 we moved to an independent and confidential external service. Staff can report concerns related to patient care and safety, whistleblowing, bullying and harassment and work grievances. This service is available for staff to report concerns via telephone 24/7 or via a dedicated e mail address. Staff can request a meeting in person with the Guardian to discuss their concerns and they are supported with next steps.

Categories monitored and themes of concerns raised

Themes	Amount
Patient Safety / Quality	2
Bullying and Harassment	6
Behaviour / Relationships	4
Management issue	12
System Process	9
Sexual Misconduct (only added since April 2025)	0
Discrimination / Inequality	0
Worker Safety / Well being	0
Total	**33**

In the previous six-month period (April 2024 to October 2024), 19 concerns were raised, reflecting similar themes. This indicates that the volume and nature of concerns have remained consistent.

Escalation to line managers/ executive team
In addition to established formal channels for raising concerns, staff also have the option to report issues directly to their respective directorate leadership teams. On occasion, concerns regarding staff attitudes have been addressed promptly by members of the triumvirate through direct engagement with the individuals involved. While these instances are not captured in formal data, informal resolutions have occurred across all directorates as a result

of staff approaching leadership teams. Furthermore, each of the four directorates has conducted multiple listening exercises, providing staff with opportunities to voice concerns through the Well-being Team. These initiatives have informed the development of action plans and led to the implementation of changes in response to staff feedback

Related Actions
A number of actions have been implemented under the Trust's Violence Prevention and Reduction programme to raise its compliance levels to 93% with the revised National VPR standards in 2025. The Trust is also ensuring that it actively complies with the NHS Sexual Safety Charter. The QVH Sexual Safety 2025 report has recently been written with QVH reporting higher disclosure rates of sexual misconduct compared to peer trusts, particularly among staff aged 21–30 and those identifying as bisexual. While the Trust has signed the NHS Sexual Safety Charter, compliance currently stands at 74%, with gaps in specialist investigator training and risk escalation processes.

Both programmes are actively seeking to address areas where compliance can be raised particularly with regards the provision of training to managers and staff and the support that is provided to victims once an incident is reported, including after action reviews and learning opportunities.

Both the VPR programme and Sexual Safety programmes of work have their own dedicated annual reports which are reported through the Trust's annual governance programme.

Conclusions and next steps
The Trust remains committed to fostering a culture of speaking up and continues to provide multiple channels for staff to raise concerns. This year, there was a significant reduction in concerns raised via the Chief Nursing Officer (CNO) route, decreasing from 31 cases last year to 15 cases. This decline may be linked to the removal of the anonymised reporting form. With an Acting Deputy Chief Nurse now in post, there is an opportunity to strengthen communication across the Trust and re-emphasise the various mechanisms available for staff to speak up.

Bullying and harassment remain the most common theme across concerns, followed by management issues and system processes. Incident reporting (Datix) shows ongoing challenges with escalation and confidence to speak up, all identified issues were investigated and actions taken.

To ensure continued opportunities for staff to be able to speak up, in collaboration with the Freedom to Speak up Guardian, we are demonstrating more visibility from the executive team with regular walkabouts to directly speak to staff giving opportunity to raise any concerns they may have.

The Freedom to Speak Up Guardian has a regular quarterly slot in Team Talk and is promoting the service across the Trust to raise awareness and help staff feel more confident about speaking up.

There is continued commitment from leaders and managers to listen up and take action if any concerns are raised by any methods.

Recommendation

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

Report cover-page					
References					
Meeting title:	Board of Directors				
Meeting date:	12/02/2026		**Agenda reference:**	**125-26**	
Report title:	Board Assurance Framework (BAF)				
Sponsor:	Leonora May, Company secretary Exec risk leads				
Author:	Leonora May, Company secretary				
Appendices:	Appendix one- BAF summary Appendix two- BAF				
Executive summary					
Purpose of report:	To present the Board Assurance Framework (BAF) for review.				
Summary of key issues	A summary of each of the BAF risks is set out within appendix one including current scores against risk appetite and key highlights including key actions completed. Of the nine strategic risks, the highest scoring are in relation to finance, estate, sustainability and leadership capacity. Seven of them are currently outside of risk appetite. Assurance ratings for eight of the risks are amber, demonstrating that there are issues which require monitoring and addressing. The assurance rating for the quality risk is green, demonstrating that there are no serious issues and that the controls are effective. The score for the digital risk has been reduced from a 16 to 12, due to the success of EPR 'Go Live' and a funding request for EPR roles post December 2025 being successful. This risk has met its target score. The score for the quality risk has been reduced from a 12 to 9, due to the positive assurance relating to quality of care. This was supported by the Quality and safety committee.				
Recommendation:	To **review** the BAF and: - Confirm that the BAF is appropriately focussed on, and accurately describes, the key risks that may impact on the Trust's ability to deliver its strategic objectives - Advise if there are any specific matters in relation to the strategic risks presented in the BAF that require follow up at a sub-committee (e.g. deep dives into risk assessments or overall assurance levels)				
Action required	Approval	Information	Discussion	**Assurance**	Review
Link to key strategic objectives (KSOs):	**KSO1:** ***To deliver outstanding care***	**KS oval O2:** ***To innovate and improve***	**KSO3:** ***To be an excellent employer***	**KSO4:** ***To deliver sustainable services***	**KSO5:** ***To collaborate with others***
Implications					
Board assurance framework:	Revised BAF to support delivery of KSO's				
Organisational risk register:	Links to organisational risks included in BAF				
Regulation:	CQC well led				
Legal:	None				

Resources:	None			
Assurance route				
Previously considered by:	Responsible sub-committees			
	Date:	Nov, Dec 2025, Jan 2026	Decision:	
Next steps:				

Report to: Board of Directors
Agenda item: 125-26
Date of meeting: 12 February 2026
Report from: Leonora May, Company secretary
Exec risk leads
Report author: Leonora May, Company secretary
Date of report: 23 January 2026
Appendices: Appendix one- BAF summary
Appendix two- BAF

Board Assurance Framework (BAF)

Introduction and background

The BAF sets out the key risks which may threaten the achievement of the Trust's key strategic objectives. It enables the Board to monitor progress in achieving the strategic objectives, attend to key accountability issues, ensure the right issues are debated and that remedial actions are taken to reduce risk as well as strengthen controls and assurances.

The Board approved the current BAF risks at its meeting on 13 November 2025. The BAF summary is included with this report as appendix one and the BAF risks are included as appendix two.

All BAF risks have a responsible committee assigned. All BAF risks have been reviewed by the responsible committee during November and December 2025 and January 2026. The Audit and risk committee completed a deep dive on the digital BAF risk at its meeting on 5 January 2026.

Executive summary

Heat map

Likelihood	*Consequence*				
	Negligible	**Minor**	**Moderate**	**Major**	**Catastrophic**
Almost certain					
Likely				**Estate** **Finance** **Leadership capacity**	
Possible			**Workforce**	**Digital**	**Sustainability**

			Quality	**Access** **Regulation**	
Unlikely					
Rare					

A summary of each of the BAF risks is set out within appendix one including current scores against risk appetite and key highlights.

Of the nine strategic risks, the highest scoring are in relation to finance, estate, sustainability and leadership capacity. Seven of them are currently outside of risk appetite.

Assurance ratings for eight of the risks are amber, demonstrating that there are issues which require monitoring and addressing. The assurance rating for the quality risk is green, demonstrating that there are no serious issues and that the controls are effective.

The score for the digital risk has been reduced from a 16 to 12, due to the success of EPR 'Go Live' and a funding request for EPR roles post December 2025 being successful. This risk has met its target score.

The score for the quality risk has been reduced from a 12 to 9, due to the positive assurance relating to quality of care. This was supported by the Quality and safety committee.

Recommendation
To **review** the BAF and:

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

Ref	Title/ description	Score			Trajectory/ direction of travel	Assurance rating	Risk appetite	Highlights
		Inherent	Current	Target				
1	**Access** There is a risk that the Trust will not deliver against its operational plan and national access standards Caused by rise in waiting lists; increased demand; national changes; support to the wider Sussex system Resulting in patients waiting longer than we would like for treatment; potential patient harm/ poor experience; widening health inequalities; the Trust not achieving its operational plan; reputational damage; increased oversight	16	12	8	⟷	Amber (indicates that there are some issues that need to be monitored and addressed)	This risk is currently outside of risk appetite, with a higher score. The risk appetite for this area is cautious (4-6)	• The score remains the same as at last review • New red/ amber assurance added related to 65 week waits and cancer 62 day target. A New action has been included to revisit the action plans to address these issues • Clinical review of patients at harm from cancer pathways delay was completed in January 2026 (action) • Key assurance required on impact for patient of health inequalities work
2	**Digital** There is a risk that the Trust may not be able to deliver its clinical, operational and financial objectives due to insufficient digitisation including the benefits of the EPR programme Caused by constraints of capital and revenue funding to support people and resources required to deliver digital transformation including lack of funding for EPR roles past December 2025 Resulting in non-alignment with the national priority to move from analogue to digital; reputational damage; potential non-realisation of benefits; impact on service delivery and quality	20	12	12	↓	Amber (indicates that there are some issues that need to be monitored and addressed)	This risk is currently outside of risk appetite, with a lower score. The risk appetite for this area is seek (15-20)	• Risk score reduced from 16 to 12 • Risk has met its target score • The funding request for the EPR programme team from December 2025 was successful (action) • EPR 'Go Live' was a success with no negative patient impact caused
3	**Estate** There is a risk that the Trust's estate deteriorates further to the point where it is no longer safe Caused by ageing estate; poor quality of previous work completed; limited capital resource to address critical infrastructure challenges; maintenance and repair backlog; estates team resource challenges; lack of compliant ventilation Resulting in harm to individuals; Potential impact on service delivery; services no longer being delivered from the QVH site; financial loss; reputational damage.	20	16	12	⟷	Amber (indicates that there are some issues that need to be monitored and addressed)	This risk is currently outside of risk appetite, with a higher score. The risk appetite for this area is minimal (1-3)	• The score remains the same as at last review • QVH does not meet 'new hospital' criteria so there is no assurance regarding a future rebuild, however, the current site is uneconomic to keep repairing • The national estates safety fund and RAAC replacement initiatives provide the only mechanism to address backlog maintenance challenges • Limited funding available to address infrastructure risks, additional funding has been sought and granted
4	**Finance**	20	16	12	⟷	Amber (indicates	This risk is currently outside of risk appetite, with a higher score. The	• The score remains the same as at last review

	There is a risk that the Trust will not deliver the full value of its £7.5m cost improvement plan for 2025/26 and cost improvement plans for future years; deliver a breakeven position for 2025/26 and for future years and/ or that the working cash balance will reduce to lower than £1m Caused by the Trust's significant cost improvement target of £7.5m for 2025/26 including the requirement for corporate service cost reductions; changes to the funding regime including capping of income levels; significant activity levels, and financial pressures across other NHS organisations delaying payments Resulting in the Trust not being financially sustainable for the future					that there are some issues that need to be monitored and addressed)	risk appetite for this area is minimal (1-3)	• Good progress has been made in delivering the 2025/26 cost improvement programme, however, more is being delivered non-recurrently than planned • Assurance is required that further recurrent savings can be made • The Trust's breakeven position at year end is high risk • National planning guidance for 2026/27 has been received and the business plan for 2026/27 was presented to the Finance and performance committee in January 2026 • Internal audit on compliance with governing documents and policies concluded reasonable assurance with considerable progress and strengthening of controls • A medium term financial plan is being developed as part of the 2026/27 business plan (action)
5	**Leadership capacity** There is a risk that there will not be leadership capacity to deliver the strategic partnership, key strategic objectives and key projects Caused by three interim executive roles including Chief executive officer; turnover in Board level roles and organisational memory loss; Chair finishing term at end of December 2025 Resulting in closure of services/ site; regulatory intervention; reputational damage; non-delivery of recurrent annual financial, productivity and efficiency savings	20	16	8	⟷	Amber (indicates that there are some issues that need to be monitored and addressed)	This risk is currently outside of risk appetite, with a higher score. The risk appetite for this area is minimal (1-3)	• The score remains the same as at last review • The Trust Chair's term ends in December 2025 and an interim Chair has been appointed from January 2026 • Proposal received from RSASP demonstrates a delay in shared Chair and CEO from the initial plan of March 2026 • Three Non-executive directors come to the end of their term in June 2026. A new action has been added in relation this this as this is a high risk area
6	**Workforce** There is a risk that the Trust is unable to fulfil its commitment to being an excellent employer and may not have a workforce fit for the future Caused by significant organisational change; uncertainty; the Trust's significant cost improvement target; requirement for corporate service cost	15	9	6	⟷	Amber (indicates that there are some issues that need to be monitored and addressed)	This risk is currently within the range of risk appetite. The risk appetite for this area is open (8-12)	• The score remains the same as at last review • MAST compliance in November 2025 is stable • There has been slight improvement in appraisal compliance rates

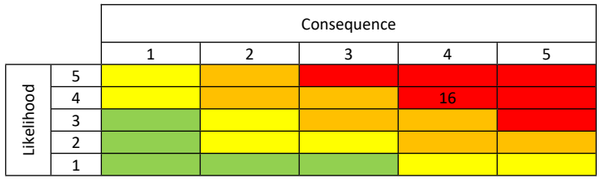
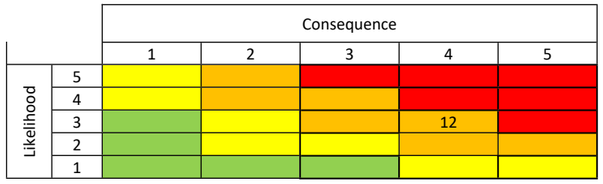
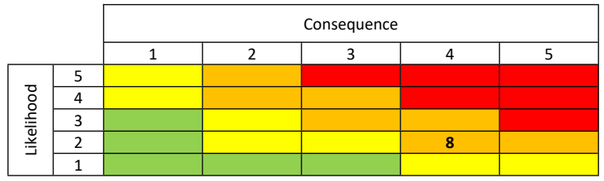
	reduction; leadership capacity and managers capability Resulting in staff turnover; single points of challenge and lack of resilience; challenges with recruitment and retention; challenges with organisational culture; a negative effect on staff wellbeing and motivation; non-delivery of key strategic objectives and projects; impact on quality							• Organisational culture assessment presented to the Board in November 2025 • The Trust does not have EDI networks- opportunity to link into partner organisations networks • Managers training programme is in place and has received positive feedback • Further assurance is required regarding the embedding of the behaviours framework • There is a decline in mood and motivation and increase in staff long term sickness
7	**Quality** There is a risk that the Trust may not consistently deliver high quality, safe and effective care Caused by failure to ensure that clinical structure enables prioritisation of quality, safety and effectiveness in care; productivity increases constrict time to care and train, financial constraint compromises progress in estate, systems and equipment supporting care, frequent and rapid organisational changes distracts from sustainable quality Resulting in poor patient experience and outcomes; potential harm; reputational damage	20	9	6	↓	Green (indicates that there are no serious issues and the controls are effective)	This risk is currently outside of risk appetite, with a higher score. The risk appetite for this area is minimal (1-3)	• The score has been reduced from 12 to 9 given positive assurance as discussed at the Quality and safety committee • There is a need to review nursing staffing levels in line with the cost improvement plan- paper to be presented to the Board at its meeting in February 2026 • Staff survey results demonstrate a decline in the percentage of staff who feel safe to speak up and confidence that concerns will be addressed- action plan and monitoring required
8	**Regulation** There is a risk that the Trust may not be able to meet its regulatory requirements Caused by scale; cost improvement plans; corporate savings; turnover at Board level; additional licence conditions; non-compliance; leadership capacity; national changes to requirements Resulting in damage to reputation; non-removal of additional licence conditions; regulatory intervention	20	12	8	↔	Amber (indicates that there are some issues that need to be monitored and addressed)	This risk is currently outside of risk appetite, with a higher score. The risk appetite for this area is minimal (1-3)	• The score remains the same as at last review • The number of our of date policies is reducing. The largest number of out of date policies are for Estates and facilities. A risk review has been undertaken for out of date clinical policies • Annual governance statement 2024/25 identified significant control issues related to contracting and procurement. Recent internal audit in this area concluded reasonable assurance with no further breaches, however, there is a need further assurance that the position has materially improved long term

								• The Provider Capability Assessment undertaken by the Board demonstrated a confirmed rating for quality of care and people and culture and a partially confirmed rating for other areas
9	**Sustainability** There is a risk that the Trust will not secure long term sustainability Caused by inability to secure a strategic partnership; Challenges with progression of engagement with shortlisted partners; a potential breakdown in relationship between the Board and the Council of Governors; leadership capacity and resilience challenges; significant national changes; changes to the commissioning of services; changes to service specifications; staff morale; time constraints; differing views of key stakeholders on options Resulting in sustainability challenges for patient services/ site; non-delivery of QVH Strategy 2025-2030; regulatory intervention; reputational damage; non-delivery of recurrent annual financial, productivity and efficiency savings	20	15	10	⟷	Amber (indicates that there are some issues that need to be monitored and addressed)	This risk is currently outside of risk appetite. The risk appetite for this area is open (8-12)	• The score remains the same as at last review • At its meeting on 16 December 2025, the Board agreed to proceed with a partnership with RSASP • Proposal received from RSASP demonstrate a delay in shared Chair and CEO from the initial plan of March 2026 • A new action has been added Re the development of a transition and implementation plan for the partnership. This work is in progress

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

BAF	**Risk description** Risk: There is a risk that the Trust will not deliver against its operational plan and national access standards Caused by: Rise in waiting lists; increased demand; national changes; support to the wider Sussex system Resulting in: Patients waiting longer than we would like for treatment; potential patient harm/ poor experience; widening health inequalities; the Trust not achieving its operational plan; reputational damage; increased NHS oversight

Responsible committee	Finance and performance committee	**Date Risk Added:**	13 November 2025		
Principal Exec – Risk Owner	Chief operating officer	**Date Risk last reviewed:**	2 December 2025		
Risk Handler(s)	Deputy Chief operating officer	**Date Risk last formally discussed:**	20 January 2026	**Group**	Finance and performance committee

Inherent Score	Current Score	Target Score
		

Direction of travel since last review		**Target date**	31 March 2026
		Risk tolerance	Current risk score outside of risk appetite (higher) (cautious)

Controls (what are we doing about risk)	Assurances and RAG rating (how do we know if it's working)	Gaps in assurance (what additional assurance is needed)
Monitoring against the operational plan 2025/26 weekly internally and externally with action plans for improvements	1st line: Review of cancer action plan by Cancer Board monthly which demonstrates that the action plan is largely on track with some challenges which related to demand, September 2025, Green/ Amber Review of long wait action plan by Operational performance group weekly which demonstrates that the action plan is off track due to increased cancer referrals constraining capacity for long waits. The Trust requires NHSE strategic review of breast reconstruction in order to reduce 65 week waits, September 2025, Red (see action 2) 2nd line:	Non-RTT waits oversight and reporting NHSE strategic review of breast reconstruction- the Trust has indicated wanting to be a key player within this

	Monthly reporting and monitoring through the IQPR demonstrates challenges with65 week waits and 62 day cancer performance, January 2026 Amber/ Red (see action 2 and 8) 3rd line: Internal audit on faster diagnosis standards demonstrates reasonable assurance with a good control framework in place, September 2025, Green Quarterly provider assurance meetings with NHSE and the ICB. Letter received from NHSE and the ICB for Q1 2025/26 demonstrates positive assurance, recognising challenges with long waits, August 2025, Amber (see action 2) National Oversight Framework rating by NHSE. The Trust was rated 34 out of 134 trusts for performance overall for Q1 2025/26, July 2025, Green	
Governance and oversight incl. twice weekly tracking list meeting, weekly operational performance meeting, system capacity meeting, monthly access and responsiveness meeting	2nd line: Monthly alert, assure, advise reporting to the ECQR from the Access and Responsiveness executive sub-committee demonstrates grip and control, appropriate oversight and escalation, September 2025, Green	
Clinical harm review process with CMO reviewing patients over 78 weeks. Metrics and learning on harm from delays in cancer pathways shared at Cancer Board	1st line: Weekly review of long waiting patients by Operational performance meeting demonstrates no patient harm, but increasing number of patients waiting over 62 days on a cancer pathway which could cause patient experience issues, September 2025, Amber (see action 4) Process established within cancer care pathways for harm from delays to be clinically evaluated resulting in targeted action and shared learning reported to Cancer Board. Reporting through Quality Committee to ECQR and by exception to Quality & Safety Committee demonstrates targeted action and shared learning, Amber (see action 4)	Currently clinical review of patients at harm from cancer pathway delays is <50% complete. Clinical Lead for Cancer has responsibility and oversight of progress in this metric.
Health inequalities priorities improving data collection around ethnicity and processes for patients under the mental capacity act	1st line: Annual report to Board on addressing health inequalities demonstrated improvement in ethnicity data capture, priorities and key risks including resource constraints. Key assurance still required is related to the impact for patients, September 2025, Amber (see actions 3, 6 and 7)	Data for patients with other protected characteristics due to patient administration system. Impact on health inequalities work for patients.
Access policy, booking policy, training manual for appointments staff, EPRR policies in place	2nd line: Internal review of policies demonstrates the majority of operational policies are in date and have been reviewed against most recent guidance, with three EPRR policies being reviewed, December 2025, Green EPRR annual assurance to Board demonstrates full compliance September 2024, Green	

	3rd line: Internal audit on faster diagnosis standards demonstrates reasonable assurance with a good control framework in place, September 2025, Green	

Actions	**Timescale**	**Lead**	**Status** (complete, on track, off track, not yet started)
1. Improvements to teledermatology pathway to improve capacity within skin. QVH part of Sussex dermatology transformation work to look at single point of access from 2027.	April 2026	COO	On track
2. QVH to inform the NHSE strategy regarding commissioning of breast reconstruction services across the South East. Internally, continue prioritisation of long waiting patients.	April 2026	COO	On track
3. Use the Health Inequalities Task and finish Group to continue to prioritise ethnicity recording, and to work through actions to reduce inequalities where these are known, e.g children with long waits.	February 2026	CNO	On track
4. Completion of clinical review of harm for cancer patients with long waits	January 2026	CMO	Complete
5. Develop oversight and reporting for non-RTT waits	April 2026	COO	Not yet started
6. Health inequalities data for patients with protected characteristics	February 2026	CNO	Not yet started
7. Provide assurance about the impact on health inequalities work completed to date and yet to be completed for patients	February 2026	CNO	Not yet started
8. Revisit action plans to address issues with 65 week waits and 62 day cancer to address any internal pathway challenges	February 2026	COO	On track
Links to Organisational Risk Register	Risk 77 (patients coming to harm whilst waiting for treatment), 88 (compliance with standards in relation to performance)		

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

BAF

Risk description

Risk:

There is a risk that the Trust may not be able to deliver its clinical, operational and financial objectives due to insufficient digitisation including the benefits of the EPR programme

Caused by:

Constraints of capital and revenue funding to support people and resources required to deliver digital transformation including lack of funding for EPR roles past December 2025;

Resulting in:

Non alignment with the national priority to move from analogue to digital; reputational damage; potential non-realisation of benefits; impact on service delivery and quality

Responsible committee	Finance and performance committee	**Date Risk Added:**	13 November 2025		
Principal Exec – Risk Owner	Helen Edmunds, Chief people officer	**Date Risk last reviewed:**	3 December 2025		
Risk Handler(s)	Bill Gordon, Chief digital information officer	**Date Risk last formally discussed:**	20 January 2026	**Group**	Finance and performance committee

Inherent Score

Current Score

Target Score

Direction of travel since last review		**Target date**	31 December 2025
		Risk tolerance	Current risk score outside of risk appetite with a lower score (seek)

Controls (what are we doing about risk)	Assurances and RAG rating (how do we know if it's working)	Gaps in assurance (what additional assurance is needed)
Digital strategy incl. alignment of digital transformation with EPR programme	1st line: Regular reporting on progress against the EPR programme and the Digital Transformation Programme to the FPC, demonstrates progress, Amber (see action 6)	Review of digital strategy in line with national changes incl. Ten-year plan and strategic partnership Development of the data strategy working with System partners
Digital policies and procedures	1st line: Policy report to ECQR demonstrates no digital policies out of date, however, there are policies currently being reviewed and updated. These will go through the governance process for approval prior to publication January 2025, Amber (see action 7) 2nd line:	Actions to be completed in CAF DSPT improvement plan

	DSPT and CAF annual submission for standards met demonstrates the Trust is approaching standards (not met), June 2025, Amber (see action 1) 3rd line: The independent assessment of the CAF- aligned DSPT undertaken by RSM in May 2025 demonstrated a very high risk rating across all five CAF objectives. Further work has been completed since the assessment was carried out. September 2025, Amber (see action 1)	
Digital security and protection procedures incl. cyber	1st line: CAF and DSPT remediation plan agreed with NHSE reviewed weekly by digital team, and bi-weekly by ELT, demonstrates progress being made against actions, Amber (see action 1) 2nd line: DSPT and CAF annual submission for standards met demonstrates the Trust is approaching standards (not met), June 2025, Amber (see action 1) Monitoring in place for key infrastructure by third party contractor and NHSE CSOC monitoring of cyber alerts, Amber Reporting to the Audit and risk committee demonstrates continued strengthening of cyber security with eight CSOC security alerts being received in the last six months and all but one of them being resolved, September 2025, Green Reporting to the Audit and risk committee on detailed security test undertaken in May 2025 by NHSE CREST. This demonstrated several areas needing attention with 127 vulnerabilities. Most areas were low or medium risk and those rated high or critical are being addressed, May 2025, Amber 3rd line: The independent assessment of the CAF- aligned DSPT undertaken by RSM in May 2025 demonstrates a very high risk rating across all five CAF objectives. Further work has been completed since the assessment was carried out. September 2025, Amber (see action 1)	Board training required to be completed Q1 2026/27 Actions to be completed in CAF DSPT improvement plan Cyber table top exercise to be completed ahead of EPR 'go live'
Horizon scanning for digital funding with NHSE incl. commissioning intentions	1st line: Discussion with NHSE about medium term planning- no confirmation about future funding, October 2025, Red (see actions 3 and 8) 3rd line: Commissioning intentions for 2026/27 demonstrate a continued commitment to driving digital transformation and plans to address duplication in digital infrastructure with opportunities to share costs and functions across the system for implementation from 1 April 2026, October 2025, Red (see actions 3 and 8)	Trust reliant on external funding to progress Significant inflationary increase in resource cost anticipated in relation to digital resources which is not budgeted for.
Workforce with specialist digital and technical skills to support digitisation	1st line: Contractors to support specific functions to support programme such EPR monitored through programme Board until December 2025, Green	Time limited resource with no confirmation of long term funding.

	2nd line: Outsourced functions to 3rd party providers through managed service contracts. Contract monitoring processes in place, Green		
Actions	**Timescale**	**Lead**	**Status** (complete, on track, off track, not yet started)
1. Completion of DSPT and CAF remediation plan	31 January 2026	CDIO	In progress
2. Cyber table top exercise to be completed ahead of EPR 'go live'	1 November 2025	CDIO	Complete
3. Request to NHSE for EPR team funding post December 2025 and budget considerations internally	31 October 2025	CDIO	Complete – funding request was successful
4. Review of the Digital strategy in line with national changes incl. ten year plan and strategic partnership	31 January 2026	CDIO	Off track
5. Board cyber training	31 March 2026	CS	Planned for Q1 2026
6. Regular reporting to the Finance and performance committee Re EPR Go Live	31 March 2026	CDIO	In progress
7. Digital policies to be updated and approved through governance routes	31 January 2026	CDIO	In progress
8. Ongoing discussions with NHSE about availability of funding to support digital	Ongoing	CDIO	In progress
Links to Organisational Risk Register	138 (failure to deliver EPR programme)		

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

BAF

Risk description

Risk:

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

Caused by:

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

Resulting in:

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

Responsible committee	Finance and Performance committee	**Date Risk Added:**	13 November 2025		
Principal Exec – Risk Owner	Chief Finance Officer	**Date Risk last reviewed:**	8 December 2025		
Risk Handler(s)	Interim Director of Estates and Facilities	**Date Risk last formally discussed:**	20 January 2026	**Group**	Finance and performance committee

Inherent Score

Current Score

Target Score

Direction of travel since last review	⟷	**Target date**	31 March 2026
		Risk tolerance	Current risk score outside of risk appetite (higher) (minimal)

Controls (what are we doing about risk)	Assurances and RAG rating (how do we know if it's working)	Gaps in assurance (what additional assurance is needed)
Estates policies and processes in place to support compliance with statutory requirements	1st line: Regular reporting on the Trust's estate to the Finance and Performance committee demonstrates that works are completed are in line with statutory requirements, September 2025, Green 2nd line: Regular report regarding out of date policies to the ECQR demonstrates 5 estate policies being out of date, November 2025, Amber (see action 7) Policy log demonstrates that key estates policies are in place to support compliance with statutory requirements, November 2025, Amber (see action 7)	Planned backlog works to be completed including fire and heating systems multi-year plans and the schemes added following the receipt of £2.8m of additional estates safety funding. The last six facet survey was completed in 2023- an updated detailed six facet survey is required by 31.3.26 Appointment of authorised engineer (AE) for electrical and review on electrical compliance to be completed Appointment of authorised engineer (AE) for medical gases and review on medical gas compliance to be completed

	Premises Assurance Model completed annually and reported to the Finance and Performance committee and the Board demonstrates significant improvement from the previous year with action planning for further improvements underway, November 2025, Amber (see action 2) 3rd line: Authorised engineer (AE) review on water compliance was completed in September 2025 and the report is being actioned Authorised engineer (AE) review on ventilation compliance is due to be completed in November/December 2025	PAM improvement action plan to be implemented Histology water action plan to be completed
Estates capital funding plan to ensure prioritisation of works in line with risks	1st line: Regular reporting on the Trust's estate to the Finance and Performance committee demonstrates limited funding available to appropriately address critical infrastructure risks, September 2025, Amber (see action 2). Receipt of the additional £2.8m of estates safety funding will go some way to address this, but further funding will still be required in future years. 2nd line: Review of estates budget by management accountant demonstrates that the directorate is overspent on its allocated budget at this stage of the year due to unplanned and unforeseen issues, November 2025, Amber (see action 2) Regular reporting on financial performance through the IQPR demonstrates that the estates capital budget is underspent at November 2025, this continues to be monitored and corrective actions are being taken. Amber (see action 8) 3rd line: £2.8m of estates safety funding received in November 2025, Amber (see action 2)	QVH does not meet the NHS new hospital programme criteria so there is no assurance regarding a future rebuild, however the current site is uneconomic to keep repairing. At the current time Estates Safety Fund and RAAC replacement bids provides the only realistic mechanisms for tackling our backlog maintenance challenges. The Trust has been successful with our estates safety bids
Business continuity plans for dealing with a range of issues, for example critical infrastructure failure	2nd line: EPRR annual assurance to Board demonstrates full compliance September 2024, Green	Lack of EPRR lead There is a need to review estates specific business continuity plans There are limited mitigations regarding emergency plant in the event of a critical failure as there is no in-built resilience. There is no normal load plus one for critical plant which is not in line with HTM guidance Reliance on key individuals to enact business continuity plans
Asbestos management plan in place to meet the statutory requirement of CAR 2012 (Control of Asbestos Regulations)	1st line: Regular review of Management Plan by estates leadership incl. visual inspection of asbestos areas demonstrates a requirement to remove certain asbestos contained roofing materials (ACM's) within six months. Red (see action 2) 3rd line:	Assurance from annual review of Asbestos Management Plan D Additional roofing actions have now been prioritised and funded.

	The Management Plan is reviewed annually by an external specialist contractor. The next review of due in November 2025. Green Regular testing (refurbishment and demolition surveys) to identify asbestos prior to any building or repair works being undertaken, demonstrates no works to be undertaken in unsafe environment, November 2025, Green	
Estates team and key roles with appropriate qualifications to manage the Trust's estate	1st line: Review of team demonstrates that some key roles are in place including Director of Estates and Facilities, Associate Director of Estates and Facilities, Project manager and Compliance Manager, however there are gaps in expertise relation to electrical and mechanical, ventilation and water and medical gases, November 2025, Red (see actions 4 and 5)	Lack of qualified persons in roles incl. fire advisor and other authorised persons such as electrical and mechanical, ventilation, water and medical gases Partnership opportunities and solutions to be resolved

Actions	**Timescale**	**Lead**	**Status** (complete, on track, off track, not yet started)
1. Statutory Fire advisor role to be recruited to	31 March 2026	ADEF	On track
2. Seeking additional funding from NHSE for funding for critical infrastructure risks	Ongoing	DEF	Completed
3. Arrange for a six facet survey to be completed	31 March 2026	DEF	Not yet started
4. Appointment of authorised engineer (AE) for electrical and review on electrical compliance to be completed	31 March 2026	DEF	Not yet started
5. Appointment of authorised engineer (AE) for medical gases and review of medical gas compliance to be completed	31 March 2026	DEF	Not yet started
6. Review of estates specific business continuity plans	31 March 2026	ADEF	Not yet started
7. All estates policies to be updated in line with requirements	31 December 2025	ADEF	Off track
8. Continued oversight of estates capital spend to support year end position	32 March 2025	CFO	Ongoing

Links to Organisational Risk Register	153 (spread of fire), 139 (electrical fire), 47 (failure of electrical systems), 48 (fire alarm), 49 (fire dampers), 53 (heating and hot water), 54 (boiler)

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

BAF

Risk description

Risk:

There is a risk that the Trust will not deliver the full value of its £7.5m cost improvement plan for 2025/26 and cost improvement plans for future years; deliver a breakeven position for 2025/26 and for future years and/ or that the working cash balance will reduce to lower than £1m.

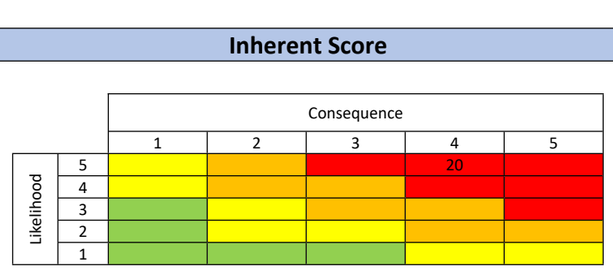
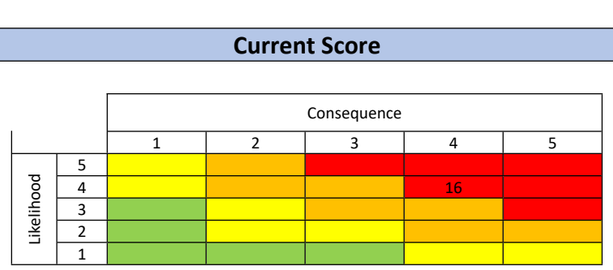
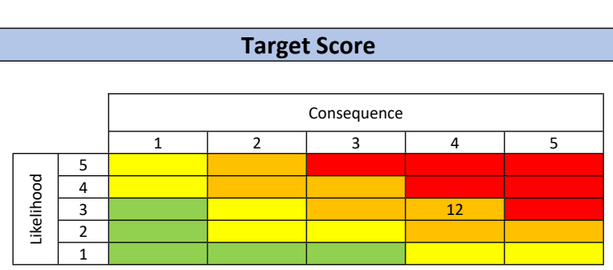
Caused by:

The Trust's significant cost improvement target of £7.5m for 2025/26 including the requirement for corporate service cost reductions; changes to the funding regime including capping of income levels; significant activity levels, and financial pressures across other NHS organisations delaying payments.

Resulting in:

The Trust not being financially sustainable for the future.

Responsible committee	Finance and performance committee	**Date Risk Added:**	13 November 2025		
Principal Exec – Risk Owner	Chief Finance Officer	**Date Risk last reviewed:**	8 December 2025		
Risk Handler(s)	Deputy Chief Finance Officer	**Date Risk last formally discussed:**	20 January 2026	**Group**	Finance and performance committee

Inherent Score	Current Score	Target Score
		
	Direction of travel since last review 	**Target date** 31 March 2026
		Risk tolerance Current risk score outside of risk appetite (higher) (minimal)

Controls (what are we doing about risk)	Assurances and RAG rating (how do we know if it's working)	Gaps in assurance (what additional assurance is needed)
Efficiency Steering Group (ESG) is charged with overseeing the Better Value Programme, including the identification of productivity and efficiency opportunities, ensuring that approved schemes are developed through to implementation including the completion of QIAs where necessary. The ESG is also responsible for the tracking and reporting of delivery of schemes and any remedial actions where needed.	1st line: Reporting on progress of the cost improvement programme through the Efficiency Steering Group, Finance and Performance committee and Board. This demonstrates delivery against programme but with more being delivered non-recurrently than planned, November 2025, Amber (see action 1) 2nd line Regular reporting on finance through the IQPR. This demonstrates delivery against programme and key corrective actions being taken, but with more	Assurance that recurrent savings can be made. Currently, more is being delivered non-recurrently than planned. Findings from internal audit on financial management review (started in November 2025).

	being delivered non-recurrently than planned, November 2025, Amber (see action 1)	
Regular oversight of overall financial position incl. regular reporting to the Resources and Financial Control Groups	1st line: Regular reporting and review of financial management arrangements, including revenue, capital, VAT, NI, ERS, balance sheet items and cash flow actuals & forecasts and the accounting treatment of significant transactions, Green 2nd line: Regular reporting on divisional financial performance, through the IQPR demonstrates that to date, the Trust remains on track for its breakeven target, but this is not without risk, November 2025, Amber	Findings from internal audit on financial management review (started in November 2025).
Financial policies including Standing Financial Instructions, Scheme of Delegation, Contract policy and Procurement policy	1st line: Regular reporting to the Audit and Risk committee regarding compliance with policies including waiver report and PO compliance report. This demonstrates a reduced number of waivers supporting better value for money and the percentage of non-PO's being less than 1% of invoices, September 2025, Green 2nd line: Regular report regarding out of date policies to the ECQR demonstrates no finance policies being out of date, November 2025, Green 3rd line: Internal audit on compliance with governing documents and policies concluded reasonable assurance with considerable progress and strengthening of controls, September 2025, Green	Assurance that staff across the organisation understand their responsibilities. Assurance that the compliance position has materially improved long term. Quarterly reviews demonstrate compliance to date. The next annual review is due to be completed and reported to the Audit and Risk committee at its meeting in March 2026.
Medium term financial plan in development to support a forward view	There is no assurance to date as the MTFP remains in development for adoption in Q4 with significant amounts of internal and system work still to be undertaken, Amber (see action 3)	Medium term financial plan sign off and ongoing monitoring of progress.
Annual business planning process incl. budget setting	1st line: Reporting on Business plan 2025/26 to the Finance Performance committee and Board demonstrates planned breakeven position, however this is high risk, November 2025, Amber (see action 1) Report to ELT on the business planning approach for 2026/27 demonstrates that learning from last year is being taken to further improve the business planning process, September 2025, Green 2nd line: Fortnightly review of business planning progress by business planning group to ensure delivery and triangulation of plans shows that the planning process for 2026/27 is underway November 2025, Amber	National planning guidance for 2026/27 received and is being fed into internal and system plans. Findings from internal audit on financial management review (started in November 2025).

	Timescale	**Lead**	**Status** (complete, on track, off track, not yet started)

Actions			
1. Continued identification of cost improvement programmes and conversion of non-recurrent to recurrent schemes	Ongoing	CFO	Ongoing
2. Develop Governance handbook to support staff across organisation	31 March 2026	CS	Ongoing
3. Medium term financial plan to be developed as part of the 2026/27 business planning process	Q4 25/26	CFO	In progress
Links to Organisational Risk Register	161 (cash balance), 148 (CIP), 149 (ERF assumptions), 144 (delivery of breakeven plan)		

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

BAF

Risk description

Risk:

There is a risk that there will not be leadership capacity to deliver the strategic partnership, key strategic objectives and key projects

Caused by:

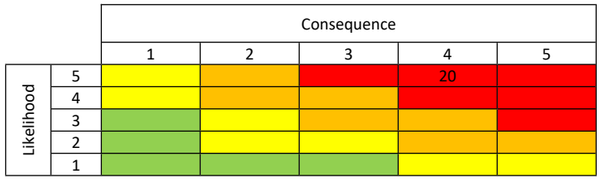
Three interim executive roles including Chief executive officer; turnover in Board level roles and organisational memory loss; Chair finishing term at end of December 2025

Resulting in:

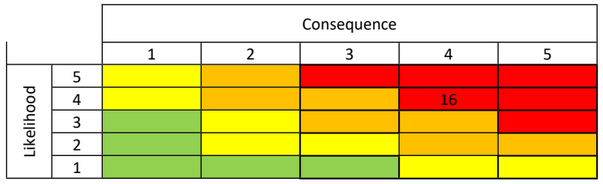
Closure of services/ site; regulatory intervention; reputational damage; non-delivery of recurrent annual financial, productivity and efficiency savings

Responsible committee	Strategy and culture committee	**Date Risk Added:**	13 November 2025		
Principal Exec – Risk Owner	Chief executive officer	**Date Risk last reviewed:**	8 December 2025		
Risk Handler(s)	Chief executive officer	**Date Risk last formally discussed:**	26 November 2025	**Group**	Strategy and culture committee

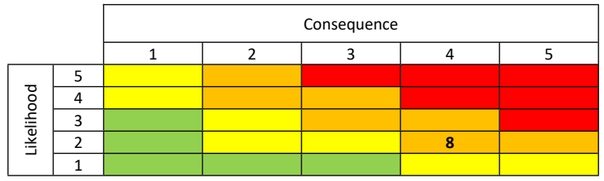
Inherent Score



Current Score



Target Score



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

Controls (what are we doing about risk)	Assurances and RAG rating (how do we know if it's working)	Gaps in assurance (what additional assurance is needed)
Key Board level roles being filled incl. executive portfolios covering all areas of operational business	1st line: Review of Board roles demonstrates all roles currently filled with some executive roles being filled by interims to ensure the required level of experience required. The Trust Chair's term ends on 31 December 2025 and an interim arrangement from January 2026 is being worked through, December2025, Red (see action 3) Board succession plan presented to the Nomination and remuneration committee in March 2025 demonstrates a limited succession pipeline for key roles, March 2025, Red (see action 2)	Confirmation of interim Chair from January 2026 (post interviews on 9 December 2025) Three Non-executive directors are coming to the end of their terms in June 2026- confirmation of arrangements from June 2026 onwards Potential delays driven by external factors beyond the control of QVH

	Reporting to the Strategy and Culture committee outlining the timeline demonstrates that the Trust is meeting milestones to have a shared Chair and CEO in post by March 2026, October 2025, Amber 3rd line: Proposals received from potential partners demonstrate potential delays to shared Chair and CEO being in post beyond March 2026, October 2025, Red	
Programme of work to deliver strategic partnership incl. timeline	1st line: Reporting to the Strategy and Culture committee outlining the timeline demonstrates that the Trust is meeting milestones, however the timeline remains challenging with external factors being a risk, November 2025, Amber Reporting to the Strategy and Culture committee outlining the option appraisal process demonstrates a robust, methodical and objective process, August 2025, Amber 3rd line: Review of NHSE timeline demonstrates alignment with QVH timeline, October 2025, Amber	
Monitoring of progress against strategic projects incl. project management office function in place to support this	1st line: Update to Board to confirm the EPR Go Live has been a success with no patient cancellations, November 2025, Green 2nd line: Reporting on major projects to the Finance and performance committee through the PMO and IQPR demonstrates the EG CDC being rated as Green/ Amber, the Bognor CDC being rated as Amber and the EPR project being rated as Amber, November 2025, Amber (see action 4) Reporting on major projects to the Finance and performance committee through the PMO demonstrates that the Trust's financial position is impacting the progress of some projects, as well as some resource challenges November 2025, Amber (see action 4)	Project benefits realisation tracking across the Trust to be developed
Key strategic objectives and priorities	1st line: Reporting to the Board demonstrates that year one implementation of the QVH Strategy 2025-2030 is included and being driven forward within the key strategic objectives for 2025/26, progress is on track, November 2025, Green Reporting to the Board demonstrates good progress against the key strategic objectives and priorities for 2025/26 during Q1 and Q2, November 2025, Amber (see action 4)	Some gaps in assurance in some strategic projects including post go live EPR funding

Actions	**Timescale**	**Lead**	**Status** (complete, on track, off track, not yet started)
1. Shared Chair and CEO to be in post by March 2026	March 2026	CEO	Off track- proposals received from potential partners demonstrate delays to original March date
2. Explore opportunities for sharing corporate services and key roles	March 2026	CEO	On track
3. Interim Chair arrangements from January 2026 to be agreed	December 2025	SID, CS	Complete- interim Chair appointed
4. Project benefits realisation tracking to be developed	February 2026	DCSO	On track

5. Non-executive director arrangements from June 2026 to be agreed	January 2026	Interim Chair, CS	Off track
Links to Organisational Risk Register	11 (relationship between Board and Council of Governors)		

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

Responsible committee	Strategy and culture committee	**Date Risk Added:**	13 November 2025		
Principal Exec – Risk Owner	Chief people officer	**Date Risk last reviewed:**	2 December 2025		
Risk Handler(s)	Deputy Chief people officer	**Date Risk last formally discussed:**	26 November 2025	**Group**	Strategy and culture committee

Inherent Score	Current Score	Target Score
		

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

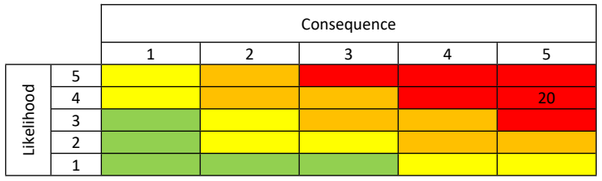
Controls (what are we doing about risk)	Assurances and RAG rating (how do we know if it's working)	Gaps in assurance (what additional assurance is needed)
Staff wellbeing support and programmes incl. occupational health, EDI champions, Vivup, Wellbeing team initiatives, monthly newsletter promoting annual wellbeing calendar	1st line: Data showing staff sickness and type. Data shows c.4% sickness level with an increase in long term sickness, October 2025. Sickness data continues to show sickness c. 4% for November 2025 Amber (see actions 1 and 4) Reporting to CTSG demonstrates progress towards using continuous improvement methodology to improve culture and challenges experienced by EDI champions with engagement, October 2025, Amber (see actions 1 and 4) 2nd line: 2024 Staff survey results published in March 2025 with a 57% response rate, demonstrate disabled staff have a less positive experience than non-disabled staff and	EDI groups not up and running. As partnership work progresses, link to partner organisation staff networks to be utilised. Responses to CTSG survey (not yet happened) will determine focus of group. November 2025, DCPO meeting with ACEO to review CTSG focus. 2025 staff survey closed 28 November. Data due for publication in March 2026.

	staff do not always feel confident action will be taken if they speak up, Amber (see actions 1 and 4) People Pulse Survey for Q2 was responded to by 14% of staff which demonstrated a decline in mood and motivation, Red (see actions 1 and 4)	
Staff development and training incl. coaching, mentoring, change management workshops, resilience workshops	1st line: Executive sub-committee for Workforce regular assurance report to ELT includes staff development and training data, demonstrates a good take up from clinical and medical staff, but less from corporate staff, September 2025. Next assurance report due at ELT in December 2025 Amber (see action 2) Apprenticeship Levy report presented to the Finance and performance committee in September 2025 demonstrates that our spend has increased as well as the number of apprentices and types of apprenticeships, but there needs to be a focus widening the diversity pool of apprentices. Paper detailing action plan to improve diversity taken to ELT in November 2025 Green 2nd line: Mandatory and statutory training compliance reported monthly through IQPR, demonstrates 92% compliance overall with improvement required in some specific areas such as Resus, October 2025. MAST compliance stable in November 2025 with a focus on Data Security (IG) training and fire training, Green	Managers training programme not yet in place- the first cohort is booked to start in October 2025. Assurance will be in manager and staff feedback, ER cases, FTSU increases – November 2025, course now in place and running
Managers training programme, prioritising bands 6-8a- two day programme including policies and softer skills such as supporting staff to speak up and holding difficult conversations	1st line: 2 cohorts underway with feedback / evaluation undertaken after each training day. Positive feedback received from participants. December 2026 Green	
Behaviour framework and implementation including embedding into 1:1's, appraisals, team charters, interview processes	1st line: Data related to number of appraisals completed is reported monthly in the IQPR, demonstrates the average compliance rate is 83% against the 90% target, October 2025. Completion rates continue to be monitored through IQPRs with slight increase in completion rate in November 2025 Amber Employee relations team weekly review of employee relations cases, demonstrates focus points for specific support and interventions required, October 2025, Amber (see action 1) 2nd line: Organisational cultural assessment undertaken to be presented to the Board in November 2025, demonstrates that there are micro cultures and ongoing focus required to embed behavioural framework. Presented to Board in November, with ongoing actions to support ongoing culture work (December 2025) Green	Further assurance required regarding embedding of behaviours framework
Mechanisms in place for staff to provide feedback incl. Staff Survey, Quarterly People Pulse Surveys, Freedom to Speak Up Service, 'Tell Edmund', 'Ask Abigail'	2nd line: 2024 Staff survey results published in March 2025 with a 57% response rate, demonstrate disabled staff have a less positive experience than non-disabled staff and staff do not always feel confident action will be taken if they speak up, Amber (see actions 1 and 4) People Pulse Survey for Q2 was responded to by 14% of staff which demonstrated a decline in mood and motivation, Red (see actions 1 and 4)	Action plan from culture review

	3rd line: FTSU Guardian report presented to the Board in July 2025 demonstrated that more staff are speaking up but some staff still wishing to stay anonymous due to concerns about the consequence, Green		
Actions		**Timescale**	**Lead**	**Status** (complete, on track, off track, not yet started)
1. Ongoing promotion and embedding of behaviour framework and values through workshops, staff survey action plans and team charters.		Ongoing	Head of Leadership and OD	Ongoing- workshops completed in September, October and November 2025
2. Communication and engagement plan to encourage non-clinical staff to apply for Charity funded training to support their development		Ongoing	Head of Leadership and OD	Ongoing
3. Communication and engagement plan to encourage a wider diversity of apprenticeship applicants		Ongoing	Head of Leadership and OD	Action plan presented to ELT November 2025 with ongoing work in place and a comms plan agreed
4. Link into to partner organisations to join/ support EDI networks		March 2026	Chief People Officer	Not yet started
5. Organisational culture review incl. associated action plan		Ongoing	Chief People Officer	Presented to Board in November 2025 with an ongoing action plan
Links to Organisational Risk Register	133 (hard to recruit to roles)			

KSO1	KSO2	KSO3	KSO4	KSO5	Overall Assurance Rating (RAG)	Q3- 2025/26	Q4- 2025/26				
✓	✓		✓								
BAF	Risk: There is a risk that the Trust may not consistently deliver high quality, safe and effective care Caused by: Failure to ensure that clinical structure enables prioritisation of quality, safety and effectiveness in care; productivity increases constrict time to care and train, financial constraint compromises progress in estate, systems and equipment supporting care, frequent and rapid organisational changes distracts from sustainable quality Resulting in: Poor patient experience and outcomes; potential harm; reputational damage										

Responsible committee	Quality and safety committee	**Date Risk Added:**	13 November 2025		
Principal Exec – Risk Owner	Chief medical officer / Chief nursing officer	**Date Risk last reviewed:**	23 January 2026		
Risk Handler(s)	Deputy Chief nursing officer	**Date Risk last formally discussed:**	20 January 2026	**Group**	Quality and safety committee

Inherent Score	Current Score	Target Score
		
	Direction of travel since last review 	**Target date** 31 March 2026 **Risk tolerance** Current risk score outside of risk appetite (higher) (minimal)

Controls (what are we doing about risk)	Assurances and RAG rating (how do we know if it's working)	Gaps in assurance (what additional assurance is needed)
Quality impact assessments - to assess risk to quality and safety from cost improvement and productivity programme initiatives	1st line: Review of all QIA (completed by directorate lead) by CNO and CMO demonstrates no significant quality and safety concerns to date from CIP programme, October 2025, Green 2nd line: Quality and safety sub-committee of Board and executive sub-committee for quality in place with oversight of quality and safety matters, November 2025, Green Incident reporting through Datix demonstrates no significant quality and safety issues as a result of cost improvement programme initiatives to date, October 2025, Green	Initial assessments only performed currently. Review process required to consider evolution and longer term effects. QIAs have not systematically been completed for productivity initiatives (theatre productivity QIA complete). The co-dependence of initiatives has not been assessed through a QIA process.

	Analysis of theatre productivity work stream presented to QSC did not show impact on quality and safety, April 2025, Green 3rd line: Friends and family test responses demonstrate that the recommendation rate was 95.12% for August 2025, Green	
Incidents - consistent reporting of incidents with learning including thematic review supported by clinical governance framework. Patient safety incident response framework (PSIRF) approach in place and central incident reporting through the Learning from Patient Safety Events (LfPSE) platform	1st line: Summary incident reports collated and actively managed through directorates and groups reporting into Quality Committee, Green Exec/ Board level time spent in clinical areas observing and listening to patients / team members, ongoing, Green 2nd line: Quality and safety sub-committee of Board and executive sub-committee for quality in place with oversight of quality and safety matters, November 2025, Green Monthly review of incident evaluation at ECQR demonstrates effectiveness of primary processes, Green IPC Surveillance to understand impact of environment on patient safety and outcomes, Green Demonstration of learning through morbidity & mortality meetings, governance meetings, IQPR and the Clinical Learning Forum, Green 3rd line: Quarterly quality review by the ICB raised no quality concerns, Q1 2025/26, Green Internal audit review of incident management during August 2025. Outcome awaited	Currently no PSIRF lead and limited staff with capability / capacity to manage PSIRF and ensure that learning is embedded in practice.
Complaints process - in line with national guidance and quality priority for 25/26. Process in place to hear patient voice and respond in a timely fashion	1st line: Summary complaint reports collated and actively managed through directorates and groups reporting into Quality Committee, Green 2nd line: Quality and safety sub-committee of Board and executive sub-committee for quality in place with oversight of quality and safety matters, November 2025, Green Responsiveness to patient complaints is embedded within assurance on 2025/26 quality priorities, Green Patients stories to Board, November 2025, Green Annual Complaints Report, July 2025, Green 3rd line: Reporting demonstrates that there have not been any complaints escalated to the PHSO during 2024/25 and 2025/26 to date, October 2025, Green	Assurance on achievement of timely response to complaints (reduced from 40 to 30 days). Dependency of process on a single individual.

Speaking up mechanisms - incl. Direct to line manager, Freedom to Speak Up Guardian, Tell Edmund, Ask Abigail, Whistleblowing ensure opportunities for an open and honest culture in which quality of care can thrive	1st line Continuous and consistent utilisation of speak up mechanisms with good real-time feedback on response received by people speaking up reported to Quality & Safety Committee, Green 2nd line: Reporting to the Audit and risk committee demonstrates that there are numerous channels available for staff to speak up and that progress is being made to drive opportunities for improvement including the introduction of the Cultural Transformation Steering Group (CTSG), June 2025, Amber (see action 1) 3rd line: Reports from FTSU guardian to Board demonstrates an increase in speak ups since independent guardian has been in post, however there remains challenges with staff feeling safe to speak up, September 2025, Amber (see action 1)	Staff survey results demonstrate a decline in the percentage of staff who feel safe to speak up and confidence that concerns will be addressed, June 2025. Action plan and monitoring required.
Clinical audit - plan to identify risks to quality, safety and effectiveness of care	1st line: Quality and Compliance Team regularly monitoring against audit and effectiveness standards. Green 2nd line: Quality and safety sub-committee of Board and executive sub-committee for quality in place with oversight of quality and safety matters, November 2025, Green Reporting on compliance with audit programme and NICE guidelines through ECQR demonstrates that where the Trust is not compliant, there are mitigations in place to manage the risks, September 2025, Green 3rd line: Audit embedded in 2025/26 quality priorities and therefore reporting into Quality Account, Amber (see action 5)	Engagement with directorates to address limited progress with audit completion. Constraints in IT resources limiting optimal data collection through digital systems need to be addressed.
Safe staffing procedures in place to ensure staffing fill rate does not fall below 98%.	1st line: Daily monitoring of staffing levels by HoNs demonstrates safe staffing levels. Staffing fill rate does not fall below 98%, October 2025, Green 2nd Line Quality and safety sub-committee of Board and executive sub-committee for quality in place with oversight of quality and safety matters, November 2025, Green Six monthly report to Board demonstrates procedures are in place and inpatient staffing levels are safe, however there is a need to review in line with cost improvement plans, May 2025, Amber (see action 6) 3rd line: NHSE Oversight of safer staffing processes and compliance, Green	Reconfiguration of nursing staff and review of the impact on quality once in place.
Archie EPR implementation included extensive clinical engagement	1st line: CNIO and CCIO in post with clinical safety capability supporting maintenance of hazard log and clinical safety case, Amber (see action 7)	Funding constraint in ongoing support for EPR programme including clinical safety

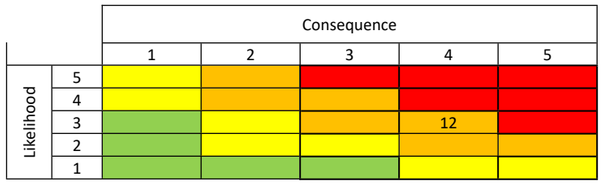
	2nd line: Third party vendor providing independent clinical safety assessment to ensure compliance with DCB1060 prior to go live, Amber (see action 7)	
Clinical Governance reporting framework established	1st line: Dedicated clinical governance staff time to ensure consistent recognition and evaluation of quality and safety metrics, Amber (see action 8) 2nd line: Quality and safety sub-committee of Board and executive sub-committee for quality in place with oversight of quality and safety matters, November 2025, Green Reporting through revised Quality, Safety and (clinical) Risk infrastructure to regularly evaluate achievement against metrics and learning from triangulated data, Green	Clinical governance structure undergone numerous changes so embedding of new processes needs to be established.
Staff Training – Designated leadership in clinical professional learning. Electronic and face to face training environments.	1st line: Line manager oversight of training compliance through ESR, Green 2nd line: MAST training compliance monitored and acted upon through Quality committee, Green 3rd line: Provider assurance framework includes oversight of training data, Green	Policies and procedures to align with training in practice.
Clinical Risk Management – drives understanding and action on identified risk to quality and safety.	1st line: Inphase risk management system in place to manage risk, Green 2nd line: Quality and safety sub-committee of Board and executive sub-committee for quality in place with oversight of quality and safety matters, November 2025, Green IQPR, ECQR and local clinical governance meetings where risk evaluation takes place, Green 3rd line: External auditing of risk management pending	Lack of robust process for risks to be escalated and approved to the risk register. Limited ability to triangulate risk with other clinical governance data due to recording in separate systems (eg. Inphase/Datix).

Actions	**Timescale**	**Lead**	**Status** (complete, on track, off track, not yet started)
1. Evidence of actions following staff survey address deficiencies in staff confidence to speak up needs to be addressed through behavioural framework initiatives	31 January 2026	CPO, CNO, CMO	In progress
2. a. QIAs to be performed for all productivity initiatives as well as CIPs b. Ongoing review process for QIAs required c. Monitoring for impact of co-dependent initiatives required	31 January 2026	CNO, COO, CIP Lead	In progress
3. Review PSIRF policy and ensure resources in place to enable delivery	31 January 2026	CNO, Head of Patient Safety	In progress
4. Monitoring of timely responsiveness to complaints target, consideration of dependency on individual for service	31 January 2026	CNO, Head of Patient Safety	In progress
5. Engagement with directorates to ensure completion of audit deliverables	31 March 2026	CMO, Head of Quality and Compliance	In progress

6. Reconfiguration of nursing staff and review of the impact on quality once in place to include care of patients in outpatient environment	31 March 2026	CNO	In progress
7. Digital transformation programme to identify opportunities for ongoing clinical safety support and digital enablement of audit and outcomes collection following EPR go live	31 January 2026	CIO, CMO	In progress
8. Clinical governance structure undergone numerous changes so embedding of new processes needs to be established.	31 March 2026	CNO, CMO	In Progress
9. All policies and procedures up to date and reflect the training within the organisation.	31 March 2026	Executive owners	In Progress
10. Embedded risk management process and adherence to policy.	31 March 2026	Trust Secretary	In Progress
11. Exploration of quality management systems to enable triangulation of intelligence.	31 March 2026	CMO, Head of Quality and Compliance	In Progress
Links to Organisational Risk Register	16 (mental capacity act), 17 (staff may not speak up with concerns), 38 (environment on peanut ward), 117 (medical devices), 125 (mental health provision), 189 (sustainability of key services)		

KSO1	KSO2	KSO3	KSO4	KSO5	Overall Assurance Rating (RAG)	Q3- 2025/26	Q4- 2025/26				
✓	✓	✓	✓	✓							
BAF	**Risk description** Risk: There is a risk that the Trust may not be able to meet its regulatory requirements Caused by: Scale; cost improvement plans; corporate savings; turnover at Board level; additional licence conditions; non-compliance; leadership capacity; national changes to requirements Resulting in: Damage to reputation; non-removal of additional licence conditions; regulatory intervention										

Responsible committee	Audit and Risk committee	**Date Risk Added:**	13 November 2025		
Principal Exec – Risk Owner	Chief executive officer	**Date Risk last reviewed:**	8 December 2025		
Risk Handler(s)	Company secretary	**Date Risk last formally discussed:**	5 January 2026	**Group**	Audit and risk committee

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

Controls (what are we doing about risk)	Assurances and RAG rating (how do we know if it's working)	Gaps in assurance (what additional assurance is needed)
Key Trust policies in place aligned to statutory and regulatory requirements	1st line: Reporting to the ECQR demonstrates that a revised 'policy for policies' is in place and has been disseminated to staff. The revised policy for policies seeks to ensure consistency for policy management across the Trust, however further assurance is required to demonstrate improvements with policy management, July 2025, Amber (see action 1) Reporting to the ECQR demonstrates that a robust process is in place to ensure that policy owners are made aware when policies are expiring incl the deadline and process for updating them, December 2025, Green 2nd line:	Assurance that the 'policy for policies' has been embedded and driving improvements in policy management Assurance that progress is being made in updating out of date policies or taking them out of circulation if they are deemed to be duplicative/ no longer required

	Reporting to the ECQR on out of date policies demonstrates that of 242 active policies, 45 are out of date which is a decrease since the last review. No key corporate policies are out of date, December 2025, Red/Amber (see action 2) 3rd line: Reporting on progress of internal audit plan to Audit and risk committee demonstrates some actions are not being completed in a timely manner, September 2025, Amber Reporting to the Audit and risk committee on progress of internal audit plan demonstrates some slippage of the annual plan for 2025/26, September 2025, Green/ Amber	
Governing documents in place including Trust Constitution, Scheme of delegation and reservation of powers, Standing financial instructions aligned to statutory and regulatory requirements	1st line: Regular reporting to the Audit and Risk committee regarding compliance with policies including waiver report and PO compliance report. This demonstrates a reduced number of waivers supporting better value for money and the percentage of non-PO's being less than 1% of invoices, September 2025, Green 2nd line: Annual governance statement conclusion for 2024/25 demonstrates significant control issues being identified during 2024/25 related to compliance, procurement and contract management, July 2025, Red (see action 4) 3rd line: External audit report for 2024/25 demonstrates significant weaknesses in governance within the value for money assessment, September 2025, Red (see action 4) Reporting on progress of internal audit plan to Audit and risk committee demonstrates some actions are not being completed in a timely manner, September 2025, Amber Reporting to the Audit and risk committee on progress of internal audit plan demonstrates some slippage of the annual plan for 2025/26, September 2025, Green/ Amber Internal audit on compliance with governing documents and policies concluded reasonable assurance with considerable progress and strengthening of controls, September 2025, Green	Assurance that staff across the organisation understand their responsibilities Assurance that the compliance position has materially improved long term. Quarterly reviews demonstrate compliance to date. The next annual review is due to be completed and reported to the Audit and Risk committee at its meeting in March 2026
Annual Provider Capability Assessment demonstrating Board awareness of gaps against key lines of enquiry from the Insightful Provider Board guidance	1st line: Provider capability assessment undertaken by the Board demonstrates a confirmed rating for quality of care and people and culture and a partially confirmed rating for other areas. The submission demonstrated action being taken to address gaps, October 2025, Amber (see action 5) 3rd line: Review of Provider capability assessment to be undertaken by NHSE including feedback	Review of progress against actions to address gaps
Code of Governance for NHS Provider trusts	2nd line: Annual review of compliance against the Code of Governance for NHS provider trusts to Board demonstrates one area of non-compliance during 2024/24, related to NED pay. This is compared to multiple areas of compliance being reported in previous years. May 2025, Green	

Actions	**Timescale**	**Lead**	**Status** (complete, on track, off track, not yet started)
1. Review of effectiveness of 'policy for policies'	July 2026	CS, executive team	On track
2. Continued oversight of management of out of date policies incl. priority areas	March 2026	Policy owners	Ontrack
3. Develop Governance handbook to support staff across organisation	31 December 2025	CS	Ongoing
4. Assurance to Audit and risk committee about compliance with governing documents	March 2026	CS, CFO	On track
5. Review of progress against actions to address gaps within Provider capability assessment	March 2026	Board	On track
Links to Organisational Risk Register	11 (relationship between Board and CoG), 14 (non-compliance with governing documents)		

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

BAF

Risk description

Risk:

There is a risk that the Trust will not secure long term sustainability

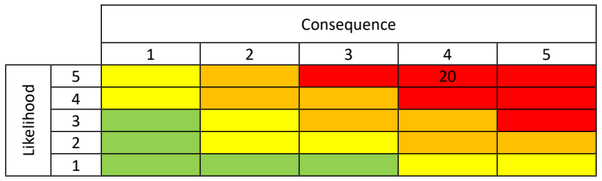
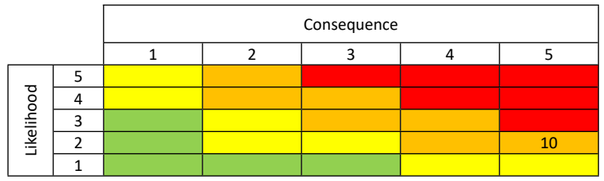
Caused by:

Inability to secure a strategic partnership; Challenges with progression of engagement with shortlisted partners; a potential breakdown in relationship between the Board and the Council of Governors; leadership capacity and resilience challenges; significant national changes; changes to the commissioning of services; changes to service specifications; staff morale; time constraints; differing views of key stakeholders on options

Resulting in:

Sustainability challenges for patient services/ site; non-delivery of QVH Strategy 2025-2030; regulatory intervention; reputational damage; non-delivery of recurrent annual financial, productivity and efficiency savings

Responsible committee	Strategy and Culture Committee	**Date Risk Added:**	13 November 2025		
Principal Exec – Risk Owner	Chief Strategy Officer	**Date Risk last reviewed:**	2 December 2025		
Risk Handler(s)	Deputy Chief Strategy Officer	**Date Risk last formally discussed:**	26 November 2025	**Group**	Strategy and Culture Committee

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

Controls (what are we doing about risk)	Assurances and RAG rating (how do we know if it's working)	Gaps in assurance (what additional assurance is needed)
Option appraisal process for strategic partner - consideration of options for strategic partner based on criteria including quality of patient care/ meets the needs of population, strategic alignment, financial sustainability and leadership and culture	1st line: Reporting to the Strategy and Culture committee outlining the option appraisal process demonstrates a robust, methodical and objective process, August 2025, Green Reporting to the Strategy and Culture committee outlining the timeline demonstrates that the Trust is meeting milestones, however the timeline remains challenging with external factors being a risk, October 2025, Amber (see actions 1 and 2) 2nd line:	

	Scoring and moderation process completed with input from wider ELT and independent moderation support, November 2025, Green 3rd line: Review of the option criteria by NHSE and ICB with confirmation of their support for the criteria, September 2025, Green	
Engagement with shortlisted partners- regarding potential partnership arrangements and option appraisal process incl. CEO and Chair engagement	3rd line: Proposals received from partners demonstrates commitment to the partnership with some risks to the timeline. October 2025, Amber (see action 2) Board to Board meeting held with SASH demonstrates their commitment to the partnership, October 2025, Green	Board to Board meeting to be held with RSASP on 25 November 2025 – completed Further engagement planned with partners following recent SCC meeting.
Engagement with key stakeholder's incl. NHSE and ICB- regarding potential partnership arrangements and option appraisal process incl. staff, patients, members, Council of Governors, primary care partners	1st line: Reporting to the Strategy and Culture committee demonstrates wide ranging engagement undertaken internally and externally, September 2025, Green 3rd line: Outcome of independent review on engagement reported to the Strategy and Culture committee. The independent report demonstrates that over 900 pieces of feedback have been received and stakeholders feedback is incorporated in option assessment criteria, October 2025, Green Engagement with NHSE/ ICB planned to inform Re Board decision following the November Strategy and culture committee meeting. Outcome of discussion TBC	Development of FAQ document for staff and key stakeholders identifying key themes and questions collated throughout engagement process (will be available on Qnet for staff and will form part of the communications and engagement plan). NHSE and ICB response to Board decision regarding the preferred partner.
Timeline - Agreed timeline in place to keep track of key milestones incl. Chair and CEO in place by March 2026 and key decision-making points	1st line: Reporting to the Strategy and Culture committee outlining the timeline demonstrates that the Trust is meeting milestones, however the timeline remains challenging with external factors being a risk, October 2025, Amber (see actions 1 and 2) 3rd line: Review of NHSE timeline demonstrates alignment with QVH timeline, October 2025, Green	Alignment of key governance meetings to ensure required approval of preferred partner. Timeline on track for December Board.
Governance and oversight - Oversight by the Strategy and culture committee (SCC) and Board including input from Council of Governors and Strategic assurance group. Strategic direction by NHSE and ICB	2nd line: Strategic Assurance Group made of up internal key stakeholders in place to ensure critical decision making is appropriate and transparent, September 2025, Green Alert, assure and advise reporting from the Strategy and culture committee to the Board demonstrates that good progress is being made with robust process, however the committee have acknowledged the significant scale of work that will need to be undertaken post-decision to ensure the partnership delivers the benefits, November 2025, Amber (see actions 1 and 2)	Transition plan in development.

Actions	**Timescale**	**Lead**	**Status** (complete, on track, off track, not yet started)
1. Continued engagement including internal and external stakeholders	March 2026	DCSO	On track

2. Governance arrangements in place to support December decision making – including Board to Board meetings	November 2025	AJ/ LM	Complete
3. Development of FAQ document for staff and key stakeholders	December 2025	DCSO	Complete
4. Development of transition and implementation (incl. Governance) plan for partnership	February 2026	CEO, DCSO, CS	On track
Links to Organisational Risk Register	132 (delivery of QVH Strategy 2025-2030), 189 (long term sustainability of key services), 190 (partnership criteria not meeting ICB and NHSE expectations), 191 (timeline not being delivered)		

Report cover-page					
References					
Meeting title:	Board of Directors				
Meeting date:	12/02/2026	Agenda reference:	126-26		
Report title:	Bi-annual Safe Staffing and Nursing Workforce Review				
Sponsor:	Liz Blackburn, Acting Chief Nursing Officer				
Author:	Liz Blackburn, Acting Chief Nursing Officer				
Appendices:	None				
Executive summary					
Purpose of report:	The workforce review is presented to the Trust Board for assurance as to the nurse safe staffing levels within inpatient areas in the Trust. It is the responsibility of the Chief Nursing Officer to advise the Board on safe staffing levels for nursing in line with national guidance and for the board to see evidence of this assurance. It is then a requirement for the board to be sighted on the deployment of those planned staffing levels monthly and this is included in the IQPR. This paper builds on the safe staffing review presented to the Board in May 2025. That review confirmed the deployment of safe staffing numbers across inpatient areas while identifying potential opportunities for efficiencies. This paper takes those findings forward and seeks to exploit those opportunities to deliver both quality improvements and financial benefits.				
Summary of key issues	• Urgent estates work in May required temporary bed closures and service relocation, which provided an opportunity to pilot a reduced bed model. Following a comprehensive review, an agreed a reconfigured bed plan that sustains this reduced bed capacity, supporting operational efficiency, improved patient flow and effective deployment of staff. • Following approval of the bed reconfiguration, staffing establishments have been refined to reflect the reduced inpatient capacity. This revised staffing model is fully aligned with national standards and designed to optimise workforce efficiency while maintaining safe, high-quality patient care. • The revision to ward establishments, in line with the updated bed configuration, has resulted in a total reduction of 11.28 WTEs across the inpatient areas. • QVH continues to sit in Quartile 4 for Care Hours per Patient Day (CHPPD) from the Model Hospital data reflecting the specialist service the Trust offers, and it allows for review of efficient deployment of staff. • Patient safety surveillance continues and there has been no deterioration in our quality metrics which remain outcomes such as incidents of pressure ulcers, falls, medical emergency team (MET) calls remain stable. • There will be monitoring of the impact of these changes on quality and safety outcomes through Integrated Quality Performance reviews.				
Recommendation:	Board is requested to: • note that we deploy safe staffing levels in all our inpatient areas • note that we meet the benchmarks recommended by Royal College of Nursing, Integrated Care System and National Institute for Health and Care Excellence • note the staffing levels and skill mix are effectively reviewed • support the recommended changes to establishments to enable staffing deployment that deliver greater efficiency				
Action required	Approval	Information	Discussion	**Assurance**	Review
	KSO1:	**KSO2:**	**KSO3:**	**KSO4:**	**KSO5:**

Link to key strategic objectives (KSOs):	*Outstanding patient experience*	*World-class clinical services*	*Operational excellence*	*Financial sustainability*	*Organisational excellence*
Implications					
Board assurance framework:	Links to all 5 KSOs				
Corporate risk register:					
Regulation:	Health & Social Care Act 2008 and National Quality Board Guidance				
Legal:	As above				
Resources:	No additional resources identified within this report				
Assurance route					
Previously considered by:	Quality & safety committee				
	Date:	20/01/26			
Next steps:					

Report to: Board of Directors
Agenda item: 126-26
Date of meeting: 12 February 2026
Report from: Liz Blackburn, Acting Chief Nursing Officer
Report author: Liz Blackburn, Acting Chief Nursing Officer
Date of report: 31 December 2025
Appendices: None

Bi-annual Safe Staffing and Nursing Workforce Review

Purpose

The purpose of this paper is to provide an overview of safe nurse staffing levels including right staff, right skills and right place. It encompasses establishment reviews, workforce planning, new and developing roles, and strategies for recruitment and retention. It also aligns with directives from NHS England/ Improvement (NHSE/I), the National Quality Board (NQB) and the Care Quality Commission (CQC).

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

Background

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

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

The QVH has five inpatient areas with a total of 60 beds (this includes 2 flexible inpatient paediatric beds). To support safe staffing decisions, we use the Safer nursing care tool (SNCT) which is based on the Shelford Model, allowing us to calculate clinical staffing requirements based on patients' needs (acuity and dependency), together with professional judgement. This paper builds on the last review, taken to Board in May 2025 and reflects the impact of proposed ward reconfiguration and staffing reductions.

This review also reflects the impact of proposed ward reconfiguration, planned reductions in inpatient bed capacity and fluctuating occupancy patterns. These changes mean that professional nursing judgment, triangulated with evidence from tools such as Care Hours per Patient Day (CHPPD), benchmarking and nursing-sensitive indicators, will play a central role in ensuring safe and sustainable staffing decisions. It is worthy of note that the staffing numbers and fill rates are presented at Board via the monthly Integrated Quality Performance Review (IQPR).

Context

The paper presented to the Board in May 2025 outlined current staffing levels and highlighted opportunities to improve and make efficiencies the deployment of nursing staff by leveraging occupancy data, CHPPD, and national standards. In recent months, QVH has conducted a comprehensive review of bed occupancy and ward utilisation to ensure specialist services are configured to deliver safe, high-quality care while optimising use of the estate. This was operationally and clinically lead and the paper was ratified by the Executive Leadership Team (ELT).

Temporary ward relocations undertaken to facilitate essential estate works in two ward areas have provided valuable insights into managing demand within reduced capacity. These changes demonstrated the Trust's ability to flex capacity across the site while maintaining quality and safety standards. The experience has informed the ongoing service reconfiguration and clarified the level of capacity required across specialties. During this period, bed availability ranged from 24 to 53. Maintaining patient safety remains the primary focus of any bed reconfiguration, and the ongoing surveillance confirms that quality metrics, including pressure ulcers, falls, and MET calls have remained stable throughout the transition. This assurance provides confidence that efficiency measures, such as revised establishments and bed reconfiguration, can be implemented without compromising care standards.

The staffing review detailed in this paper sets out the nursing levels required to deliver safe care, identifies associated efficiencies, and outlines the quality metrics monitored. It is also important to note that strengthened governance has been introduced through the establishment of the Temporary Staffing Oversight Group. This has already resulted in reductions in nurse staffing costs, driven by decreased reliance on temporary staff.

National Benchmarking

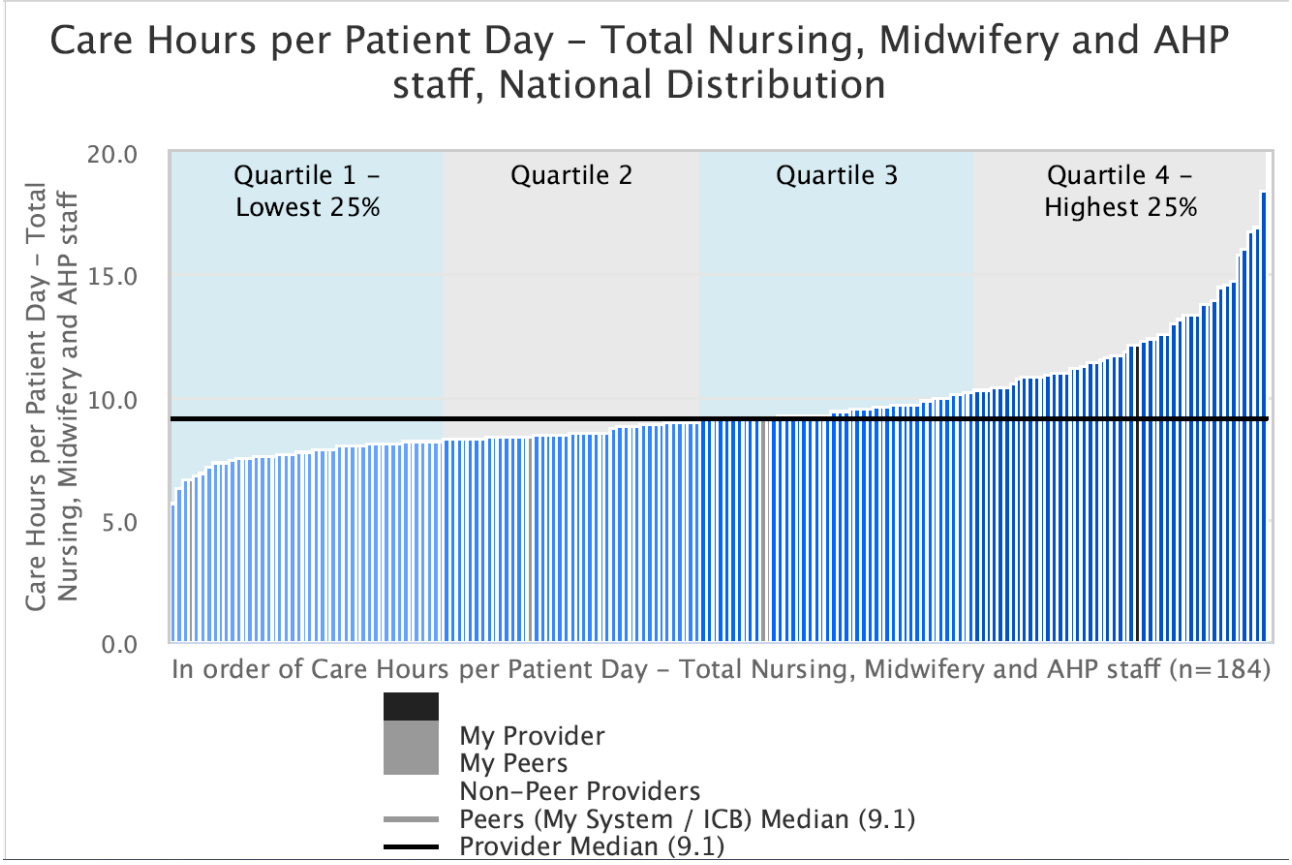
CHPPD is a workforce metric that calculates the average number of care hours provided to each patient over a 24-hour period by registered nurses and healthcare assistants (ie, 24 reflects a nurse to patient ratio of 1:1). CHPPD is a nationally benchmarked metric through the NHSE/I 'Model Hospital' that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

Table 2 shows the Trust CHPPD between April 2025 and Sept 2025.

Wards/Unit	Apr 2025	May 2025	Jun 2025	Jul 2025	Aug 25	Sept 25
Margaret Duncombe	10.8	9.0		8.6	8	7.6
Ross Tilley	7.5	7.4	9.1	6.7	8.3	9.9
Head and Neck	15.5	13.3				
Burns Unit	43	25.3	25.7	23	27.5	36.5
Critical Care Unit	36.8	39.4	33.3	34.2	42.2	38.4
OVERALL	**13.7**	**12.4**	**12.6**	**11**	**12.1**	**12.5**

The ward moves have contributed to a reduction in overall CHPPD, reflecting efficiencies achieved through the amalgamation of the Head and Neck ward with Canadian Wing and a significant decrease in the use of temporary staffing. However, the Burns ward remains an outlier in CHPPD due to the specialist nature of the service and the wide fluctuations in inpatient admissions.

Figure 1 provides a comparison analysis of QVH against peer and other provider organisations, using the Model Hospital data from August 2025.



The figure above shows that QVH is in Quartile 4 with a CHPPD of 12.1, indicating that the Trust is delivering more care hours per patient days than most other Trusts (System/ICB peers), it also reflects the Trust's specialist service profile (QVH total CHPPD is comparable to other Specialist Trusts). This highlights potential staffing inefficiencies and/or over resourcing. It is important to note that CHPPD is only one measure of staff deployment, and this paper triangulates this measure alongside staff to patient ratios, quality metrics and professional judgement.

Establishment review of inpatient areas
This establishment review has been undertaken in the context of the planned reconfiguration of inpatient areas. Its purpose is to ensure that staffing establishments remain proportionate to the revised bed base, aligned with national safe staffing guidance, financially sustainable, and consistent with professional nursing judgement.

The previous bed base and function

- Canadian Wing (39 beds)
    - *Margaret Duncombe Ward* - 15 beds, including 4 Enhanced Recovery beds (breast and orthognathic patients)
    - *Ross Tilley Ward* - 24 beds
    - Canadian Wing is staffed as a "whole unit" deploying staff across both wards, with patient transfers between them as needed.
- Burns Ward (6 beds)
    - Provides specialist inpatient care for burns patients.
    - Dual function: inpatient care and outpatient burns clinics delivered within the same footprint.
    - Staffed in line with the Burns Care Standards (2023)
- Head and Neck Unit (8 beds)
    - Provides post-operative and surgical inpatient care for Head and Neck patients.
- Peanut Ward (Paediatrics, 2 flexible overnight beds)
    - Predominantly day-case paediatric activity with occasional overnight admissions.
    - Dual function: inpatient beds and paediatric outpatient clinics.
    - Staffed in line with RCN guidance (2013), supported by paediatric-trained nurses.
- Critical Care Unit (4 beds, with the flexibility to increase to 5 beds as needed)
    - Provides specialist Level 2 and Level 3 critical care, with staffing ratios of 1:1 or 1:2 depending on acuity.
    - Staffed in line with GPICS guidance (2022)

Agreed Bed Configuration
A paper on bed occupancy and service configuration was presented to the Executive Leadership Team on 4 August 2025, and the following changes were approved:

- Canadian Wing - Closure of 8 beds: Ross Tilley's 24 beds remain open, in conjunction with the 7 beds on Margaret Duncombe. This reduces Canadian Wing capacity from 39 to 31 beds. Enhanced recovery patients (breast and orthognathic) will be managed within the Head and Neck Unit.
- Head and Neck Unit - Remains an 8-bed unit but expands function to care for enhanced recovery patients, maximising utilisation of the footprint and capacity.
- Burns Ward- Retains 6 inpatient beds and an outpatient service.
- Peanut Ward -Retains its current role: day-case activity with 2 flexible overnight beds and outpatient services.
- Critical Care Unit - No change, retaining 4 beds, with the flexibility to increase to 5 beds as needed.

Rationale for change
Quality and Safety

- Current occupancy patterns show variability, with some beds under-utilised.
- Consolidating activity into fewer, better-utilised wards supports safer, more consistent nurse-to-patient ratios and optimised skill mix.

Workforce Sustainability

- National workforce pressures, highlighted in the NHS Long Term Plan, emphasise reducing reliance on temporary staff and optimising deployment of substantive staff.
- Aligning establishments with a smaller but better-utilised bed base will enhance staff resilience, reduce unnecessary pressure, and support retention.

Financial Responsibility

- Benchmarking through CHPPD places QVH in Quartile 4, delivering more care hours per patient as compared to our System/ICB providers, however is aligned with other Specialist Trusts.
- While this reflects the specialist case mix, it also highlights opportunities to refine deployment to balance safety with efficiency.

Establishment realignment

The establishment proposals ensure compliance with national safe staffing standards:

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

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

Table 4 outlines our budgeted establishment for 2025/26 and the proposed changes following bed configuration.

Ward	Funded establishment supporting ward clinical staffing (WTE)		Bank and Agency line (WTE)	**Total (WTE**	Proposed establishment with 22% uplift*		Changes to the establish ment	**Total**
	RN	HCA			RN	HCA		
Canadian Wing	27.07	12.44	1.83	**41.34**	22.43	11.60	-7.31	**34.03**
Head and Neck	9.36	2.01	No B&A line	**11.37**	10.48	5.34	+ 4.45	**15.82**
Peanut (inc PAU)	11.51	3.80	1.65	**16.96**	12.7	5.22	+0.96	**17.92**
Burns	11.6	6.08	7.4	**25.08**	13.08	2.62	-9.38	**15.7**
CCU	15.88	6.0	2.29	**24.17**	17.78	6.39	0	**24.17**
TOTALS				**118.92**				**107.64**

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

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

Financial overview

The establishment review has identified a reduction of 11.28 WTE and preliminary estimates equate to £500k recurrent saving, primarily through alignment of staffing levels with the revised

bed base and safer staffing standards. The majority of this will be through the reduction in temporary staffing, a reduction in substantive posts will be realised through natural attrition. To date, £111k has been delivered through the efforts of the Temporary Staffing Oversight Group, which has successfully reduced reliance on temporary staff.

Further efficiencies have been identified through:

- A review and adjustment of study leave allowances
- A reduction in supernumerary time for new starters
- Strengthened governance for agency and bank sign-off processes

These measures collectively support the Trust's financial recovery plan while maintaining quality and safety. They also demonstrate robust governance and assurance mechanisms, ensuring that workforce decisions are evidence-based, sustainable, and aligned with national standards

Conclusion
This paper provides assurance that the Trust has undertaken a robust, evidence-based review of nurse staffing establishments in the context of planned inpatient reconfiguration, national safe staffing guidance, and financial sustainability. The changes implemented due to the essential estates work have delivered significant efficiencies, including a £111k year to date saving from reduced temporary staffing. Additional governance measures such as tighter controls on study leave, supernumerary time, and agency/bank sign-off further strengthen workforce resilience and financial accountability. Importantly, quality and safety metrics have remained stable throughout this process, demonstrating that the Trust can flex capacity and optimise staffing without compromising care standards.

Next steps
To align with the new bed configuration, the following actions will be taken:

- *Reconfigure Bed Layouts*
  - Adjust inpatient areas to reflect the proposals outlined in this paper.
- *Update Roster Templates*
  - Create new templates that match the proposed staffing requirements for each area.
- *Maintain Tight Control on Temporary Staffing*
  - Continue monitoring and limiting the use of agency and bank staff to ensure cost efficiency.
- *Recruitment Approach*
  - Run internal adverts only for nursing and healthcare assistant vacancies.
  - All nurse vacancies must be approved by the CNO before proceeding.
- *Cost-Saving Measures*
  - Identify and implement additional strategies to achieve the required financial savings.
  - Monitor financial savings achieved through the efficiencies programme, begin tracking once bed reconfiguration is complete.
  - Provide updates to the Finance and Performance Committee to ensure transparency and alignment with organisational goals.

There will be monitoring of the impact of these changes on quality and safety outcomes such as incidents of pressure ulcers, falls, MET calls and patient experience feedback through the IQPRs. The triangulation will also ensure that the new staffing requirements will continue to deliver high quality care and workforce efficiency. In addition, there are four points throughout the day where staffing and safety is reviewed, at 08.00, 10.00, 15.00 and 20.00 via the site handover and bed meetings chaired by the Site Practitioner team with multidisciplinary input.

Recommendation
Board is requested to:

- note that we deploy safe staffing levels in all our inpatient areas
- note that we meet the benchmarks recommended by RCN, ICS and NICE
- note the staffing levels and skill mix are effectively reviewed
- support the recommended changes to establishments to enable staffing deployment that deliver greater efficiency

Report cover-page					
References					
Meeting title:	Board of Directors				
Meeting date:	12/12/2026	**Agenda reference:**	**127-26**		
Report title:	Annual equality, diversity and inclusion (EDI) annual report 2024/25				
Sponsor:	Helen Edmunds, Chief People Officer				
Author:	Sacha Campbell, Wellbeing and Inclusion Manager Ellie Winter, Programme Manager – Strategy and Improvement Cat Bradshaw, Professional Lead – Core Clinical & Community Services				
Appendices:	Appendix 1 – QVH 2025 EDI Assurance Report				
Executive summary					
Purpose of report:	Provide the Board with the equality information relating to workforce, volunteers and patients that QVH have a requirement to publish annually.				
Summary of key issues	The report covers 1 April 2024 – 31 March 2025 for workforce and volunteers: • At 31 March 2025 QVH employed 1,263 members of staff • 74.5% are female and 25.5% are male • 22% identify as being from ethnic minority backgrounds • 7.6% have declared a disability • As at 31 March 2025 QVH had 56 volunteers, of whom 73% are aged 61 and over, 93% identify as white and 80% are female The report covers December 2024 – November 2025 for patients: • QVH provided 231,554 appointments to 80,364 unique patients • The patient population is 49.7% female and 50.3% male • Circa 75% are recorded as white, 2.5% Asian or Asian British, 1.5% black or black British and 1.3% mixed, with 15% having no ethnicity recorded • More than a third of patients come from the most affluent areas, with just over 5% from the most deprived areas • Religion and belief is largely incomplete (72% unknown) • Disability and sexuality data are not currently captured Compliance with mandatory Equality, Diversity and Human Rights training was at 93.8% as at 31 March 2025.				
Recommendation:	The Board is asked to note the report and approve 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:	None				
Organisational risk register:	None				
Regulation:	Public Sector Equality Duty of the Equality Act 2010				
Legal:	None				
Resources:	None				

Assurance route				
Previously considered by:	Executive Leadership Team			
	Date:	19 January 2025	Decision:	Present report to Trust Board
Next steps:	Publication of the report on the QVH website			

Annual Equalities Report
2024-25

Contents

Foreword

“At Queen Victoria Hospital NHS Foundation Trust, we are committed to creating an inclusive organisation where every patient, colleague and volunteer feels valued, respected and supported. Equality, diversity and inclusion (EDI) are central to our values and to the care we provide. This Annual Equalities Report reflects both the progress we have made and the challenges we continue to address.

Over the past year, we have strengthened our approach to inclusive practice through initiatives such as the launch of our EDI Champions, the formation of the Cultural Transformation Steering Group, and the introduction of Active Bystander training. These steps build on our commitment to embed fairness and compassion into every aspect of our work.

Our data shows that while we have strong compliance with mandatory EDI training and improving governance, gaps remain in demographic recording for patients and volunteers, particularly around disability and sexuality. Addressing these data quality and collection challenges remains a priority for QVH and will be supported by the implementation of our new Electronic Patient Record and ongoing digital improvements.

We know that inclusion is not a one-off project but a continuous journey. By listening to our staff, patients and communities, and by acting on what we learn, we will continue to advance equality of opportunity, tackle discrimination and foster good relations. Together, we can ensure that QVH remains a place where diversity is celebrated and everyone can thrive.”

Helen Edmunds

Chief People Officer, Queen Victoria Hospital Foundation Trust

Executive Summary

This report covers the period from 1 April 2024 to 31 March 2025 for workforce and volunteer information and December 2024 to November 2025 for patient information. The report outlines what we know about our workforce, patients and volunteers, as well as the steps taken to advance equality, diversity, and inclusion (EDI).

On 31 March 2025, Queen Victoria Hospital employed 1,263 staff members (according to the Trust's personnel system, ESR) and had 56 active volunteers. The majority of staff (74.5%) are female, compared to 25.5% male, and 22% identify as being from ethnic minority backgrounds. Around 7.6% of staff have declared a disability, with the most common types being learning disabilities and long-standing illnesses. Among volunteers, diversity is more limited: 73% are aged 61 and over, 93% identify as white, and 80% are female.

Between December 2024 and November 2025, from a service user perspective, QVH provided 231,554 appointments to 80,364 unique patients. The patient population is almost evenly split between female (49.7%) and male (50.3%). Around three quarters of patients are recorded as white, with 2.5% Asian or Asian British, 1.5% black or black British, and 1.3% mixed; 15% have no recorded ethnicity. More than a third of patients come from the most affluent areas (Index of Multiple Deprivation (IMD) deciles 9–10), while just over 5% are from the most deprived areas (deciles 1–2). Religion and belief data is largely incomplete, with 72% unknown; among recorded values, Christian denominations account for around 12%, and none/no religion/atheist/agnostic combined account for 14%. Disability and sexuality data are not currently captured in patient records.

We have made progress in embedding EDI principles. Compliance with mandatory Equality, Diversity and Human Rights training was at 93.8% as of 31 March 2025, and active bystander training was introduced to help staff challenge unacceptable behaviours. Inclusive recruitment practices continue to advance equality of opportunity, with the 'Guaranteed Interview Scheme' improving outcomes for disabled applicants. The Trust is a level 2 'Disability Confident Employer'.

Governance has been strengthened through the launch of EDI Champions, who work to represent and amplify staff and patient voices. The formation of the Cultural Transformation Steering Group and the ratification of updated Equality, Diversity and Inclusion and Sexual Safety policies demonstrates our ongoing commitment to EDI.

Equality Impact Assessments are embedded in decision-making, with 97 assessments completed in 2024-25, covering policies, clinical documents and change projects. This process is being strengthened in 2025-26 to further embed impact assessments as part of change processes. This is to be supported by the development of a training workshop to build manager capability.

Formal staff networks have not been re-established, limiting opportunities for engagement and peer support. Discriminatory incident reporting is low, with nine

reports logged in 2024–25 and NHS staff survey data indicating that under half of staff (49.6%) who experienced harassment, bullying, or abuse at work went on to report it.

Background

As an NHS Trust, QVH is legally required to promote equality in all that we do, both as an employer and as a service provider. Under the Public Sector Equality Duty of the Equality Act 2010, we have a duty to:

- Put an end to unlawful discrimination
- Advance equality of opportunity
- Foster good relations between different people.

To evidence how we are meeting these duties, we are required to publish equality information annually. This should include information that helps us to identify equality issues and information about the steps we have taken to meet our legal duties.

In addition to this report, we also publish our Gender and Ethnicity Pay Gap reports annually on our public website, as well as our Workforce Race Equality Standard and Workforce Disability Equality Standard reports.

This ensures that our staff, service users, regulators and members of the public can hold us to account for our performance around equalities.

Service User Demographics

This analysis covers December 2024 to November 2025, providing the most up-to-date full-year view of patient demographics at Queen Victoria Hospital NHS Foundation Trust (QVH). During this period, QVH recorded 231,554 appointments across all services, involving 80,364 unique patients. We hold complete data on age and sex for almost all patients because these fields are part of the NHS minimum dataset.

For other protected characteristics, including ethnicity, marital status, religion and belief, and deprivation, data completeness varies. Recording completeness varies significantly across protected characteristics. Age and sex are highly complete, while ethnicity, marital status, and religion have large gaps. Disability and sexuality are not captured. These limitations constrain our ability to analyse equity in access and outcomes. Addressing these gaps is a key part of our digital transformation and health inequalities work. Improving demographic data collection is a key QVH priority, supported by implementation of the new Electronic Patient Record (EPR) system and compliance with the Accessible Information Standard.

Methodology

- Age is reported using an “All Appointments” dataset because age can change during the year, and this approach reflects service use patterns across all contacts.

- For all other characteristics (sex, ethnicity, marital status, deprivation, religion and belief), we report data from the Unique Patients dataset to provide a true picture of the patient population.
- Disability and sexuality data cannot currently be reported because our system does not support structured recording of these fields.

Age at Appointment (All Appointments):

Age band	Count	Percent
0–17	27,109	11.7%
18–24	12,985	5.6%
25–59	86,182	37.2%
60–79	72,970	31.5%
80–99	32,203	13.9%
100+	105	0.05%
Total	231,554	100%

Adults aged 25–59 account for the largest share of appointments (just over a third), followed by those aged 60–79 (nearly a third). Children and young people aged 0–17 represent around twelve percent of appointments, while patients aged 80–99 make up fourteen percent.

Sex (Unique Patients)

Female	Male	Intersex	Blank
39,950 (49.7%)	40,386 (50.3%)	23	5

The unique patient population is almost evenly split between female and male patients, with very small numbers recorded as intersex or blank.

Ethnicity (Unique Patients)

Ethnicity	Count	Percent
White	60,721	75.6%
Asian or Asian British	2,036	2.5%
Black or Black British	1,202	1.5%
Mixed	1,070	1.3%
Other	697	0.9%
Gypsy or Irish Traveller	19	0.02%
Not stated (patient declined)	2,450	3.0%
Not collected	12,169	15.1%

Around three quarters of unique patients are recorded as White. Fifteen percent have no recorded ethnicity, and three percent declined to state. Asian or Asian British accounts for 2.5%, Black or Black British 1.5%, Mixed 1.3%, and Other 0.9%.

Marital Status (Unique Patients)

Status	Count	Percent

Married	10,579	13.2%
Single	11,768	14.6%
Other recorded statuses	3,522	4.3%
Unknown	54,535	67.9%

Marital status is recorded for about one third of patients, with the majority listed as Unknown.

Indices of Multiple Deprivation, Unique Patients

IMD Decile	Count	Percent
1 to 2	**4,322**	**5.4%**
3 to 4	**10,362**	**12.9%**
5 to 6	**15,544**	**19.3%**
7 to 8	**20,619**	**25.7%**
9 to 10	**29,264**	**36.4%**
Unknown	**253**	**0.3%**
Total	**80,364**	**100%**

IMD is a national measure of relative deprivation that ranks areas in England from 1 most deprived to 10 most affluent, based on factors such as income, employment, health, education, housing and crime. More than a third of unique patients at QVH come from the most affluent areas, IMD deciles 9 to 10. Just over one in twenty are from the most deprived areas, IMD deciles 1 to 2. Around two thirds are from the middle bands, IMD deciles 3 to 8.

Religion and Belief (Unique Patients)

Religion / Belief	Count	Percent
Unknown	57,916	72.07%
None	9,160	11.40%
Church of England	5,884	7.32%
Christian	2,324	2.89%
No religion	1,562	1.94%
Roman Catholic	1,444	1.80%
Not stated	555	0.69%
Muslim	321	0.40%
Other religion	185	0.23%
Hindu	168	0.21%
Atheist	137	0.17%
Islam	128	0.16%
Methodist	81	0.10%
Sikh	71	0.09%
Jewish	46	0.06%
Buddhist	44	0.05%
Jehovah Witness	43	0.05%
Agnostic	41	0.05%
Baptist	36	0.04%
Spiritualist	35	0.04%

Anglican	34	0.04%
Church of Scotland	25	0.03%
Greek Orthodox	24	0.03%
Protestant	22	0.03%
Congregational	18	0.02%
United Reformed	15	0.02%
Mormon	14	0.02%
Non Conform	8	0.01%
Free Church	7	0.01%
Church of Ireland	4	0.00%
Quaker	4	0.00%
Salvation Army	4	0.00%
Jainism	3	0.00%
Baha'i Faith	1	0.00%

Unknown accounts for about 72% of records. Among recorded values, Christian denominations combined account for around 12%, and None/No religion/Atheist/Agnostic combined account for 14%. Other faiths each account for less than 1%.

Staff Protected Characteristics

We had 1,263 staff members on 31 March 2025. Of those:

- 71.9% of staff are 31-60 years old, with 14.1% aged 30 and under and 14.0% aged 61 and over
- 7.6% have declared that they have at least one disability and 3.0% have not provided an answer
- Of those that have told us they have a disability, 26.6% have a learning disability or difficulty, 23.4% have a long-standing illness, 8.5% have a mental health condition, 10.6% have a physical impairment, 5.3% have a sensory impairment and 7.4% have a disability that does not fit into one of these categories.
- 76.0% are white, 22.0% are from ethnic minority groups and 3.0% have not responded
- 65.0% are religious, with 17.4% saying they are not religious and 17.6% not providing an answer
- 74.5% are female and 25.5% are male (the Electronic Staff Record system only allows these 2 options)
- 85.7% are heterosexual or straight, with 3.1% gay, lesbian, bisexual or another sexual orientation, and 11.2% not providing an answer
- 13 Armed Forces community roles have been declared
- 10 staff have told us they are working carers.

Volunteer Protected Characteristics

At the time of this report, QVH has 56 listed volunteers. Of those:

- 27% are aged 36-60 years old, with none aged 35 and under and 73% aged 61 and over
- 10% have declared that they have at least one disability and 3.3.0% have not provided an answer
- Of those that have told us they have a disability, 33% have a learning disability or difficulty, and 17% have told us they have a long-standing illness, a mental health condition, a physical impairment or a disability that does not fit into one of these categories respectively
- 93% are white, 2% are from ethnic minority groups and 5% have not disclosed their ethnicity
- 79% are religious, with 15% saying they are not religious and 6% not providing an answer
- 80% are female and 20% are male (the Electronic Staff Record system only allows these 2 options)
- 84% are heterosexual or straight, with 4% gay, lesbian, bisexual or another sexual orientation, and 12% not providing an answer.

Equality, Diversity and Inclusion Training

Mandatory Training

All staff undertake mandatory training in Equality, Diversity, and Human Rights to meet the national UK Core Skills Training Framework, which is renewed every three years.

Across 1,263 substantive staff members, 93.8% (1,185) were up to date with this training as of 31 March 2025, with 6.2% (78) overdue.

Staff group	Headcount	Compliant	Compliant %
Add Prof Scientific and Technic	30	29	96.7%
Additional Clinical Services	178	169	94.9%
Administrative and Clerical	386	356	93.8%
Allied Health Professionals	103	98	97.1%
Estates and Ancillary	62	58	96.8%
Healthcare Scientists	43	40	95.4%
Medical and Dental	199	181	92.5%
Nursing and Midwifery Registered	246	239	96.8%
Students	16	15	87.5%

Recruitment and Selection Training

All recruitment and selection panels must include at least one member that has attended the Trust's recruitment and selection training and be able to advise the rest of the panel of the process.

This training was provided monthly until June 2025, when the schedule was amended to become ad hoc. The training is delivered by the Trust's Resourcing team and covers

best practice in recruitment and selection, including ensuring diverse panels, offering reasonable adjustments and promoting equality of opportunity.

Active Bystander Training

In 2024, the Trust offered active bystander training via an external provider to give staff the skills to challenge unacceptable behaviours such as racism, bullying and sexual harassment, including those that may have become normalised over time.

Alongside the training, attendees were given a toolkit of resources to use, including strategies and practical tips to approach difficult conversations and act as an ally.

Networks

Armed Forces Network

QVH's growing Armed Forces Network provides a forum to advocate for the interests of the Armed Forces Community.

In addition to our Armed Forces Network, QVH has signed the Armed Forces Covenant, holds a Bronze Award from the Ministry of Defence Employer Recognition Scheme (and are working towards the Silver Award) and is involved with the Step Into Health scheme, which helps to connect members of the Armed Forces community with NHS organisations.

EDI Champions

In 2025, QVH launched its EDI Champions scheme. Six staff took up this voluntary role, contributing to accessibility initiatives for staff, patients and visitors.

Our EDI Champions sit as members of the Cultural Transformation Steering Group and act as amplifiers for staff and patient voice, advocating for inclusive practices and driving local change.

Cultural Transformation Steering Group

The Cultural Transformation Steering Group was created in 2025 with the aim to lead, guide and keep track of the cultural changes happening within our organisation.

The group helps to ensure that we stay on track with actions that promote a more inclusive and culturally aware workplace. To support this, the group is sponsored by our Chief Executive Officer and Chief Medical Officer and attended by colleagues in our Workforce, Organisational Development & Learning, Communications and Continuous Improvement teams as well as our EDI Champions. The groups' current focus is building psychological safety across the Trust.

Additional Needs Group

The Trust's Additional Needs Group provides leadership and direction to improve the delivery of care to patients with additional needs by working in partnership with patients, the public and QVH's workforce.

The Additional Needs Group work with QVH colleagues to review patient pathways and identify areas for improvement as well as having oversight of key programmes of work relating to any additional need.

Interpreting

Usage

Throughout 2024-25, QVH utilised interpreting services on 347 occasions to support patients across both inpatient and outpatient settings.

These services, delivered through a combination of face-to-face and telephone interpreting, ensured effective communication and equitable access to care for patients with language needs.

The total expenditure for interpreting services during this period was £43,856.81, reflecting the Trust's commitment to providing inclusive and patient-centred care.

Inclusive Recruitment

QVH is a Level 2 'Disability Confident Employer'. To support inclusive recruitment, QVH's Resourcing team offers training that covers best practice during recruitment and selection. This includes inclusive approaches, reasonable adjustments and fair decision-making, reflecting the Trust's commitment to equality, diversity and inclusion.

Guaranteed Interview Schemes

During 2024-25, 162 candidates stated they had a disability in their application on the TRAC recruitment system, representing approximately 4% of all applications.

71% (115) of disabled applicants opted in to the guaranteed interview scheme as part of their application. Of those:

- 34% (39) were shortlisted for interview
- 7% (8) were successfully appointed.

This suggests that the guaranteed interview scheme successfully advances equality of opportunity for disabled candidates, as 17% of non-disabled candidates were shortlisted for interview, and 4% were successfully appointed.

Discriminatory Incidents

Incident Reports

Staff are able to report incidents of discrimination and harassment on the Trust's incident management system, Datix.

In 2024-25, 5 reports of discrimination and harassment based on protected characteristics were made via this system. Of these, 3 were related to race and 2 were related to sex. 4 of these incidents were abuse towards staff from service users, and 1 involved abuse towards staff from a third party.

In addition, 4 reports of discrimination and harassment from staff toward staff were made under Workforce policies, with 3 relating to sexual harassment and 1 relating to race.

Advancing Equality, Diversity and Inclusion at QVH

In 2025, QVH published its 2025-2030 People and Culture Strategy, which sets out our vision, values and objectives and actions to tackle inequalities, foster good relations and advance equality of opportunity for our diverse workforce.

This was developed through engagement with patients, carers and staff as well as data and insights about our staff, our local area and our patients to ensure that it reflects the needs of our workforce and our community.

QVH's Core Behaviours Framework, developed through engagement and workshops with a large number of staff and published in 2024, details how we put our values into practice. This sets out how we do things, what we say and how we say it, how we treat others and how we expect to be treated.

To support the implementation of the framework, a series of 1 hour workshops were offered to provide an understanding of how to apply and embed the framework into different areas of responsibility.

We also regularly assess our performance against EDI indicators; most recently, we completed an assessment around how we ensure inclusivity through change, which can be seen in Appendix 1 – QVH 2025 EDI Assurance Report (Change).

Policies

The Trust's updated Equality, Diversity and Inclusion Policy was ratified on 6 October 2025. This policy helps the Trust respond to discrimination by setting clear expectations and processes that promote fairness, dignity, and respect for all individuals.

It outlines legal obligations under the Equality Act 2010 and the Public Sector Equality Duty, ensuring that unlawful discrimination, harassment, and victimisation are actively prevented and addressed.

The policy provides practical guidance for reporting concerns and emphasises restorative approaches to resolve issues and protect affected individuals. The policy works in conjunction with our workforce policies and is aligned to the Trust's People and Culture Strategy 2025-2030.

In addition to this, the Trust published its first Sexual Safety Policy on 24 Mach 2025. This is aligned to the NHS Sexual Safety Charter and sets out the ways in which QVH will respond to and prevent incidents of sexual harassment.

Equality Impact Assessments

Under the Public Sector Equality Duty 2011, we have a duty to eliminate discrimination, advance equality of opportunity and foster positive relationships. The duty also encourages public bodies to deliver better and safer services by understanding the needs of the communities it serves. At QVH, we evidence this by completing Equality Impact Assessments (EIAs).

All QVH policies and projects must consider if and to what extent they will impact equalities for our patients and staff and document any evidence of this. Where any negative impacts are identified, the project lead must document the actions they will take to minimise that impact, or justify why they cannot. Project leads must also document the evidence and engagement they used to inform their assessment.

EIAs are reviewed and signed off by a group of staff assessors with an interest in equalities, led by the Wellbeing & Inclusion Manager. In 2024-25, 97 EIAs were submitted to the EIA assessors, including 78 policies, 9 clinical documents, 7 change projects and 3 rejected flexible working requests.

Acknowledgements

We remain thankful to colleagues across QVH who have been supporting our value of being compassionate and inclusive over all else, whether this is through promoting EDI activities, championing improvements in their local areas or advocating for more inclusive patient care.

Appendix 1 - QVH 2025 EDI Assurance Report

Guidance Theme	Assurance consideration	Recommended Action	Compliance Status (Full / Partial / Not Met)	Evidence of Compliance	Gaps / Risks	Mitigations, Planned Actions & Timescale
Leading Through Change	Organisational boards and senior leaders must be able to demonstrate the prioritisation of Equality considerations as BAU and throughout change.	**Board members all have a measurable equality objective** **All committees or decision making groups are set up in their understanding of Equality Impact and adherence to core duties** Further initiatives might include a Board Equality Champion or distributed ownership of different EDI responsibilities	Partial	Board members have EDI objectives Board undertaking Diversity MOT Board equality champions are CEO / CMO - attendance at CTSG CPO is responsible for WRES / WDES / Pay gap reporting Trust EIA process for Policy and Change Management processes All Workforce and People	Executive Directors were previously aligned as the lead for a staff network. Staff networks aren't currently running at QVH.	QVH are working towards a partnership with another Trust. Partnership with Royal Surrey / Ashford & St Peters Both Trusts have active networks in place. The Executive Directors will link in with their peers in future partnership to support staff networks.

		among different Board members.		committees have Equality Impact built in CIP and Efficiency Programmes require Equality Impact		
Compassion Through Change	What should be considered: Staff may face uncertainty, selection processes, new teams/managers, personal challenges — requiring compassion, dignity, empathy.	**The organisation can demonstrate the four behaviours of compassionate leadership through change — Attending (listening), Understanding (exploring challenges), Empathising, Helping (removing obstacles).**	Full	A programme of support has been designed for anyone who is directly affected by change. This includes: • Wellbeing support • Training workshops on resilience through change • Addition to the redeployment register if at risk • Reasonable time off to attend interviews if needed		

Communication – Accessibility & Inclusivity	All communications must be accessible for disabled, neurodivergent staff, those using assistive technology, and those whose first language isn't English. Accessibility of communications must be tested with relevant staff groups (for example, Staff Disability Network and Staff Neurodiversity Network).	**The organisation has a plan for Accessible information. Staff who produce consultation materials, staff briefings, newsletters and intranet pages are trained and confident in how to produce accessible content.** Examples include: use of plain English; defined acronyms; simple words ("show" instead of "demonstrate"), offer 'quick read' and Easy Read versions; avoid overreliance on PowerPoint; visual descriptors/alt text for images; high colour	Partial	An easy read version of the Trust's 5 year strategy has been produced, awaiting final sign off. New intranet has an accessibility function on it to enable staff to adapt the site in a way that suits them e.g. contrast, bigger text etc. Alt text on images on the intranet is mandated Produced best practice guidelines for intranet admins and includes writing in plain English and link to guidance We have introduced a short set of bullet points	No colleagues are specifically trained in the production of accessible information	To produce a style guide covering accessibility.

		contrast on documents, avoid passive voice; left-justify text; run accessibility and readability checks; give advance notice; offer alternative formats; schedule inclusively; BSL-interpreted briefings where needed; keep staff engaged if they are away from work; ongoing anonymous Q&A and feedback channels. A reminder that NHS England South East Region is offering Digital Accessibility training until November 2025: https://tinyurl.com/nhssoutheastedi		on briefings that are sent from our executive leadership team. Also the Connect email that also links in with connecting with staff, has a list of teaser content to make it more accessible Anon Q&A and feedback channels offered through Team Talk and using Menti (anonymous) and also the Ask Abigail and Tell Edmund (not anonymous). Rollout of the upgraded Microsoft suite will offer further accessibility options and checks		

Evaluating the Equality Impact of Change	Decision makers are aware of their duty to pay due regard. All major proposals or organisational change junctures evaluated through an EIA lens; identify positive, neutral, and negative impacts on protected and inclusion health groups; plan mitigations for negative impacts; data-informed decisions.	**The organisation has:** **• A clear governance structure for EIAs** **• A nominated risk holder for Equality Risk against PSED** **• Mapped organisational change junctures in relation to the need to 'pay due regard'** **• An EIA framework to assess the impact of change programmes on different protected characteristics and any disproportionate impact** **• A SMART action plan in change-related EIAs with clear action owners to**	Partial	A clear governance structure is in place for EIAs, with these being assessed by an independent group of assessors. EIA status and approval numbers are recorded on a central log. Policies cannot go to their ratification groups without an approved EIA. EIAs must be completed for any change management project, and timescales are set out for when this should happen in the process. These require project leads to document positive, neutral and negative impacts to	No staff networks in place to engage on impacts to change management programmes	Other forums are in place for staff engagement throughout organisational change - for smaller scale changes, line managers must engage meaningfully at both team and individual levels, providing both group and confidential spaces to facilitate staff voice. Partnership model will offer an opportunity for QVH staff to join partner organisation's networks

		mitigate against negative impact • A staff engagement mechanism via staff networks and other forums to ensure marginalised staff voices are incorporated into EIAs		protected and health inclusion groups. Actions to mitigate potential negative impacts must be recorded on EIA forms.		
Engaging Staff & Communities	Actively involve staff networks in co-production/co-design of change programmes; networks provide insight and support; involve wider stakeholders and staff who might not be members of any staff networks; ensure communication is clear and accessible; co-production builds trust and self-worth.	**The organisation can demonstrate the effective management of and support for staff networks and diverse staff communities, and their inclusion in key coproduction programmes such as policy development, change management etc.** **The organisation can demonstrate that they are**	Partial	QVH involves diverse communities in policy development by engaging with its EDI Champions, as well as facilitating targeted focus groups for policies and guidance that affect specific groups, e.g. neurodiversity support resources. All staff are offered the	QVH does not have formal Staff Networks	Other forums are in place for staff engagement throughout organisational change - for smaller scale changes, line managers must engage meaningfully at both team and individual levels, providing both group and confidential spaces to facilitate staff voice. Partnership

		proactively providing engagement opportunities for underrepresented staff.		opportunity to feed back on organisation-wide change, such as the proposed partnership model between QVH and a nearby Trust.		model will offer an opportunity for QVH staff to join partner organisation's networks
Inclusive Assessment & Selection	Recruitment/selection practices may create barriers; adjustments may be needed for various groups; support hiring managers in inclusive practices; monitor diversity data.	**The organisation has a clear inclusive recruitment/selection process and policy, including for any competitive selection process for redundancies.** This should include principles for advertisement (e.g. at least 2 weeks), inclusive selection processes, decision making criteria, panel composition (including Independent Panel Members) and moderation.	Partial	Recruitment and Selection Policy is in the process of being updated in line with trust 3 year update process. Update will ensure equality and accessibility is clear for candidates, those being on-boarded, starters and managers. Additional paragraph in interview invite asking people to contact us for support through interview process with reasonable adjustments.	WRES indicators suggest further work is required in this area Consideration of providing interview questions to candidates ahead of the interview	Introducing communication to appointing manager advising them they may need to consider adjustments for candidates if requests received. We also recommend written interview questions are given. Trust is looking at use of AI in longlisting and shortlisting with final decision from human input to avoid any bias through this element of the

		The organisation can demonstrate how it intends to or has reduced bias across its recruitment and selection processes as well as creating an inclusive experience for staff being interviewed (disability, neurodiversity, menopause, staff who need to rearrange interviews due to medical appointments, caring/parental responsibilities or prayers, etc.).		Offer of interview questions in writing during and prior to interview if requested. The recruitment team encourages managers to consider all requests to alter interview arrangements, we don't actively ask why a candidate wants to move it but try to accommodate where the services can. We offer MS Teams interviews rather than face to face when requested due to neurodiversity, support applicants in person or by phone on application and on-boarding process when requested.		recruitment process.

Career Support During Change	Provide job search, CV, application, interview skills support; create opportunities for reflection and skills articulation; build confidence.	**The organisation has a career support programme available for staff amidst organisational change. Career support uptake must be evaluated against protected characteristics.**	Full	QVH has a range of support for individuals relating to career support. These include: • Career Coaching offer • Interview skills workshop • Dedicated Career Conversations with line manager (where required) incorporating the Scope for Growth Model • Dedicated intranet pages on career development, interview help and techniques • Workshops and 1-1 support on getting the		Partnership model will offer an opportunity for QVH staff to join partner organisation's networks

				most out of your appraisal • Any external offers are promoted internally (NHS Elect, NHSE, etc.)		
Organisational Development Interventions	OD programmes supported to help staff process change and build resilience.	**The organisation has key programmes in place to support staff resilience throughout change. These programmes must have diverse participation across protected characteristics, different professions and pay grades.** This could include: Reciprocal mentoring; coaching and mentoring; team coaching; action learning sets;	Full	QVH OD support for teams and individuals include both internal and external opportunities: • Coaching (1-2-1) • Resilience workshops • Managing self through change workshops • Leading others through change workshops • Action Learning Sets • Schwartz rounds	Team coaching to be explored / implemented in 2026/27	Reciprocal mentoring to be developed in 2026/27 to add to the programme of OD interventions available

		career support groups; proactive adjustment conversations; health passports; Schwartz Rounds; safe reflective spaces.		• Health passports (known locally as Personal Support Profiles) are in place and readily available to staff • Existing or newly required reasonable adjustments must be considered as part of any change management EIA		
Wellbeing Support	Provide broad, relevant wellbeing offer during change, tailored to marginalised groups; ensure consistency between messaging and actions.	**The organisation has a broad wellbeing support offer for staff, recognising specific needs around Ability, Mental Health, Neurodiversity and is measured taking into account specific**	Partial	EAP – Vivup QVH personal support profile Guidance on embracing neurodiversity in the workplace MHFA in departments	We have been unsuccessful in establishing and maintaining networks, including for Women/Menopause, disability, etc.	Partnership model will offer an opportunity for QVH staff to join partner organisation's networks

		demographic uptake. This could include: Employee Assistance Programmes and targeted support (mental health apps, peer networks, financial wellbeing, and menopause support); resilience training; clear signposting; ensure accessibility.		across the organisation Monthly wellbeing bulletin from Stay Well team with a variety of signposting across a broad range of themes Reasonable Adjustments and Flexible Working Policy Financial Services poster signposting to Vivup, Stream, salary sacrifice, etc.		

Report cover-page					
References					
Meeting title:	Board of Directors				
Meeting date:	12/02/2026		**Agenda reference:**	**128-26**	
Report title:	Audit & risk committee assurance report				
Sponsor:	Jagjit Dosanjh-Elton, committee Chair				
Author:	Jagjit Dosanjh-Elton, 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	- An internal audit of substantive medical and dental job planning has received a partial assurance outcome. Management actions to address the gaps in compliance have been agreed and are being progressed. - The committee has undertaken the annual review of compliance with Standards of Business conduct policy. Spot checks and the job planning internal audit have highlighted a challenge with missing declarations for private practice and directorships and incomplete declarations amongst medical staff. - The annual review of compliance with the policy for policies shows improved engagement from policy authors is resulting in a reduction in the number of out of date policies, however, there is still work to do. The highest number of out of date policies is currently in Estates and Facilities. - The committee received assurance on the compliance with Trust's governing documents and welcomes the progress which has been made to strengthen financial control and governance. - The annual review of raising concerns shows that staff are accessing multiple routes to raise issues, with bullying and harassment remaining the most common themes. The Committee urged the Executive to continue to seek assurance that these themes do not reflect any deeply rooted cultural issues. - Due process is being followed for contract awards, the use of single tender waivers and No Purchase Order – No Pay policy with transparency on the rationale for any exceptions. - The committee undertook a deep dive of the digital BAF and was pleased to note the sustained progress to deliver the 2024/25 Data Security Protection Toolkit (DSPT) improvement plan. The 2025/26 interim DSPT assessment was due on 31 December 2025 which reported 'Approaching Standards' due to the current position with the 2024/25 DSPT improvement plan. A further internal audit on the 2025/26 DSPT is scheduled for March 2026 which will also review the completeness of the 2024/25 action plan.				
Recommendation:	The Board is asked to **note** the contents of the report				
Action required	Approval	Information	Discussion	**Assurance**	Review
Link to key strategic objectives (KSOs):	**KSO1:** *To deliver outstanding care*	**KSO2:** *To innovate and improve*	**KSO3:** *To be an excellent employer*	**KSO4:** *To deliver sustainable services*	**KSO5:** *To collaborate with others*
Implications					
Board assurance framework:	Deep dive on the digital BAF undertaken				
Organisational risk register:	None				

Regulation:	None			
Legal:	None			
Resources:	None			
Assurance route				
Previously considered by:				
	Date:		Decision:	
Next steps:				

Report to: Board of Directors
Agenda item: 128-26
Date of meeting: 12 February 2026
Report from: Jagjit Dosanjh-Elton, committee Chair
Report author: Jagjit Dosanjh-Elton, committee Chair
Ellie Simpkin, Governance manager
Date of report: 23 January 2026
Appendices: None

Sub-committee assurance report
Audit & risk committee - 5 January 2026

Key agenda items

- **Board Assurance Framework (BAF)**
- **Deep dive on digital BAF**
- **Annual review of raising concerns**
- **Assurance on compliance with governing documents**
- **Financial assurance**
- **Review of losses & special payments**
- **Timeline & approach for annual report and accounts including external audit & fees**
- **Internal audit progress report**
- **Local Counter Fraud progress report**
- **Annual review of compliance with policy for policies**
- **Annual review of compliance with Standards of Business conduct policy and report on any breaches**

Alert

- An internal audit of substantive medical and dental job planning has received a partial assurance outcome. Although there has been improvement in the number of job plans completed, key issues identified by the audit included accuracy of information held on systems, limited monitoring resulting in outdated job plans, absence of Working Time Directive Waivers, and inconsistent declarations of interest. The audit also noted the high usage of bank staff. Management actions to address the gaps in compliance have been agreed and are being progressed.
- The committee has undertaken the annual review of compliance with Standards of Business conduct policy. During 2025/26, no members of staff have been disciplined or formally investigated for a breach of the policy, however, the spot checks and the job planning internal audit have highlighted a challenge with missing declarations for private practice and directorships and incomplete declarations amongst medical staff. The Local Counter Fraud

Service will be carrying out a compliance exercise on declarations of interest which will include a focus on consultant declarations. The committee will receive an update on this at its next meeting.
- The annual review of compliance with the policy for policies shows improved engagement from policy authors is resulting in a reduction in the number of out of date policies, however, there is still work to do. The highest number of out of date policies is currently in Estates and Facilities. Risk stratification of out of date policies has been undertaken with all identified as being low or medium risk. The Executive has agreed to review the approach to find a way to address the longstanding and continued challenge of out of date policies.

Assure
- The committee received assurance on the compliance with Trust's governing documents and welcomes the progress which has been made to strengthen financial control and governance. Since quarter four of 2024/25 there have been no reported breaches of compliance which demonstrates that the strengthened control environment is effective. An internal audit on compliance has received a reasonable assurance outcome.
- The annual review of raising concerns shows that staff are using a variety of routes to speak up and the committee is assured there are sufficient mechanisms in place. Bullying and harassment remains the most common theme across all concerns raised. The committee was reassured that departmental level cultural deep dives led by the Organisational development team would identify any fundamental deep-rooted concerns. There has been an increase in the number of employee relation cases which is potentially reflective of the cultural shift in the organisation as staff are feeling more able to speak up and the behavioural framework is embedding. The Executive team recognises the importance of staff having a variety of mechanisms for staff to speak openly and raise concerns, especially given the period of change for the Trust.
- Internal audit reviews of data quality and performance and incident management received reasonable assurance outcomes, with low and medium priority management actions agreed to further strength compliance.
- Due process is being followed for contract awards and the use of single tender waivers. The Local Counter Fraud Service have provided benchmarking information on the use of single tender waivers across its client base in 2024/25. In 2024/25 QVH single tender waiver value was £7.17m, significantly higher than Trusts of a similar size. This year to December 2025, the Trust single tender waiver value has decreased to £1.5m.
- The Committee has requested a compliance dashboard for continued monitoring of grip and control on approvals, contracts awards, waivers and the Trust's No Purchase Order - No Pay policy.
- At the time of reporting, all due management actions arising from internal audit reviews had been completed.

Advise
- The timetable for the preparation and audit of the 2025/26 annual report and accounts has been agreed with Trust's external auditor, Azets. There will be a change in the Trust's audit partner from Azets for the 2025/26 audit. The audit manager and other key personnel will provide continuity.

Risks discussed and new risks identified
- The committee undertook a deep dive of the digital BAF. There is sustained progress to deliver the 2024/25 Data Security Protection Toolkit (DSPT) improvement plan, with only the training element outstanding. The 2025/26

interim DSPT assessment was due on 31 December 2025 which reported 'Approaching Standards' due to the current position with the 2024/25 DSPT improvement plan. The expectation is that the submission in June 2026 for the 2025/26 DSPT assessment will be 'Standards Met'. A further internal audit on the 2025/26 DSPT assessment is scheduled for March 2026 which will also review the completeness of the 2024/25 action plan. Additional funding has been secured up until March 2026 to support the Electronic Patient Record optimisation and benefits realisation. Further cyber security desktop exercises are planned for 2026/27.

- The committee queried whether the sustainability BAF current score can be reduced now that a strategic partner has now been agreed. It noted that scoring will be reviewed once discussions on the governance arrangements and next steps of the implementation plan have taken place.

Recommendation

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

Report cover-page					
References					
Meeting title:	Board of Directors				
Meeting date:	12/02/2026		**Agenda reference:**	**129-26**	
Report title:	Quality and safety committee assurance report				
Sponsor:	Jo Emmanuel, committee Chair				
Author:	Jo Emmanuel, committee Chair Katie Ally, Governance Officer				
Appendices:	Appendix one - Improving Doctors Working Lives Programme - The 10 Point Plan - Progress report				
Executive summary					
Purpose of report:	To alert, assure and advise the Board regarding matters considered at the last committee meeting.				
Summary of key issues	– The Trust is not meeting its plan for patients waiting over 65 weeks overall – The committee received a clinical harm review of patients at risk of waiting over 65 weeks as at 31 March 2026 (oral and maxillofacial and non-breast plastic surgery patients). There are a number of measures being implemented and strengthened to support the management of long waiting patients including ensuring robust and effective patient tracking list (PTL) management – Progress has been made in completing clinical harm reviews for cancer patients where their treatment has been delayed, however, the committee noted that there remains a backlog of clinical harm reviews outstanding as of November 2025. The committee were assured that the clinical harm review process has been strengthened and that the backlog is reducing – There remains a challenge with out of date policies which the committee will continue to monitor – There was one never event during the period – The committee has taken assurance from data which shows that the Trust has made good progress on the Improving Doctors Working Lives Programme. Compliance has increased from 87% to 92%. To achieve full compliance further action is required relating to protected breaks and dedicated parking for on call resident doctors. The report is attached at appendix one for the Board's information.				
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:	Committee reviewed the BAF risk relevant to its remit (quality)				
Organisational risk register:	Committee received the organisational risk register				
Regulation:	None				
Legal:	None				
Resources:	None				
Assurance route					
Previously considered by:					

	Date:		Decision:	
Next steps:				

Report to: Board of Directors
Agenda item: 129-26
Date of meeting: 12 February 2026
Report from: Jo Emmanuel, committee Chair
Report author: Jo Emmanuel, committee Chair
Katie Ally, Governance Officer
Date of report: 21 January 2026
Appendices: Appendix one - Improving Doctors Working Lives Programme - The 10 Point Plan - Progress report

Sub-committee assurance report
Quality & safety committee – 20 January 2026 (rescheduled 13 January 2026 meeting)

Key agenda items

- **Clinical policy update**
- **Day care model for Children' care**
- **Executive Committee for Quality and risk assurance report**
- **Integrated Quality and Performance Report (month seven)**
- **Potential harm to patients at risk of waiting over 65 weeks for treatment on 31st March 2026 and cancer clinical harm review**
- **Estate update**
- **Health & Safety action plan – progress update**
- **Patient safety overview and update**
- **Bi Annual Safe Staffing and Nursing Workforce review**
- **NICE and Clinical Audit programme update**
- **Resident doctor 10 point plan update**
- **Board assurance framework (BAF) and Organisational risk register (ORR)**

Alert

- The committee noted that the Trust is not meeting its plan for patients waiting over 65 weeks overall; breast reconstruction is ahead of plan and other specialties (oral and maxillofacial and non-breast plastic surgery patients) are not meeting the plan. The committee explored the factors underlying the number of patients waiting over 65 weeks, acknowledging demand and a parity in some areas but also requesting further clarification of other factors, including reporting compliance, contributing to these delays.
- The committee received a clinical harm review of patients at risk of waiting over 65 weeks as at 31 March 2026 (oral and maxillofacial and non-breast plastic surgery patients). There are a number of measures being implemented and strengthened to support the management of long waiting patients including ensuring robust and effective patient tracking list (PTL) management; utilising improvement methodology 'The QVH Way' and digital transformation.
- Progress has been made in completing clinical harm reviews for cancer patients where their treatment has been delayed, however, the committee noted that there remains a backlog of clinical harm reviews outstanding as of November 2025. The committee were assured that the clinical harm review process has been

strengthened and that the backlog is reducing. The committee requested a follow up report to be presented to the next meeting.
- There remains a challenge with out of date policies. The committee received an update at its meeting, including the outcome of the risk assessment for each out of date clinical policy. Engagement with Executive leads and policy authors is ongoing to ensure appropriate prioritisation and mitigation. The committee requested a further update at its next meeting.
- There was one never event during the period which resulted in low harm. A patient safety internal investigation is underway.

Assure
- The committee has taken assurance from the Improving Doctors Working Lives Programme – The ten point plan – Progress report. The ten point plan was launched in August 2025 to set out ways to improve resident doctors' working conditions with an ambitious 12 week programme of activity. Data shows the Trust has made good progress over the initial 12 weeks. Compliance has increased from 87% to 92%. Two factors required resolution to achieve greater compliance are appointment of a resident doctor peer lead (now appointed) and early processing of course related expenses. To achieve full compliance further action is required relating to protected breaks and dedicated parking for on call resident doctors.
- The Committee was assured that current risks associated with the development of the Children's Daycase Model are being managed through a quality impact assessment, with mitigations in place for staffing, estates, and system engagement
- The committee received assurance that estates related risks impacting quality and safety are being effectively managed, with successful fire drills, water safety audits, ventilation oversight, and asbestos compliance in progress, supported by detailed action plans and governance monitoring to maintain patient and staff safety. The Trust is recruiting to a Fire safety officer role
- With regards to the Health & Safety compliance stocktake, the committee was assured that good progress has been made with 63% of actions completed, 32% on track for year-end, and targeted focus on FIT testing and COSHH compliance, supported by detailed action plans and governance
- The committee reviewed the Bi-annual Safe Staffing and Nursing Workforce report. The committee received assurance that staffing levels for nursing are safe and align with national guidance. The deployment of safe staffing numbers across inpatient areas identified potential opportunities for efficiencies. The committee were supportive of the changes to establishment contained in the report

Advise
- The NICE and Clinical Audit programme update quarter two confirmed the three objectives set for the quarter were achieved and good progress continues on the monitoring of projects and actions.

Risks discussed and new risks identified
The committee reviewed the Board assurance framework (BAF) risk relevant to its remit (quality), and received the organisational risk register (ORR). The committee reviewed the score for the quality BAF risk and agreed that it should be reduced from 12 to 9 given the positive assurance available.

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

Report cover-page					
References					
Meeting title:	Quality and Safety Committee				
Meeting date:	13 January 2026		**Agenda reference:**	**95-26**	
Report title:	Improving Doctors Working Lives Programme - The 10 Point Plan - Progress report				
Sponsor:	Tamara Everington, Chief Medical Officer				
Author:	Helen Moore, Medical Education Manager				
Appendices:	None				
Executive summary					
Purpose of report:	An update on progress with the 10 point plan to improve resident doctors' working lives				
Summary of key issues	• NHSE's 10 point plan has been mandated to improve resident doctor experience • Initial assessment against the 10 point plan showed that QVH was 87% compliant, new compliance rate after 12 weeks is 92%				
Recommendation:	The Committee is asked to **NOTE** this report including progress on the 10 point plan				
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:	ELT				
	Date:	18 December 25	Decision:	Approved	
Next steps:	For Board assurance				

Report to:	Quality and Safety committee
Agenda item:	95-26
Date of meeting:	13 January 2026
Report from:	Tamara Everington, Chief Medical Officer
Report author:	Helen Moore, Medical Education Manager
Date of report:	30 December 2025
Appendices:	None

Improving Doctors Working Lives Programme - The 10 Point Plan - Progress report

Introduction

The 10 point plan was launched on 29 August to set out ways to improve resident doctors' working conditions, with an ambitious 12 week programme of activity. This report presents an update at the end of that 12 week period, with a summary of what has been achieved so far and our outstanding actions.

Executive summary

Data shows that QVH has made good progress with the 10 point plan over the course of the initial 12 weeks. Resident doctor peer leads have been appointed and early reimbursement of study leave expenses has been introduced. The Trust score has increased from 87% to 92%.

Situation

The Trust performed a baseline self-assessment against the 10-point plan and analysis returned showed that we were 87% compliant with the plan. Two factors needed resolution to achieve greater compliance; appointment of a resident doctor peer lead, and early processing of course related expenses.

Resident doctor peer lead:
A competitive interview process was initiated inviting all resident doctors in training at QVH to apply. Two candidates were identified and were appointed on a job share basis at 2 hours per week each.

Early reimbursement of study leave expenses:
With effect from 1 December processes have been put in place to allow all resident doctors (including locally employed doctors) to claim early reimbursement of course fees, before attending a course. To date (16 Dec) two claims have already been successfully processed.

Background

A revised assessment following 12 weeks of activity was submitted by the Chief Medical Officer, with the approval of the resident doctor peer leads, on 2 Dec 25. The results were received on 16 December and are summarised below.

Assessment

Summary table

Trust	Baseline Score	Re-Survey Score
Queen Victoria Hospital NHS Foundation Trust	87%	92%
South East Average	71%	85%
South East Range	43%-87%	64%-96%

It can be noted that good initial progress has been made. Going forward, the resident doctor peer leads are engaging with all QVH resident doctors to gather feedback on other areas specific to QVH that we can work to improve. This will develop into a longer term plan to ensure that the gains made to date are sustained and built upon.

Following ELT it was noted that further actions are required relating to evidence of staff being given breaks, and dedicated parking for on call resident doctors.

Detailed scoring:

Improving Doctors Working Lives Programme - The 10 Point Plan

Provider: QUEEN VICTORIA HOSPITAL NHS FOUNDATION TRUST

Amenities	Baseline survey	12-week progress
Access to Lockers	Yes, <50%	Yes, >50%
Rest facilities	Yes, <50%	Yes, >50%
Designated on-call parking access	Yes	Yes, >50%
Access to hot and cold food 24/7	Yes	Yes
Access to cold food 24/7	Yes	Yes
Inductions specifically designed to meet the needs of Resident Doctors	Yes	Yes
Beds/sleeping pods available free of charge	Yes	Yes
Are Resident doctors able to work from home for portfolio and self-directed learning?	Yes	Yes
Access to free psychological support treatment?	Yes	Yes
Positive feedback mechanisms in place to reward and promote staff?	Yes	Yes
Protected breaks?	No	No
Do you promote the Safe Learning Environment Charter?	Yes	Yes
Sexual safety/harassment training and awareness?	Yes	Yes

Appointing senior leads to take action on Resident Doctor issues	Baseline survey	12-week progress
Has your Trust Board appointed a senior named, accountable Resident Doctor Lead?	Yes	Yes
Has your Trust Board appointed a Resident Doctor Peer Lead?	No (consult with LNC/ equiv. bodies)	Yes
At what levels of your organisation have you reviewed and discussed the following surveys? (None, Executive team, Trust Board, People Committee, Two out of Three, or All)		
GMC Training survey	All	All
NETS survey	All	All
National Staff Survey		All
National Student Survey		None

Annual Leave	Baseline survey	12-week progress
Is there a local policy to encourage good annual leave management which references resident doctors?	Yes	Yes
Good annual leave practice covered at resident doctor induction?	Yes	Yes
Allow resident doctors to carry over annual leave between rotations?	Yes (internal rotations)	Yes (internal rotations)
Do rostering systems for Resident Doctors allow for self/preferential rostering?	Yes	Yes

Payroll and Expenses	Baseline survey	12-week progress
Implemented local SLAs and introduced board-level governance for tracking/reporting payroll errors?	Yes	Yes
Changes in payroll errors over the last 12 months?	Decrease in errors	No change
Processing of course related expenses?	After attendance, plan to change	When course is booked

Mandatory Training & Learning	Baseline survey	12-week progress
Do you accept resident doctors' mandatory training from other sites and follow the People Policy Framework (May 2025)?	Yes, both	Yes, both

Does the Resident Doctor Peer Lead support the findings as set out in this survey?	Fully supports

* 12-week progress survey | 92% | (Improvement of 5pp)

* The survey score is calculated by averaging the percentage scores of each scored question. . Please refer to the points scheme for specific scoring criteria.

Recommendation

The Committee is asked to **NOTE** this report including progress on the 10 point plan.

Report cover-page					
References					
Meeting title:	Board of Directors				
Meeting date:	12/02/2026		**Agenda reference:**	**130-26**	
Report title:	Strategy & culture committee assurance report				
Sponsor:	Shaun O'Leary, Senior independent director				
Author:	Ellie Simpkin, Governance manager				
Appendices:	None				
Executive summary					
Purpose of report:	To alert, assure and advise the Board regarding matters considered at the last committee meeting.				
Summary of key issues	- The committee considered the evaluation of the strategic partnership proposals from Royal Surrey NHS Foundation Trust and Ashford & St Peter's NHS Foundation Trust (RSASP) and Surrey and Sussex Healthcare Trust (SaSH). The committee was unanimous in recommending to the Board that QVH proceeds with a strategic partnership with RSASP. - The committee reviewed BAF risks which relate to the long term sustainability of the Trust and leadership capacity.				
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:	130-26
Date of meeting:	12 February 2026
Report from:	Shaun O'Leary, Senior independent director
Report author:	Ellie Simpkin, Governance manager
Date of report:	06 January 2026
Appendices:	None

Sub-committee assurance report

Strategy & culture committee – 26 November 2025

Key agenda items

- **Strategic partnership option appraisal**
- **Board Assurance Framework (BAF) and organisational risks**

Alert

No matters to raise.

Assure

The committee considered the outcome of the evaluation of the strategic partnership proposals from Royal Surrey NHS Foundation Trust and Ashford & St Peter's NHS Foundation Trust (RSASP) and Surrey and Sussex Healthcare Trust (SaSH). All Board members were invited to the meeting to contribute their views. Detailed discussion was had on the financial assessment, the benefits of the partnership for both the Trust, service users and the System and the risks which will need to mitigated and managed. The alignment of organisational cultures was recognised as being key to the success of the partnership. The involvement of clinical leadership in the evaluation process was welcomed. The committee was unanimous in recommending to the Board that QVH proceeds with a strategic partnership with RSASP. The partnership will be a transformational change for Trust and the committee stressed the importance of clear and timely communications with staff, patients and key partners and stakeholders.

Advise

No matters to raise.

Risks discussed and new risks identified

The committee reviewed BAF risks which relate to the long term sustainability of the Trust and leadership capacity. The scores for both BAF risks remained the same, with assurance ratings of amber. Both BAF risks are outside of risk appetite with a higher score. The action needed with regard to three Non-executive directors coming to the end of their term in June 2026 was noted.

Recommendation

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

Report cover-page					
References					
Meeting title:	Board of Directors				
Meeting date:	12/02/2026	**Agenda reference:**	**131-26**		
Report title:	Finance & performance committee assurance report				
Sponsor:	Peter O'Donnell, committee Chair				
Author:	Peter O'Donnell, committee Chair Katie Ally, Governance Officer				
Appendices:	None				
Executive summary					
Purpose of report:	To alert, assure and advise the Board regarding matters considered at the committee meetings held on 20 January and 26 January 2026.				
Summary of key issues	– The Trust is behind plan for patients waiting over 65 weeks overall; breast reconstruction is ahead of plan and other specialties are not meeting the plan. The committee has sought further assurance about the accuracy of performance data related to long waiting patients, and that these pathways are being monitored appropriately. – The committee has sought additional assurance regarding operational governance and oversight more broadly to ensure that key stakeholders are appropriately informed – There has been a deterioration in the Trust's 62 day performance largely due to a significant increase in skin cancer volumes and referrals with 25 patients waiting over 104 days. Improvement plans and recovery actions are in place and being actively monitored. The committee will continue to monitor performance in this area closely, including the length of time spent waiting and progress against the recovery trajectory. – The Trust is on track to breakeven and meet its financial saving target for 2025/26, however there remains a level of risk to this position. – The savings target for 2026/27 is likely to be very challenging and the committee has continued to seek further detail about cost improvement schemes in order to be assured about delivery. – The Director of estates and facilities post is currently vacant and plans are underway to recruit an interim Director of estates and facilities to ensure the continued management of critical infrastructure risks – The East Grinstead Community diagnostic centre (CDC) build is 3-6 weeks behind schedule and there is a financial risk due to the delay.				
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:	The committee reviewed the BAF risks relevant to its remit at the meeting				
Organisational risk register:	The committee received the organisational risk register at the meeting				
Regulation:	None				

Legal:	None			
Resources:	None			
Assurance route				
Previously considered by:				
	Date:		Decision:	
Next steps:	NA			

Report to: Board of Directors
Agenda item: 131-26
Date of meeting: 12 February 2026
Report from: Peter O'Donnell, committee Chair
Report author: Peter O'Donnell, committee Chair
Katie Ally, Governance Officer
Date of report: 22 January 2026
Appendices: None

Sub-committee assurance report
Finance & performance committee – 20 January 2026, (rescheduled from 12 January 2026) and 26 January 2026

20 January 2026

Key agenda items

- **Cancer performance & improvement**
- **Integrated Quality and Performance Report (month seven)**
- **65 week wait reporting**
- **Cost improvement programme update**
- **Business planning update 2026/27**
- **Major projects updates**
- **Update on estates infrastructure delivery**
- **Information management technology (IM&T) and cyber assurance**
- **Information governance assurance (incl. FOIs)**
- **Board Assurance Framework and Organisational risk register**

Alert

- The committee received a verbal update on the Trust's position regarding patients waiting over 65 weeks. The committee noted that the Trust is behind plan for patients waiting over 65 weeks overall; breast reconstruction is ahead of plan and other specialties are not meeting the plan. The committee noted that of this cohort of patients, 35 are breast patients, 21 are non-reconstruction, 3 are oral and maxillofacial and 5 are skin. The committee has sought further assurance about the accuracy of performance data related to long waiting patients, and that these pathways are being monitored with the appropriate level of oversight. The committee has sought additional assurance regarding operational governance and oversight more broadly to ensure that key stakeholders are appropriately informed
- There has been a deterioration in the Trust's 62 day performance largely due to a significant increase in skin cancer volumes and referrals with 25 patients waiting over 104 days. Improvement plans and recovery actions are in place

and being actively monitored. The committee will continue to monitor performance in this area closely, including the length of time spent waiting and progress against the recovery trajectory. The Trust is on track to meet its 2025/26 financial plan to breakeven however, there remains a level of risk to this position. Detail about cost improvement schemes in order to be assured about delivery.

- The East Grinstead Community diagnostic centre (CDC) build is 3-6 weeks behind schedule and there is a financial risk due to the delay. The committee were assured that the team continue to have the appropriate level of oversight with the contractor and the committee will receive a further update at its next meeting
- The committee received the Business planning 2026/2027 iteration submitted on 17 December 2025. An efficiency requirement of 6.1% (£7.5m) remains the current expectation although this may increase should allocations be reduced which will be very challenging. Further iterations will be shared with the committee as these are developed. An extraordinary committee meeting has been scheduled for 26 January 2026 to support the development of the final submission due on 12 February 2026.
- The Director of estates and facilities post is currently vacant and plans are underway to recruit an interim Director of estates and facilities to ensure the continued management of critical infrastructure risks

Assure

- The estates critical infrastructure backlog of works is being supported through capital funding and national estates safety funding for heating improvements and critical backlog schemes. The committee supported further bids being made for external funding, acknowledging that much more is needed to mitigate the risks related to the ageing estate. Key works to progress during 2026/27 include a boiler replacement, theatre roof repairs and ventilation improvement. The committee requested that further thought is given to the longer term strategy given the inherent risks of running a very old and ageing estate.
- The Trust met all of the Referral to Treatment (RTT) elective care targets at month 7: time to first appointment, 18 week wait performance, and 52 week wait performance (in terms of patient numbers rather than % of waiting list which the Trust missed the target by 0.1%).
- As at October 2025, the Trust reported an Income and expenditure position in line with planned breakeven and had a cash balance of £11.3m. The in-month position was supported by £0.2m of non-recurrent benefits. Forecast remains a year end breakeven position assuming income and pay will be maintained at current levels, and with some planned non recurrent benefits required.
- Archie EPR went live successfully as planned on 4th November. Funding of £762k capital was approved by NHS England, which will be used to extend the programme team until end of March 2026. There was a good update on benefit realisation and the team will revert on assuring the committee on value for money. Approximately £1m will be required in 2026/27 to complete the PAS implementation assuming an end 2026 go live. The committee noted that the Finance team are building that into the 2026/27 capital plans and that a business case will be required.

Advise

- East Grinstead Community diagnostic centre (CDC) activity continues to be behind plan in month 7 at 96%, driven by a requirement to increase demand from GPs and other providers. The activity is further behind plan for month 8, however the committee noted that management are confident in meeting the

income plan. The Trust is seeking opportunities to increase demand including offering mutual aid to other trusts.

- The committee noted the Information Management & Technology (IM&T) report including Cyber Security report and the excellent progress on the actions undertaken for the DSPT submission and noted the revision of the improvement plan from 31 December 2025 to 31 March 2026.
- The committee noted the information governance assurance report. Freedom of Information requests responded to within 20 days declined in M7 to 71.8% as older FOIs were being responded to. This continues to be an area of focus.

Risks discussed and new risks identified
The committee received the Board assurance framework (BAF) and Organisational risk register (ORR). The digital BAF risk score has reduced following the successful Electronic patient record (EPR) go live and funding being secured for EPR roles to March 2026. The ORR includes 27 open risks, with the most significant being CIP delivery and estates-related issues; targeted actions are underway to address these priorities. The committee remains focused on the ageing estate, recognising that there needs to be significant investment in this area in order to mitigate the risks.

26 January 2026
The committee held an extraordinary meeting on 26 January 2026 to review the second iteration of the business plan for 2026/27 ahead of submission to the Board for approval. The committee reviewed the draft plan in detail, requesting that further justification is included in the Board assurance statements before being presented to the Board as well as evidence to support the financial information in the plan. The committee acknowledged that the delivery of the 2026/27 plan will be very challenging and that quality impact assessments will be key in escalating to the Board where there are risks services may be compromised and staff morale is likely to be impacted.

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