Bundle Public Board 12 March 2026

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142.26 Welcome, apologies and declarations of interest

Angela McNab, interim Trust Chair

143.26 Draft minutes of the public meeting held on 12 February 2026

Angela McNab, interim Trust Chair
Approval

Minutes- PUBLIC Board meeting- 12 February 2026 DRAFT V1

144.26 Matters arising and actions pending from previous meeting

Angela McNab, interim Trust Chair
Review

144-26 PUBLIC Matters arising

145.26 Staff story

Helen Edmunds, Chief people officer
Discussion

146.26 Chair's report

Angela McNab, interim Trust Chair
Assurance

146-26 Chairs report FINAL

147.26 Chief executive's report

Abigail Jago, acting Chief executive officer
Assurance

147-26 CEO's report March 26 FINAL

148.26 Integrated quality and performance report

Kirsten Timmins, Chief operating officer
Assurance
Research & Innovation strategy update (Tamara Everington, Chief medical officer)
Estates update (Simon Marshall, interim Chief finance officer)

148-26 Board Cover sheet IQPR M9v1
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148-26.3 Estates update March 2026

149.26 Green plan

Simon Marshall, interim Chief finance officer
Approval

149-26 QVH Green plan
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150.26 Board of Directors work programme 2026/27

Leonora May, Company secretary
Approval

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151.26 Annual report on the use of Trust seal 2025/26

Leonora May, Company secretary
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152.26 Constitution updates

Leonora May, Company secretary
Approval

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Leonora May, Company secretary
All executive directors
Assurance

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154.26 Emergency Preparedness Resilience and Response

Kirsten Timmins, Chief operating officer
Assurance

154-26 EPRR Annual Report March 2026
154-26.1 QVH EPRR Assurance 2025 Draft Outcome Letter (SIGNED)

155.26 Audit and risk assurance

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

155-26 Audit & risk assurance report March 2026 FINAL

156.26 Quality and safety assurance

Jo Emmanuel, Non-executive director and committee Chair
Assurance

156-26 Quality & safety assurance report March 2026 FINAL

157.26 Strategy and culture assurance

Peter O'Donnell, Non-Executive Director and committee Chair
Assurance

157-26 Strategy & culture assurance report March 2026 FINAL

158.26 Financial, workforce and operational performance assurance

Peter O'Donnell, Non-Executive Director and committee Chair
Assurance

158-26 Finance & performance assurance report March 2026 FINAL

159.26 Any other business (by application to the Chair)

Angela McNab, interim Trust Chair
Discussion

160.26 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 March 2026

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

MEMBERSHIP
BOARD OF DIRECTORS
March 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	Azets (Trust's external auditor) support with annual tax return including evaluation of pension tax liability	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							
Jackie Smith 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 March 2026
10.00-12.00

Agenda: session held in public		
WELCOME		
142-26	**Welcome, apologies and declarations of interest** *Angela McNab, interim Trust Chair*	
STANDING ITEMS		**Purpose**
143-26	**Draft minutes of the public meeting held on 12 February 2026** *Angela McNab, interim Trust Chair*	*Approval*
144-26	**Matters arising and actions pending from previous meetings** *Angela McNab, interim Trust Chair*	*Review*
145-26	**Staff story** *Helen Edmunds, Chief people officer*	*Discussion*
146-26	**Chair's report** *Angela McNab, interim Trust Chair*	*Assurance*
147-26	**Chief Executive's report** *Abigail Jago, acting Chief executive officer*	*Assurance*
PERFORMANCE		
148-26	**Integrated quality and performance report** *Kirsten Timmins, Chief operating officer* • **Research & Innovation strategy update (Tamara Everington, Chief medical officer)** • **Estates update (Simon Marshall, interim Chief finance officer)**	*Assurance*
GOVERNANCE, STRATEGY & RISK		
149-26	**Green plan** *Simon Marshall, interim Chief finance officer*	*Approval*
150-26	**Board of Directors work programme 2026/27** *Leonora May, Company secretary*	*Approval*
151-26	**Annual report on the use of the Trust seal 2025/26** *Leonora May, Company secretary*	*Information*
152-26	**Constitution updates** *Leonora May, Company secretary*	*Approval*

153-26	**Board Assurance Framework** *Leonora May, Company secretary* *All executive directors*	*Assurance*
ANNUAL REPORTS		
154-26	**Emergency Preparedness Resilience and Response** *Kirsten Timmins, Chief operating officer*	*Assurance*
COMMITTEE ASSURANCE REPORTS		
155-26	**Audit and risk assurance** *Jagjit Dosanjh-Elton, Non-executive director and committee Chair*	*Assurance*
156-26	**Quality and safety assurance** *Jo Emmanuel, Non-executive director and committee Chair*	*Assurance*
157-26	**Strategy and culture assurance** *Peter O'Donnell, Non-Executive Director and committee Chair*	*Assurance*
158-26	**Financial, workforce and operational performance assurance** *Peter O'Donnell, Non-Executive Director and committee Chair*	*Assurance*
MEETING CLOSURE		
159-26	**Any other business (by application to the Chair)** *Angela McNab, interim Trust Chair*	*Discussion*
MEMBERS OF PUBLIC		
160-26	**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)** **12.00-14.00 12 February 2026 (rescheduled from 22 January 2026)** **Education Centre, QVH**	
Present:	Angela McNab (AM)	Interim Trust Chair (voting)
	Jagjit Dosanjh-Elton (JDE)	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) [from item 119-26]
	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)
In attendance:	Leonora May (LM)	Company Secretary
	Jackie Doherty (JDo)	Freedom to Speak Up Guardian (The Guardian Service) [MS Teams]
	Janet Robb (JR)	Patient story [MS Teams] [until item 120-26]
Apologies:	Aleema Shivji (AS)	Associate Non-executive director (non-voting)
	Peter O'Donnell (POD)	Non-executive director (voting)
	Vivek Chaudhri (VC)	Associate Non-executive director (non-voting)
	Jane Dickson (JD)	Interim deputy Chief executive officer (non-voting)
Members of the public:	5 members of staff, 12 governors	

116-26 **Welcome, apologies and declarations of interest**

The Chair opened the meeting welcoming members of the Board and those observing the meeting.

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

Apologies were received from AS, POD, VC and JD and the meeting was declared as quorate. RH joined the meeting virtually.

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

117-26 **Draft minutes of the public meetings held on 13 November and 16 December 2026**

The Board **agreed** that the minutes of the public Board meetings held on 13 November and 16 December 2025 are a true and accurate record of those meetings and **approved** them on that basis.

118-26 **Matters arising and actions pending from previous meetings**

LM provided an update on action 3 (compliance). She reported that the Audit and risk committee had recently received an update on progress against governance actions within the Annual governance statement. These are all complete bar the Governance handbook which is in development and will be complete before the end of March 2026. Once that is complete the action can be closed.

The Board noted that there were three further open actions which are not due until March 2026.

	The Board **noted** the updates.
119-26	**Patient story** The Board extended a warm welcome to Janet Robb, a facial palsy patient, who had joined the meeting on MS Teams to share her patient story. JR shared the following background with the Board. She lives in Northern Ireland and has had facial palsy for 13 years. She is an active campaigner for facial palsy in Northern Ireland as there are no facial palsy services local to her. JR explained that she was not referred to QVH; she did her own research and chose to be treated by QVH following a misdiagnosis. Her facial palsy appointments at QVH are extremely important to her and it takes her 19 hours to travel to QVH for an appointment. When she attended for her first appointment, she was able to see a clinical psychologist. She had lost function in her face, was experiencing nerve pain and could not see very well. She felt as though she had lost her identity due to her facial palsy. She met Charles Nduka (Consultant Plastic Surgeon) who diagnosed her with facial palsy. She described that for the first time she felt like someone cared and understood how she felt. She described the compassionate and expert care that Charles provided which changed her life for the better, and she feels as though she has her identity back. She had a total of six operations and was unable to receive the specialist level of aftercare required in Northern Ireland. [SM joined the meeting] AJ stated that what JR had shared resonates with the Board and highlighted that holistic care is at the centre of QVH's strategy. She asked JR if there was anything she thought that QVH could do better for facial palsy patients. In response, JR shared that she would appreciate an advanced phone call regarding appointments as this would help with booking flights and arranging accommodation if necessary. Staying at a hotel after operations has been difficult as well as receiving aftercare in Northern Ireland. She thought it would be helpful if QVH was able to liaise with medical staff in Northern Ireland regarding how do provide the specialist aftercare required. JR described a time when she had travelled to QVH to find that her appointment had been cancelled as there was no one available to give her the botox injection. The Board agreed that this valuable feedback would be taken away and considered. The Board extended thanks to JR for sharing her story and wished her well for the future. [JR left the meeting]
120-26	**Senior independent director's report** SOL presented the report to the Board, extending a welcome on behalf of the Board to AM who had joined the Trust in January 2026 as interim Trust Chair. He thanked Jackie Smith, who had finished her term as Trust Chair in January 2026, for all that she had done during her time as Trust Chair. AM thanked all for the warm welcome that she had received. She explained that in her first month, she has had the opportunity to meet a number of colleagues and staff across the organisation as well as key stakeholders. She would provide a full Chair's report to the Board at its next meeting. The Board **noted** the updates.
121-26	**Chief Executive's report** AJ presented her report to the Board, highlighting the following:

	- The Trust remains on track with delivering a breakeven position at year end, although there is a need to maintain momentum with the better value programme - The business plan for 2026/27 has been submitted today. It is a challenging plan which requires significant cost reductions - The Trust is making good progress against access standards but is behind plan for patients waiting over 65 weeks for treatment. The Trust had committed to zero patients outside of breast reconstruction waiting for more than 65 weeks at year end - Progress is being made with the East Grinstead community diagnostic centre (CDC) build, however, there is a delay. Good progress is being made with transitioning the Bognor Regis CDC - Strategic work continues to address and implement the next steps for the strategic partnership with a strong commitment to engagement - During January 2026, the Trust declared a business continuity incident due to water supply issues. She extended thanks to everyone who had been involved with the management of the incident The Board thanked everyone involved in managing the business continuity incident, which it acknowledged was managed effectively with services being maintained. This was a testament to everyone involved. A Board member asked what are the benefits to patients and to QVH from QVH's engagement with the Provider collaborative. AJ explained that the Provider Collaborative is gaining momentum. Its focus is not on individual organisations and their patients, but on the wider population and neighbourhood offers. A key consideration is how can the collaborative deliver the best services with collective resources for the wider population. The collaborative is also considering a single point of access for patients. It is too early to track tangible benefits. In response to a question, AJ explained that a draft implementation plan for the partnership will be presented to the Strategy and culture committee at its meeting in February 2026. This is dependent on alignment with partners. Discussion was had about the Trust's estate challenges and how the Board maintains robust oversight, given that the Director of estates and facilities had left the Trust. AJ explained that plans are in place to replace to appoint to this key role to support strategic programmes and day to day delivery. SM continues to be focussed on the Trust being able to access as much capital funding as possible to mitigate risk in this area. The Board **noted** the contents of the report.
122-26	**Integrated quality and performance report** KT presented the report to Board and provided an update on operational performance. She reported that December has been a challenging month due to industrial action, annual leave and increased sickness. There had also been a high level of patient cancellations. The Trust continues to have patients waiting in excess of 65 weeks which is driven by growth in complexity, delayed referrals and an increase in urgent cancer referrals. There is a national shortage in breast reconstruction services. KT reported that at month 9, there were 53 patients waiting over 65 weeks and that a revised trajectory has been submitted to NHSE. The planned trajectory for 52 week waits was achieved for month 9. There is a record number of skin cancer referrals and putting on additional activity has been a challenge with no additional resource. There has been improvement in the faster diagnostic standard. CDC activity is below plan. There has been some issues with reporting since the launch of Archie EPR and KT acknowledged that a dip in performance may not reflect reality. There is continued increased focus on productivity.

	Discussion was had regarding patients waiting more than 65 weeks and the Board sought assurance that the revised trajectory for January to March 2026 will be met. In response, KT acknowledged that there are patients outside of breast reconstruction waiting more than 65 weeks. The team have strengthened reporting around 65 week waits as well as escalation. There is a written plan which will be shared with the Quality and safety committee and KT is confident in the deliverability of the plan. She stated that there are some factors which are outside of the Trust's control, including late referrals. The Board requested that the granular detail of this plan be presented to the Quality and safety committee and that KT gives further consideration to how the Trust can influence late referrals within the plan. There was a suggestion that the Trust could consider working more closely with those making referrals and giving feedback. A Board member highlighted the importance of there being a robust record related to 65 week waits and the issues related to reporting and that new information related to patients outside of breast reconstruction is included clearly in future reporting. A Board member asked about confidence levels in delivery of CDC activity to 90%. KT thought that the plan for 2025/26 was challenging and that some of the demand has not been there. The team are focussed on trying to make it as easy as possible for GPs to refer into the CDC. The Trust will be below plan for CDC activity at year end and KT was confident that next year's plan is more achievable. LB and TE provided an update on quality and safety. LB reported that there has been a small reduction in ethnicity recording and that the Trust has not met the 90% complaints compliance target. This relates to two patient complaints. HE provided an update on workforce. She reported that the use of temporary staffing continues to reduce and that sickness absence increased in months 8 and 9, but she expected to see a reduction in this for month 10. In response to a question, HE confirmed that the staff survey response rate has decreased by 1%. A Board member requested that consideration be given to benchmarking and comparatives being included in future iterations of the IQPR for workforce metrics to provide assurance about performance. In response to questions from Board members, HE confirmed that the majority of staff turnover is voluntary and the Trust overall has low turnover. SM provided an update on finance. He reported that the Trust remains on plan and that cost reductions are being delivered. Risks to the plan are largely system wide risks and risks related to deficit support funding. The Trust has been successful in receiving additional capital: £750k for digital and £3.8m for estates safety. The teams are working to ensure that this is spent before year end. The key risk related to capital is ensuring the funds for the CDC's are moved into next year effectively. SM expects that the capital plan will be met by year end. <u>Digital update</u> HE presented the digital update to the Board. She highlighted the following: - Since the launch of Archie EPR there has been over 110,000 patient in-context links to other systems - The windows 11 migration project is almost complete - All actions related to the data security protection toolkit have now been completed - The implementation of the Trust's new patient administration system (PAS) is planned for 2026/27

	Discussion was had regarding the PAS and TE shared that this is inherently risky. The provisional go live date is 2 November 2026. The Board **noted** the contents of the reports.
123-26	**Freedom to speak up guardian report** JDo presented the report to the Board. She reported that the service is getting a lot of support from the Chief nursing officer, the acting Chief executive officer and the Freedom to speak up guardian Non-executive champion. On average, there have been around four speak ups per month and 56% of those who have used the channel have said that they would be happy for their concern to be escalated which is an improvement. She highlighted that 39% of people had raised concerns because they felt they had not been listened to when their concern was raised internally. The Board emphasised the importance of managers creating an open culture where feedback is welcomed and acted upon. Discussion was had about whether speaking up training should be mandatory for managers. HE confirmed that this is covered via corporate induction. AJ thought that what really matters is that colleagues see this as important and she emphasised the importance of leading by example. The Board **noted** the contents of the report and **supported** the recommendations.
124-26	**Annual review of raising concerns** LB presented the report to the Board, highlighting that there had been a reduction in use of the 'tell the Chief nurse' channel for raising concerns. LB explained that she thought that this was due to the channel no longer being anonymous. This changed due to the need to be able to provide feedback to staff who raised concerns. LB confirmed that the effectiveness of this channel will continue to be monitored. HE explained that whilst the number of cases had remained static, the team have seen an increase in people raising concerns through HR and employee relations. The Board acknowledged that there are many routes for speaking up and agreed that it was important to have enough channels, especially during a period of significant change where staff morale is likely to dip. A Board member suggested that it would be helpful if the next report included information about what actions have been taken in response to concerns being raised. The Board **noted** the contents of the report.
125-26	**Board assurance framework (BAF)** LM presented the report to the Board, highlighting the following: - The Quality and safety committee have considered the score of the quality risk and agreed that the score should be reduced from 12 to 9 based on the positive assurance related tio patient care - A new amber/ red assurance has been added to the access riusk related to patients waiting more than 65 weeks and challenges with the 62 day cancer target - The digital risk score has been reduced from 16 to 12 to due to the EPR launch success and funding for key roles being confirmed. This risk has met its target score The Board agreed that the following matters should be discussed in more detail by the relevant sub-committees:

	- Consideration about whether there should be a standalone cyber risk to ensure the appropriate level of focus - Progress against ensuring that there is appropriate resource to support PSIRF - Updating the sustainability risk to reflect the current position, which is moving quickly The Board: - **Noted** the contents of the report - **Confirmed** that the BAF is appropriately focussed on, and accurately desribes the key risks that may impact on the Trust's ability to deliver its key strategic objectives
126-26	**Six monthly safe staffing review** LB presented the report to the Board. She explained that the team had identified an opportunity for efficiencies with staffing levels and that a review of bed occupancy and ward utilisation has been undertaken. The executive team had approved the new bed configuration which resulted in a reduction in beds on the general ward, whilst ensuring that staffing levels remain safe and proportionate. There has been a whole time equivalent reduction of 11. The Board noted that there are tools used to assure management that staffing levels are safe. A Board member asked about how softer intelligence is used to feed into the assessment. In response, LB confirmed that incidents, complaints and feedback are monitored. The Board **noted** the contents of the report and **supported** the changes to establishments to enable staffing deployment that delivers greater efficiency.
127-26	**Annual equality, diversity and inclusion (EDI) annual report 2024/25** HE presented the report to the Board. She explained that the Trust is required to publish this information on its website under the public sector Equality Act. HE provided the Board with the key highlights from the data as set out within the front cover of the report. A Board member questioned the statement within the report about staff training related to accessible information. They suggested HE think about rewording this to make clear the action that the Trust is taking in this area. Discussion was had about staff networks and HE confirmed that the Trust had tried to embed these networks many times, however there had been a challenge with engagement. HE thought that there may be an opportunity to join networks as part of the partnership. A Board member requested that learning and reflection from quality impact assessments undertaken is fed back to the Board via the appropriate channel. **ACTION HE** The Board **noted** the contents of the report and **approved** it for publication on the Trust's website.
128-26	**Audit and risk assurance** JDE presented the report to the Board, She reported that the committee had received a partial assurance internal audit related to job planning but that it had been acknowledged that good progress had been made in this area. The committee had also received an update on compliance with the standards of business conduct policy. There were some issues with timely declarations of interest which the team are following up on. The committee had received assurance about strengthened financial governance and confirmation of actions from last year's Annual governance statement being completed. The Board **noted** the contents of the report.

129-26	**Quality and safety committee assurance** JE presented the report to the Board. She reported that the committee had discussed the 65 week wait issue and had received an update on the clinical harm reviews completed. The committee have requested sight of the detailed action plan to address the challenge. There are a number of policies which remain out of date and the committee will continue to monitor this position. The committee received positive assurance about the work being done to improve resident doctors working lives in line with the resident doctor ten point plan. The Board **noted** the contents of the report including the resident doctor ten point plan actions update.
130-26	**Strategy and culture assurance** The Board **noted** the contents of the report.
131-26	**Financial, workforce and operational performance assurance** RH presented the report on behalf of POD. He highlighted the following: - The committee are focussed on 65 week waits including accuracy of reporting. The committee are working constructively with the executive team to learn lessons from recent challenges - The delivery of this year's financial plan is a huge credit to the executive team, and it should be acknowledged that future plans will become increasingly challenging - Estates is a high risk area and the committee must continue to maintain focus here The Board **noted** the contents of the report.
132-26	**Any other business (by application to the Chair)** There was no further business and the meeting closed.
133-26	**Questions from members of the public** There were no questions received from members of public. The Chair invited the lead governor to ask questions regarding any of the items discussed during the meeting on behalf of the governors. The lead governor asked the following questions. Question Has staff morale improved now that the partnership has been announced and there is more certainty? Response AJ thought that there are many changes which are impacting staff morale and that management must continue to be sensitive to this. Staff morale seems to be variable across different departments and the outcome of the most recent staff survey will be shared once it is un embargoed. Question How does the Trust plan to collaborate with Surrey and Sussex Healthcare Trust (SASH)? Response AJ confirmed that the Trust does work with numerous providers on cancer pathways and trauma services and that this will continue. The Trust is working with SASH as part of the provider collaborative with consideration about what can be done differently together. Question

	You said that some staff are having challenges with using EPR. Can you tell us about the benefits of the EPR system? Response TE explained that in some areas such as MIU, staff have described faster more efficient ways of working and for others the Trust is partially digital with document management systems. Question Why is the the 'tell the CNO' raising concerns route no longer anonymous? Response LB explained that the Trust cannot address concerns and respond to individuals if concerns are raised anonymously. There is an anonymous option through the freedom to speak up guardian if staff do not feel comfortable and this way they can receive a response.

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**
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 March 2026: Update provided to the FPC in March 2026	**CLOSED**
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 March 2026: Update scheduled for Strategy and culture committee at its meeting in March 2026	**PENDING**
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**	**May 2026***	March 2026: Updates scheduled on the Quality and safety committee work plan for every meeting from May 2026 onwards	**PENDING**
6	February 2026	127-26	EDI Annual report 2024/25	Share learning and reflections from Equality Impact Assessments (EIA) completed	**HE**	**May 2026***	March 2026: To be shared with the Strategy and culture committee at its meeting in May 2026	**NOT YET DUE**

Report cover-page					
References					
Meeting title:	Board of Directors				
Meeting date:	12/03/2026	**Agenda reference:**	**146-26**		
Report title:	Chair's report				
Sponsor:	Angela McNab, interim Trust Chair				
Author:	Angela McNab, interim Trust Chair				
Appendices:	None				
Executive summary					
Purpose of report:	To update the Board of Directors on Chair, non-executive director and governor activities since the last meeting.				
Summary of key issues	• I was delighted to join QVH as interim Chair on 19 January 2026. I have received a warm welcome from Board colleagues, the Council of Governors, other colleagues from across the Trust and key system partners. • The key priority for the Board in the coming months remains driving forward the strategic partnership to ensure that our services remain sustainable for the future. • I have been able to visit a number of services already, including Theatres and Pharmacy. • Peter O'Donnell, Shaun O'Leary and Russell Hobby come to the end of their terms as Non-executive directors at the end of June 2026. We will shortly be starting a recruitment process for Non-executive roles with the Council of Governors. • During February 2026, the Board completed its annual effectiveness review, the results of which will be considered in detail by the Board at its seminar in April 2026. • During February 2026, Colin Fry stepped down from his role as a public governor. I would like to extend thanks on behalf of the Council of Governors and Board to Colin for his support to QVH in his capacity as a public governor. • There are a number of public and staff governors coming to the end of their terms in June 2026. At its meeting on 25 February 2026, the Council of Governors agreed to hold an election process to fill those roles to ensure that governor statutory duties can be fulfilled and ensure that the Council of Governors can hold quorate meetings.				
Recommendation:	The Board is asked to **note** the contents of the report.				
Action required	Approval	**Information**	Discussion	Assurance	Review
Link to key strategic objectives (KSOs):	**KSO1:**	**KSO2:**	**KSO3:**	**KSO4:**	**KSO5:**
	To deliver outstanding care	***To innovate and improve***	***To be an excellent employer***	***To deliver sustainable services***	***To collaborate with others***
Implications					
Board assurance framework:	None				
Organisational risk register:	None				
Regulation:	None				
Legal:	None				
Resources:	None				

Assurance route				
Previously considered by:	NA			
	Date:		Decision:	
Next steps:	NA			

Report to:	Board of Directors
Agenda item:	146-26
Date of meeting:	12 March 2026
Report from:	Angela McNab, interim Trust Chair
Report author:	Angela McNab, interim Trust Chair
Date of report:	3 March 2026
Appendices:	None

Chair's report

Introduction

I was delighted to join QVH as interim Chair on 19 January 2026. QVH is an amazing organisation that cares deeply about its patients. I have received a warm welcome from Board colleagues, the Council of Governors, other colleagues from across the Trust and key system partners. I would like to thank everyone who has supported me in the first couple of months in my role as interim Chair. I have been impressed by the dedication to patient care by everyone that I have met so far and look forward to meeting more colleagues in the coming months.

Since joining QVH, I have had the opportunity to meet with Board colleagues, governors and colleagues from NHSE and the ICB.

I have been able to observe Board sub-committee meetings and have visited the pharmacy and theatres. I am looking forward to visiting many more areas across the hospital including prosthetics, theatres and the charity in coming weeks.

Board of Directors

The key priority for the Board in the coming months remains driving forward the strategic partnership to ensure that our services remain sustainable for the future. Abigail and I remain closely connected to the Group Chair and Chief Executive Officer of the Royal Surrey NHS FT and Ashford and St Peters Hospitals NHS FT Group (RSASP Group) regarding strategic partnership developments and are actively discussing the potential benefits for clinical services.

Peter O'Donnell, Shaun O'Leary and Russell Hobby come to the end of their terms as Non-executive directors at the end of June 2026. We will shortly be starting a recruitment process for Non-executive roles with the Council of Governors. Once this recruitment process has concluded, I will make a proposal to the Board and Council of Governors regarding Senior Independent Director arrangements from July 2026 and will provide an update on committee membership and Chairing arrangements for both the Strategy and culture committee and Finance and performance committee. There will be an opportunity for reflections and thanks to Peter, Shaun and Russell at their last Board meeting which will be in May 2026.

During February 2026, the Board completed its annual effectiveness review, the results of which will be considered in detail by the Board at its seminar in April 2026. Some high level findings of that review are:

- Board members acknowledged that the quality of papers has much improved, however, there is still room for further improvements including triangulation, analysis and clearer summaries

- There are strong working relationships between the Non-executive and Executive Board members and the Board will need to continue to focus on relationships given the changes to Board membership during 2026
- Assurance reporting from the sub-committees is effective and the alert, assure and advise format of these reports is welcomed
- Board members acknowledged that the cultural assessment discussed by the Board in November 2025 was a positive step forward, and that the culture conversation must be kept alive at Board level
- The approach to Board seminars has worked well and there is a need to consider a forward plan for these during 2026/27. The majority of Board seminars has been spent on the strategic partnership as this has been the Board's key priority
- Board members acknowledged a need for increased strategic focus on the three shifts within the NHS ten-year plan 'fit for the future'

Council of Governors
I have established regular meetings with our lead and deputy lead governor to discuss key issues.

During February 2026, Colin Fry stepped down from his role as a public governor. I would like to extend thanks on behalf of the Council of Governors and Board to Colin for his support to QVH in his capacity as a public governor.

Governor working groups continue to be held with committee Chairs, executive leads and governors. Governors received an update on the strategic partnership at their private meeting on 25 February 2026.

There are a number of public and staff governors coming to the end of their terms in June 2026. At its meeting on 25 February 2026, the Council of Governors agreed to hold an election process to fill those roles to ensure that governor statutory duties can be fulfilled and ensure that the Council of Governors can hold quorate meetings.

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

Report cover-page					
References					
Meeting title:	Board of Directors				
Meeting date:	12/03/2026	**Agenda reference:**	**147-26**		
Report title:	Chief Executive Officer (CEO) report				
Sponsor:	Abigail Jago, Acting Chief Executive Officer				
Author:	Kathy Brasier, Deputy Chief Strategy Officer Allison Hunter, Strategy Support Officer				
Appendices:	None				
Executive summary					
Purpose of report:	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 submitted its three-year business plan to NHS England. • QVH has delivered the Month 10 financial plan. Work continues to accelerate the Better Value programme and to increase patient activity to deliver the planned year-end break-even position. Financial pressures remain significant as planning continues for 2026/27 and beyond. • Trust is behind plan on delivering the December 2025 target for zero patients waiting over 65 weeks, excluding breast reconstruction, however the revised trajectory agreed with NHSE was met in January. RTT18 performance is 1% below plan at Month 10, and while further recovery actions are underway to strengthen validation, management and assurance, there remains a risk to achieving year-end RTT targets. • East Grinstead Community Diagnostic Centre build is progressing, with a two-month delay due to adverse weather conditions. This is not expected to have a financial impact on activity income. • QVH has been assessed as Amber-Green within the National Oversight Assessment Framework. • Key organisational risks relate to the financial position, estates, operational performance standards and managing the impact of potential 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					

Report to:	Board of Directors
Agenda item:	147-26
Date of meeting:	12 March 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:	26 February 2026
Appendices:	None

Chief Executive Officer (CEO) report

Alert

- QVH has delivered its Month 10 year to date financial plan. It continues to accelerate the Better Value programme and to increase elective patient activity, both of which are essential to achieving the planned year-end break-even position. There remains considerable financial challenge as we plan for 2026/27 and beyond.
- 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. A revised trajectory has been submitted to NHSE and this was delivered in January (32 patients awaiting delayed breast reconstruction and 17 patients awaiting non breast care). The Trust is behind plan for RTT 18-week performance by 1%. Recovery plans are being further developed to strengthen management, increase validation and oversight and assurance, yet there remains risk in achieving the RTT year-end operational targets.
- East Grinstead Community Diagnostic Centre (CDC) build continues to progress. There is a two-month delay to the build due to factors including the recent adverse weather conditions. It is not expected to have any impact on activity income next year.
- Key risks for the organisation relate to the financial position, estates challenges and delivery of performance standards.

Assure

- The Trust continues to deliver its planned capital improvements within the available financial envelope. £2.8m of additional Estates Safety capital funding and £0.75m of digital capital funding was confirmed during November and December. This investment will allow us to reduce many of our immediate high-level estate risks by the year end and accelerate the next stage of our digital programme.
- Significant Q3 progress has been achieved across 2025/26 Key Strategic Objectives (KSOs).
- The Trust achieved the Cancer Faster Diagnostic Standard (FDS) in M9, achieving 82% which exceeded the national standard and Trust trajectory. The proportion of patients on a cancer pathway who were treated within 62 days improved, increasing from 66% to 73% in M9, and met the Trust plan. At the end of M10, 78 patients (14.4% of the cancer PTL) had waited over 62 days, including 27 patients waiting over 104 days. Clinical harm reviews continue to be undertaken for all patients waiting over 62 days, and no harm was identified during this period. The Trust is working closely with the Surrey and Sussex Cancer Alliance to review the skin cancer pathway given the national increase in referrals on this pathway.
- QVH continues to work on the planning phases of the strategic partnership with Royal Surrey and Ashford St. Peters (RSFT/ASPH). This approach includes undertaking planning reviews for both finance and governance, a suite of priority workstreams and governance arrangements. Focused work is underway to develop the communication and engagement plan for this phase. QVH will continue the Stakeholder Assurance Group to support direct staff involvement in the process.

- All wards have now returned to their original locations following completion of urgent estates works.

Advise
- The Trust submitted its updated business plan on the 12 February in line with the national submission timetable and will continue to refine this during March 2026.
- 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 local partners regarding its long-term management.

Business Planning
The Trust submitted its three-year business plan to NHS England on the 12 February in line with the national timetable. High level feedback has now been received and work continues to finalise the plan including confirming final contract offers with commissioners.

Key elements of the plan include:
- The Trust intends to deliver a break-even position for 2026/27 and beyond, and to increase activity in order to work to a trajectory towards the delivery of constitutional standards as per national guidance.
- The national and local rules have been applied including funded inflation at 2% offset by the expected 2% productivity improvements, the capped 2.5% contract reduction (including deficit support funding & convergence adjustments) and the 1% elective recovery transformation reserve.
- £2.5m of activity related income growth has been included in order to deliver the planned care standards and CDC workload. Contract negotiations are expected to continue up to the end of March.
- £7.5m (6.3%) of efficiency savings are required in 2026/27 in order to deliver the required activity and a break-even position. The unidentified element of the best value plan has reduced to £0.8m between the first and second submissions.
- Workforce numbers, reflect the increase in RTT and CDC activity, but are reduced by the efficiency programme requirements and consequently show a net reduction in WTE of 49 for 2026/27.
- Capital allocations have been given for the next 4 years. QVH has been allocated £4.2m, £4.0m, £5.0m and £5.1m respectively.
- Due to the capital required to fund PAS transition and complete the CDC in 2026/27 there is £2.2m available to spend on digital, estates, and medical equipment. The Trust has been provisionally allocated £3.6m of estates safety funding and is awaiting final confirmation of this following the submission of the required bids.

Provider Capability Assessment
The NHS Oversight Framework (NOF) 2025/6 outlines the approach to assessing integrated care boards (ICB), NHS Trusts and Foundation Trusts. As part of this framework NHSE assess NHS trust board capability. A key element of this was a board self-assessment in regard to six domains including:
- Strategy, leadership and planning
- Quality of Care
- People and culture
- Access and delivery of services
- Productivity and value for money
- Financial performance and oversight

In line with requirements QVH submitted the self-assessment in October. The assessment has been assessed by the regional team and triangulated with track record of delivery,

regulatory history and any relevant third party information. The ratings were subject to review and ratification by NHS England's (NHSE) Executive Board.

There are four outcome ratings from the assessment, Green, Amber-green, Amber-red and Red. Following this process QVH has been allocated an overall capability rating of Amber-Green for 2025/6. NHSE will continue to monitor the performance of QVH.

Finance and Performance
For Month 10 the Trust reported a deficit of £0.1m, and for the year to date a break-even position. Both of these were in line with plan. Whilst the position at Month 10 remains on plan, it is important we continue to deliver the Better Value programme and additional elective activity levels to assure a break even position for the year end. To date £7.6m of Better Value schemes have been identified and are in progress. Actual delivery to Month 10 was £6.1m in line with the plan.

From an operational performance perspective for Month 10, the Trust met two of the three Referral to Treatment (RTT) elective care targets: time to first appointment, and 52 week wait performance. The Trust was behind plan by 1% for RTT 18-week performance. QVH reported 49 patients waiting over 65 weeks in Month 10, meeting the revised trajectory for 65-week waits submitted to NHSE in January.

Cancer performance improved in M10 and met the Trust planned trajectories for Faster Diagnostic Standards (FDS) and 62-day referral to treat. Whilst the Trust continues to have a high proportion of patients waiting over 62 days, this is an improving position.

Urgent Emergency Care (UEC) performance achieved 99% meeting the national standard and internal trajectory. Diagnostic Waiting time (DM01) performance delivered 89% and remains relatively stable.

Key Strategic Objectives (KSOs) Update
The Trust continued to make progress in Q3 across all 2025/26 KSOs. Looking ahead to 2026/27, the proposed Trust KSOs, have been developed with the Executive Leadership Team and Clinical Directors through the Executive Leadership Team forum. The objectives align to national priorities, system transformation requirements, the *QVH Strategy 2025-30*, and the learning from the current year's delivery.

The ambitions of the NHS 10-Year Health Plan's three shifts of 'acute to community', 'analogue to digital' and 'treatment to prevention' are reflected through the ongoing transformation to deliver access standards, the Digital Transformation Programme and community diagnostic initiatives to prevent avoidable hospital attendances and treatment.

	To deliver outstanding care	To innovate and improve	To be an excellent employer	To deliver sustainable services	To collaborate with others
Key strategic objective detail	Quality and access at the **centre** of what we are and do for patients, families and communities	Research, innovation and continuous improvement underpinning all that we do	People are our greatest asset and we need to work hard to develop and deliver our workforce for the future	Deliver best value, support a sustainable environment and future digital pathways and literacy	Develop partnership ambition - anchor, NHS, academic and commercial activities for the future
Annual objective (inc. major projects)	Delivery of Access Targets (RTT, Cancer, UEC, DMO1) delivery, including the National Cancer Plan Strategic Service Reviews for burns, prosthetics and breast in liaison with commissioners Quality Priority Delivery: Health Inequality DNA & Access, Patient Schools, Outcomes & Effectiveness measures	Research & Innovation Hub and strengthen academic and commercial partners Ensure the QVH Way underpins all improvement and transformation programmes Digital transformation to support trust and system priority objectives, including Patient Administration System (PAS)	Enhance inclusive collaborative culture including behaviours framework and speaking up (EDI) Develop trust and directorate leadership capability	Maintain financial sustainability, reduction of corporate costs and delivery of Better value Programme Delivery of key estates infrastructure projects and improving estates resilience and backlog maintenance	Strategic partnership transition and implementation Delivery of external and internal engagement plan Transform diagnostic pathways using Community Diagnostic Centre (CDC) for neighbourhood care Support system transformation through provider collaborative and outcomes of the Major Services Review (MSR)

The next steps will focus on further developing the Trust annual goals and watch metrics that will underpin the overarching Trust KSOs. This work is critical to ensuring the organisation maintains a clear strategic direction, enables effective prioritisation, and supports a consistent approach to performance management. By establishing well defined goals supported by measurable outcomes, the Trust will be better positioned to monitor progress, demonstrate accountability and drive continuous improvement in the quality of patient care.

Quality and Safety
Work is underway to finalise the quality priorities for 2026/27, these are being developed with the engagement of frontline staff.

Following the completion of urgent estates works, all wards have now been reinstated to their original locations. An approved reduction in bed configuration has been implemented to

optimise staff efficiency and operational effectiveness, while safeguarding the provision of high quality patient care and experience.

The first version of the Health Inequalities Dashboard is now in place, enabling initial analysis of variation in attendance, waiting lists and Did Not Attend (DNA) rates across key demographic groups. Manual review of complaints and Patient Advice and Liaison Service (PALS) enquiries by protected characteristics has begun, offering early insight into potential differences in patient experience not visible through routine reporting.

Strategic Partnership Development
Progress continues on the strategic partnership with RSFT and ASPH, with core programme governance in development. A period of shared planning, analysis and assurance has started which includes finance and governance reviews to enable all three trusts to identify future benefits. This phase is important as it will help ensure expectations, governance arrangements and timescales are fully aligned.

A structured programme with six workstreams has been developed. A QVH Partnership Steering and joint Partnership Working Group are in place.

QVH continues to progress a shared structured engagement and communication approach. This approach continues to support the transition, building on extensive staff, volunteer, patient, Council of Governors and stakeholder involvement that took place during the development of the *QVH Strategy 2025-2030* and partnership appraisal work.

Celebrating our QVH Team

Values in Practice (VIP) Award Winners
The monthly Values in Practice (VIP) awards continue to highlight the outstanding commitment and professionalism demonstrated by colleagues across the Trust. These awards highlight the dedication, teamwork and values-driven excellence seen every day across our organisation.

Our December winner was Jill Lindsey, Radiology Department Assistant, who was recognised for being caring and inclusive above all else. Jill is described as consistently going above and beyond to support colleagues and maintain smooth patient flow, helping improve both patient experience and team efficiency.

Our January winner, marking the start of the second year of the awards, was Alex Honeysett, Theatre Practitioner. Alex was recognised for being supportive and challenging over staying comfortable, providing invaluable support when colleagues are caring for distressed patients, including assisting a patient on a ward with whom he had built rapport in theatre. His can-do approach helps manage busy lists to ensure patients receive timely care.

Patient recognises QVH therapist on national radio
Sam Briggs, Clinical Lead for Speech and Language Therapy, was recognised on BBC Radio 5 Live after a QVH patient nominated her as his *"Cancer Star"* for the exceptional support she provided throughout his cancer treatment and rehabilitation. During the interview, Sam highlighted the vital role of speech and language therapy across the head and neck cancer pathway, supporting patients from diagnosis through recovery and beyond. This recognition reflects the impact of our specialist teams and their commitment to QVH values.

Acknowledgement – Company Secretary
As this is Leonora May's final Board meeting before leaving the Trust in May, I would like to place on record my thanks for her significant contribution as Company Secretary. Leonora has provided exceptional support to the Board, Council of Governors and Executive team,

bringing considerable expertise, professionalism and leadership to the Trust's governance arrangements. Her hard work and thoughtful advice have been greatly valued, particularly at such an important time for the Trust as we consider our future strategic direction. On behalf of colleagues, I would like to thank her for her significant commitment and wish her every success in her new role.

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

Report cover-page			
References			
Meeting title:	Board of Directors		
Meeting date:	12/03/2026	**Agenda reference:**	**148-26**
Report title:	Integrated Quality and Performance Report Month 9		
Sponsor:	Kirsten Timmins, Chief Operating Officer		
Author:	Allison Hunter, Strategy and Partnership Project Support Officer		
Appendices:	Appendix – Integrated Quality and Performance Report (IQ&PR) M9 slide pack		
Executive summary			
Purpose of report:	To discuss the Month 9 Integrated Quality and Performance Report 2025/26		
Summary of key issues	**KSO1** - December was a more challenging month from an operational performance perspective, with industrial action, increased sickness and patient cancellations impacting performance. The Trust achieved the M9 performance trajectory for two of the three elective care Referral to Treatment (RTT) metrics (18 week wait, and 52 week wait performance) but was behind plan by 1% for RTT first appointment in 18 weeks, and behind plan in achieving zero 65 week waits in all specialties outside of breast reconstruction. The Trust met the national standard and internal trajectory for FDS Cancer performance (Faster Diagnosis standard). However, 62-day cancer performance deteriorated further in M8 and fell below 70%, driven by challenges within the skin cancer pathway in part due to a significant increase in urgent suspected cancer referrals in 2025. The Trust is focused on strengthening oversight of the PTL, increasing use of teledermatology, continued additional weekend sessions, and pathway improvement work supported by the Surrey and Sussex Cancer Alliance. Urgent and Emergency Care (UEC) performance was 99.57%, exceeding the national standard and internal trajectory. Diagnostic Waiting time (DM01) performance showed an expected decrease in performance due to fewer sleep diagnostics over the festive period. CDC activity was below plan in M9, delivering 72% Activity vs Plan and 67% Income vs Plan. The year to date (YTD) position for CDC as at M9 was 83% income vs plan. Trust income from all activities was 96.34% vs plan for M9. Ethnicity data recording is now reporting 84.74% against the 95% target. Directorates continue to focus on improving reporting and data capture **KSO 2** – Final National Institute of Health Care Research (NIHR) funding for 2026/27 is awaited following refreshed data capture. Development of collaborative research with the Primary Care Network and University of Sussex. Quality priority work is underway including health inequalities. National Confidential Enquiry into Patient Outcome (NCEPOD) report reviewing emergency paediatric surgery in which QVH participated, has been received. QVH has good practice at QVH around use of trauma co-ordination and our rollout of "sip to send", children's model work is supporting other recommendations. Revision of Q4 continuous improvement plan to support organisational priorities to be explored in February Quality and Safety Seminar. Delivered multidisciplinary paediatric burns teaching for teams at Surrey and Sussex Healthcare NHS Trust (SASH) which was well received. Development of Kent, Surrey and Sussex (KSS) Plastic Surgery training programme including plans for cadaveric teaching. **KSO 3** – Temporary staffing remains well-managed, with bank usage reducing further in M9 to 56.21 whole time equivalent (WTE) and agency reduced to 4.36 WTE; sickness absence remained at 4.1%, driven by long-term cases and an increase in short term absences of seasonal cough, cold and flu. Support for managers is in place from the ER team to focus on reducing sickness absence. The Trust's time to hire increased marginally to an average of 35.18 days (below KPI), ranging from 8 days to 51 days.		

	Appraisal completion in M9 had a marginal increase from 81.8% in M8 to 82.2%. The number of appraisals outstanding >3 months increased from 86 to 101 in M8, with focused work underway with senior managers to follow up in areas where rates of completion are low. **KSO 4** – At the close of December 2025, the Trust reported an Income and Expenditure position slightly ahead (£39k) of the planned breakeven and had a cash balance of £11.9m. The Trust continues to report a forecast breakeven position on the assumption that income is maintained at current income per working day, that pay expenditure is maintained at recent run rate levels, and some planned non-recurrent benefits will be required. Archie Electronic Patient Record (EPR) optimisation and planning for Patient Administration System (PAS) migration together with other priority digital transformation activity is underway. Freedom of Information (FOI) requests responded to within 20 days improved in the M9 from to 67.2% to 71.7%.				
Recommendation:	The Trust Board is requested to review the Month 9 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:	02/03/26 26/02/26	Decision:		
Next steps:					

Queen Victoria Hospital
NHS Foundation Trust

Queen Victoria Hospital

Integrated Quality and Performance Report

Month 9: January 2026

BALANCED SCORECARD

Queen Victoria Hospital
NHS Foundation Trust

Priority Metrics	M12 target	Latest month	Planned trajectory in month	Actual performance in month	Previous Month	Summary	Confidence in delivery (RAG)
Breakeven YTD	£0.0m	Dec-25	£0.4m (deficit)	£0.4m (deficit)	£0.0m	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%	Dec-25	1.40%	1.32%	1.34%	Achieving target in month, delivery of year end target remains a risk.	
Cancer 62 days	75%	Nov-25	75.7%	65.76%	72.78%	Not achieving target in month. Driven by skin cancer pathway challenges.	
% Overall FFT Recommendation Rate	90%	Dec-25	90%	94.45%	94.91%	Achieving target. Special cause - concerning variation.	
Trust vacancy rate (excluding bank and agency)	8%	Dec-25	7%	4.91%	4.69%	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)		Steel works completed and slab works commencing on East Grinstead site. Engagement continues with University of Chichester regarding next steps for the Bognor site.
To deliver the Sussex Pathology Network Programme		Behind schedule		Revised approach and timescales agreed by ESHT and QVH but not yet by UHSx
To implement year one of the Electronic Records Programme (EPR)		On track		Optimisation and Patient Administration system (PAS) activities have commenced.

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 was slightly ahead of plan (£39k) but continues to have a challenging financial outlook for the year 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 Trust has experienced a significant increase in skin cancer referrals, which mirrors the national position, and this is impacting the Trust's cancer performance in the third quarter of the year. Looking forward, the Trust is at risk of missing the 62 day cancer trajectory in M9 and M10. The Trust is working closely with the Surrey and Sussex Cancer Alliance to review pathway improvements internally, while continuing to schedule additional weekend capacity and improve the teledermatology pathway to meet the increased demand.
- The Trust is behind plan to ensure that there are zero patients waiting more than 65 weeks with the exception of breast reconstruction by December 2025 as agreed with NHS England (NHSE) and Integrated Care Board (ICB). The total number of aggregate patients is in line with the trajectory, the number of breast reconstruction patients is ahead of plan however there remain a cohort of non-breast reconstruction patients that are behind plan due to a number of factors including cancer demand, late referrals and capacity. The Trust is focussed on bringing forward treatment dates for these patients wherever possible.
- The Trust was behind plan for RTT first appointment within 18 weeks and missed the internal trajectory by 1% in month. Increased validation and strengthening oversight of the PTL is required to meet the year end targets for RTT.
- Community Diagnostic Centre (CDC) activity continues to be behind plan in M9 largely due to the need to increase demand in some modalities. The year to date (YTD) position for CDC as at M9 was 83% income vs plan. The Trust is seeking opportunities to increase demand including offering mutual aid to other trusts and making it easier for GPs to refer patients using e-referral system.
- Income vs plan (excluding CDC activity) was 96.3% of plan in M9, impacted by industrial action, and higher levels of short-term sickness and patient cancellations during December.

Assure

- The Trust achieved the planned performance metrics for Referral to Treatment Time (RTT) 18-weeks, RTT 52 week waits, Urgent and Emergency Care performance in our Minor Injuries Unit and Cancer Faster Diagnosis Standard (FDS).
- Archie Electronic Patient Record (EPR) optimisation and planning for Patient Administration System (PAS) migration together with other priority digital transformation activity is underway.

Advise

- High level transition plan under development for the Trust to progress with Royal Surrey NHS Foundation Trust (RSFT) and Ashford and St Peters (ASPH) strategic partnership following Board approval in December 2025.
- The Trust's Income and Expenditure YTD position was in line with the planned breakeven and had a cash balance of £11.9m. The main risks remain the delivery of best value schemes of £7.5m (6%) for the year and the required activity levels. There is also a risk that should the system miss it financial targets that £375k of Q4 Deficit Support Funding may be clawed back.
- Organisational culture remains a key priority for the Trust. Culture reviews continue across several departments. The annual staff survey closed at the end of November. QVH achieved a 56% completion rate (compared to 57% from the previous year). The full results will be available from March 2026.
- Negotiations continue with University of Chichester on Heads of Terms for the Bognor CDC programme. The steel framework installation at the East Grinstead Community Diagnostic Centre (CDC) site is in progress.
- Following extensive clinical engagement across the system, key priorities have been agreed for 2026/27 . QVH will be participating in longer term transformational work to support the priorities, including work to establish a single point of access for specified elective services across Sussex.

Abigail Jago
Acting Chief Executive Officer

KEY STRATEGIC OBJECTIVES – SUMMARY

Queen Victoria Hospital
NHS Foundation Trust

KSO1

- December was a more challenging month from an operational performance perspective, with industrial action, increased sickness and patient cancellations impacting performance.
- The Trust achieved the M9 performance trajectory for two of the three elective care Referral to Treatment (RTT) metrics (18 week wait, and 52 week wait performance) but was behind plan by 1% for RTT first appointment in 18 weeks, and behind plan in achieving zero 65 week waits in all specialties outside of breast reconstruction.
- The Trust met the national standard and internal trajectory for FDS Cancer performance (Faster Diagnosis standard). However, 62-day cancer performance deteriorated further in M8 and fell below 70%, driven by challenges within the skin cancer pathway in part due to a significant increase in urgent suspected cancer referrals in 2025. The Trust is focused on strengthening oversight of the PTL, increasing use of teledermatology, continued additional weekend sessions, and pathway improvement work supported by the Surrey and Sussex Cancer Alliance.
- Urgent and Emergency Care (UEC) performance was 99.57%, exceeding the national standard and internal trajectory. Diagnostic Waiting time (DM01) performance showed an expected decrease in performance due to fewer sleep diagnostics over the festive period. CDC activity was below plan in M9, delivering 72% Activity vs Plan and 67% Income vs Plan. The year to date (YTD) position for CDC as at M9 was 83% income vs plan. Trust income from all activities was 96.34% vs plan for M9.
- Ethnicity data recording is now reporting 84.74% against the 95% target. Directorates continue to focus on improving reporting and data capture.

KSO2

- Final National Institute of Health Care Research (NIHR) funding for 2026/27 awaited following refreshed data capture. Development of collaborative research with the Primary Care Network and University of Sussex
- Quality priority work is underway including health inequalities. National Confidential Enquiry into Patient Outcome (NCEPOD) report reviewing emergency paediatric surgery in which QVH participated, has been received. QVH has good practice at QVH around use of trauma co-ordination and our rollout of "sip to send", children's model work is supporting other recommendations
- Revision of Q4 continuous improvement plan to support organisational priorities to be explored in February Quality and Safety Seminar
- Delivered multidisciplinary paediatric burns teaching for teams at Surrey and Sussex Healthcare NHS Trust (SASH) which was well received. Development of Kent, Surrey and Sussex (KSS) Plastic Surgery training programme including plans for cadaveric teaching.

KSO3

- Temporary staffing remains well-managed, with bank usage reducing further in M9 to 56.21 whole time equivalent (WTE) and agency reduced to 4.36 WTE; sickness absence remained at 4.1%, driven by long-term cases and an increase in short term absences of seasonal cough, cold and flu. Support for managers is in place from the ER team to focus on reducing sickness absence.
- The Trust's time to hire increased marginally to an average of 35.18 days (below KPI), ranging from 8 days to 51 days.
- Appraisal completion in M9 had a marginal increase from 81.8% in M8 to 82.2%. The number of appraisals outstanding >3 months increased from 86 to 101 in M8, with focused work underway with senior managers to follow up in areas where rates of completion are low.

KSO4

- At the close of December 2025, the Trust reported an Income and Expenditure position slightly ahead (£39k) of the planned breakeven and had a cash balance of £11.9m. The Trust continues to report a forecast breakeven position on the assumption that income is maintained at current income per working day, that pay expenditure is maintained at recent run rate levels, and some planned non-recurrent benefits will be required.
- Archie Electronic Patient Record (EPR) optimisation and planning for Patient Administration System (PAS) migration together with other priority digital transformation activity is underway.
- Freedom of Information (FOI) requests responded to within 20 days improved in the M9 from to 67.2% to 71.7%.

KSO5

- The steel framework installation at the East Grinstead Community Diagnostic Centre (CDC) site is in progress. CDC activity remains a key area of focus, as well as negotiations with University of Chichester on Heads of Terms for the Bognor programme.
- Following extensive clinical engagement across the system, key priorities have been agreed for 2026/27. QVH will be participating in longer term transformational work to support the priorities, including work to establish a single point of access for specified elective services across Sussex.

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 remains stable in M9 although behind the Trust trajectory of 95% compliance. Work continues with the administrative and clinical teams to ensure accurate recording of ethnicity. The Health Inequalities Dashboard is now available, enabling initial analysis of variation in attendance, waiting lists and Did-not-attend (DNA) by age, ethnicity and deprivation.

Venous Thromboembolism (VTE) assessment compliance was recorded at 93% for a second month which is reflective of the changes to VTE assessment within Archie EPR. Business Intelligence Unit (BIU), admin staff and the EPR team are working together to ensure that the data accurately reflects the assessments completed and that training for staff is completed.

One complaint was not responded to within the 30-day target, with a delay noted in the response from staff involved in the complaint.

The Children's Model Task & Finish group is on track to deliver a recommended strategic approach and delivery plan supported by collaboration with the South Thames Paediatric Surgical Network and extensive internal and external engagement by year end. This will include compliance monitoring against final standards, supporting estates and staffing model and a multi-professional collaborative engagement structure to support continuous improvement.

From an operational performance perspective for December, the Trust faced a more challenging month with industrial action, increased staff sickness and patient cancellations over the festive period. The Trust met the Referral to Treatment (RTT) trajectories for 18 week wait, and 52 week wait performance, yet was 1% below plan for the % of patients having a first appointment in 18 weeks. While the Trust was on plan at M9 for the number of patients waiting in excess of 52 weeks, capacity to treat long waiting patients remains constrained by late patient referrals from external Trusts and oncology demand. Looking forward, there remains risk in delivering the RTT trajectories for M10. The Trust reported 53 patients waiting over 65 weeks in M9. The trust is behind plan to ensure that there are zero patients waiting more than 65 weeks with the exception of breast reconstruction by December 2025 as agreed with NHSE and ICB. The total number of aggregate patients is in line with the trajectory, the number of breast reconstruction patients is ahead of plan however there remain a cohort of non-breast reconstruction patients that are behind plan due to a number of factors including cancer demand, late referrals and capacity. The Trust is focussed on bringing forward treatment dates for these patients wherever possible.

The Trust achieved the Cancer Faster Diagnostic Standard (FDS) in M8 meeting the national and internal target, having been below plan for 3 months. However, 62-day performance deteriorated in M8 delivering 65.76% against the 75% national standard 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. At the end of M9, 85 patients were patients waiting over 62 days. Of the 85 patients, 25 patients had been waiting over 104 days (5 breast patients, 4 Head and Neck patients and 16 skin patients). Late referrals, capacity, patient choice, and complexity were the key drivers of the delays. 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. Clinical harm reviews of cancer patients are undertaken for anyone waiting over 62 days, and there was no harm identified for patients in M8.

Urgent Emergency Care (UEC) performance achieved above the national standard and trajectory delivering 99.57%. Diagnostic Waiting time (DM01) performance experienced a seasonal drop in performance due to fewer diagnostic tests being undertaken in sleep over the festive period. DM01 performance is forecast to improve in M10.

The Trust reported income vs plan (excluding CDC activity) of 96.4% in M9, impacted in part due to industrial action, sickness and patient cancellations. CDC activity was below plan in M9, delivering 72% Activity vs Plan and 67% Income vs Plan. The Year to Date CDC position is 83% income vs plan The trust continues to offer mutual aid to other trusts, and CDC pathways are planned to move to eRS (the primary digital platform used by GPs and other referrers to send patient referrals to specialists) in M11, facilitating a greater number of GP practices to access the services.

Kirsten Timmins
Chief Operating Officer

Liz Blackburn
Acting 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	Dec-25	95%			84.74%	84.92%	80.73%	77.94%	83.53%	Special Cause - improving variation
Smoking Status	Dec-25	95%			99.39%	99.38%	99.10%	97.94%	100.27%	Common cause - no signficant change
Falls per 1,000 Occupied Bed Days	Dec-25	7			3.0	2.6	4.00	-3.24	11.24	Common cause - no signficant change
Hospital Aquired PU Per 1,000 Occupied Bed Days	Dec-25	0			0.0	0.0	0.77	-1.87	3.41	Common cause - no signficant change
% Complaints Responded On Time	Dec-25	90%			88.89%	100.00%	93.00%	66.43%	119.57%	Common cause - no signficant change
Safer Staffing Compliance	Dec-25	90%			99.36%	99.70%	99.62%	98.46%	100.77%	Common cause - no signficant change
% Overall FFT Recommendation Rate	Dec-25	90%			94.45%	94.91%	95.31%	94.47%	96.15%	Special Cause - concerning variation
Overall FFT Response Rate	Dec-25	25%			18.54%	18.62%	20.50%	17.27%	23.73%	Common cause - no signficant change
FFT Recommendation Rate - Inpatients	Dec-25	90%			100.00%	98.82%	99.65%	98.11%	101.19%	Common cause - no signficant change
FFT Response Rate - Inpatients	Dec-25	25%			25.74%	22.67%	37.24%	16.63%	57.85%	Common cause - no signficant change
FFT Recommendation Rate - Inpatients Children	Dec-25	90%			100.00%	100.00%	99.61%	98.16%	101.05%	Common cause - no signficant change
FFT Response Rate - Inpatients Children	Dec-25	25%			41.38%	36.67%	28.58%	2.40%	54.76%	Special Cause - improving variation
FFT Recommendation Rate - MIU	Dec-25	90%			91.33%	94.09%	92.56%	87.64%	97.48%	Common cause - no signficant change
FFT Response Rate - MIU	Dec-25	25%			16.85%	19.18%	28.02%	-27.49%	83.54%	Common cause - no signficant change
FFT Recommendation Rate - Outpatients	Dec-25	90%			94.11%	94.57%	95.02%	94.00%	96.04%	Common cause - no signficant change
FFT Response Rate - Outpatients	Dec-25	25%			16.05%	16.21%	17.42%	15.10%	19.73%	Common cause - no signficant change
Readmissions< 30 Days	Dec-25	2%			1.81%	2.02%	2.16%	0.87%	3.45%	Common cause - no signficant change
VTE Risk Assessment	Dec-25	95%			93.63%	93.03%	97.23%	93.49%	100.97%	Special Cause - concerning variation

KSO1 BALANCED SCORECARDS

Queen Victoria Hospital
NHS Foundation Trust

QUALITY & SAFETY METRICS

Metric	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25
Number of Complaints	5	8	7	4	6	7	6	9	9	9	9	6	6
Number of Open CAS Alerts	1	0	0	0	0	0	0	1	0	0	0	1	1
Number of Patient Falls Incidents	1	5	2	4	1	5	4	5	4	1	2	2	2
Number of QVH Acquired Pressure Ulcers Cat. 2 and above	0	0	0	4	2	0	2	1	1	1	0	0	0
Never Events declared	0	0	0	1	0	1	0	0	0	0	0	1	0
Medication Incidents (No and low harm)	7	4	8	12	9	6	10	15	12	12	4	10	10
Medication Incidents (Moderate harm or above)	0	0	0	0	0	0	0	0	1	0	0	0	0
Internal Investigation declared	0	0	1	0	0	0	0	0	1	0	0	0	1
Patient safety incident investigations declared	0	0	0	0	0	0	1	0	0	0	0	0	0
Mortalities	0	1	0	1	1	0	0	1	0	0	0	0	0
Hospital Acquired CDI, MRSA, E.Coli, MSSA	1	0	1	1	0	1	0	1	0	0	0	0	0
Occupied Bed Days	755	803	893	991	781	848	800	933	704	739	860	778	676
Oliver McGowan Training Compliance	92.2%	92.4%	92.3%	91.8%	91.9%	91.5%	91.8%	92.2%	92.4%	92.9%	92.4%	93.1%	93.1%

KSO1 BALANCED SCORECARDS

Queen Victoria Hospital
NHS Foundation Trust

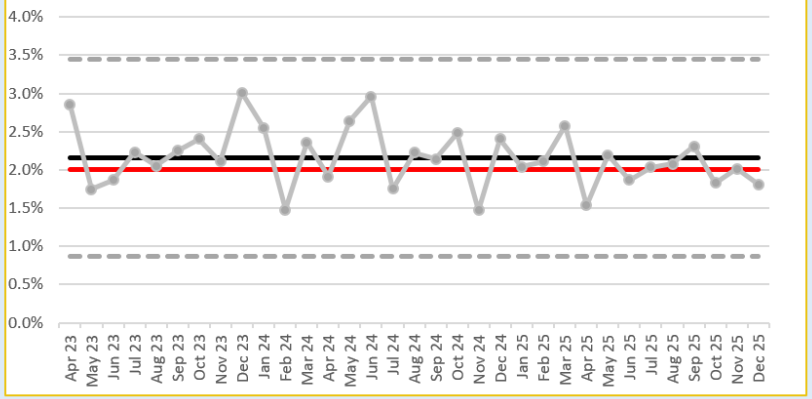
OPERATIONAL PERFORMANCE METRICS

Metric	Latest Month	Target	Variation	Assurance	Actual	Actual Previous Month	Mean	LCL	UCL	Summary
RTT 18 week wait performance - first appointment	Dec-25	75.32%			73.44%	76.36%	72.70%	69.08%	76.33%	Special Cause - improving variation
RTT 18 Week Wait Performance	Dec-25	62.35%			60.85%	62.39%	60.25%	57.36%	63.14%	Special Cause - improving variation
RTT Waiting List	Dec-25	-			20,186	20,026	18401.42	17669.18	19133.67	Special Cause - concerning variation
RTT >52 Weeks	Dec-25	-			266	268	400.55	321.99	479.10	Special Cause - improving variation
RTT >52 Weeks as a proportion of Waiting List	Dec-25	1.00%			1.32%	1.34%	2.18%	1.80%	2.57%	Special Cause - improving variation
CDC activity vs plan	Dec-25	100.00%			70.11%	66.83%	90.88%	41.67%	140.08%	Common cause - no signficant change
% Income Vs Plan	Dec-25	100.00%			96.34%	104.99%	99.87%	89.41%	110.33%	Common cause - no signficant change
Cancer 28 Day FDS	Nov-25	80.00%			80.12%	78.91%	81.81%	69.54%	94.09%	Common cause - no signficant change
Cancer 62 Days	Nov-25	75.00%			65.76%	72.78%	77.24%	63.81%	90.68%	Common cause - no signficant change
Outpatient Productivity - Patient Initiated Follow Ups (PIFU)	Dec-25	2.00%			1.73%	1.63%	1.82%	1.25%	2.39%	Common cause - no signficant change
Outpatient Productivity - Missed Appointment Rate	Dec-25	4.00%			5.53%	5.01%	5.28%	4.63%	5.94%	Common cause - no signficant change
Diagnostics 6 Week Wait Performance	Dec-25	95.00%			88.48%	91.73%	86.29%	78.10%	94.48%	Common cause - no signficant change
UEC 4 Hour Performance	Dec-25	98.00%			99.57%	99.00%	99.19%	97.67%	100.72%	Common cause - no signficant change
Theatre Productivity - % of Cancellations on the Day	Dec-25	5.00%			4.75%	3.74%	4.92%	0.97%	8.88%	Common cause - no signficant change
Theatre Elective Utilisation - QVH Site (Capped)	Dec-25	85.00%			71.30%	74.45%	82.01%	76.28%	87.75%	Special Cause - concerning variation
NHS App appointments available	Dec-25	70.00%			84.41%	85.27%	84.57%	82.87%	86.28%	Common cause - no signficant change

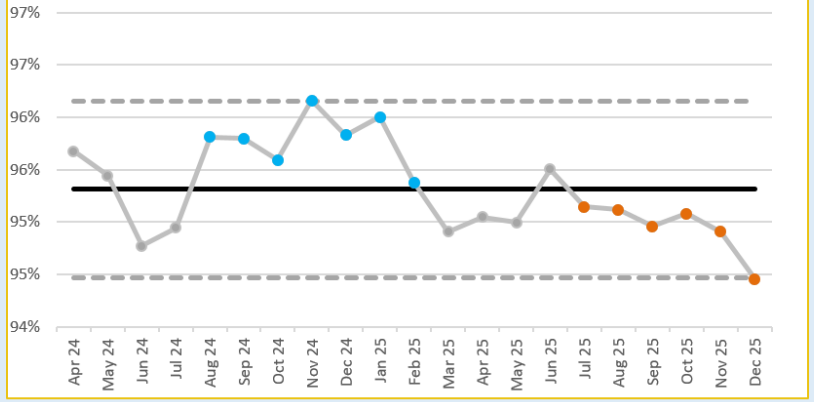
QUALITY & SAFETY METRICS

Queen Victoria Hospital
NHS Foundation Trust

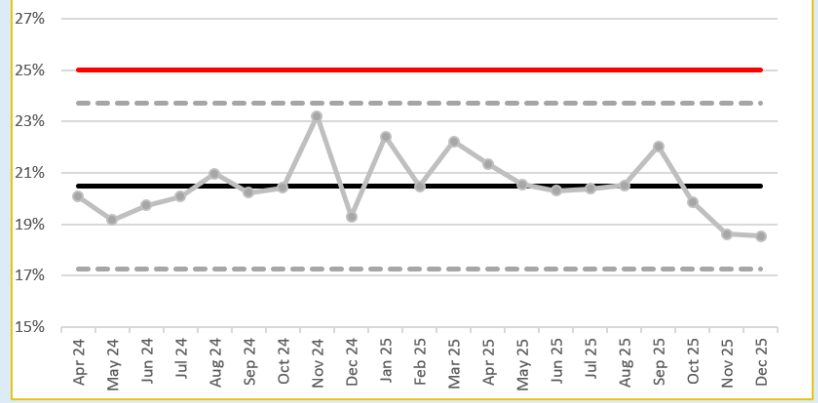
Readmissions< 30 Days



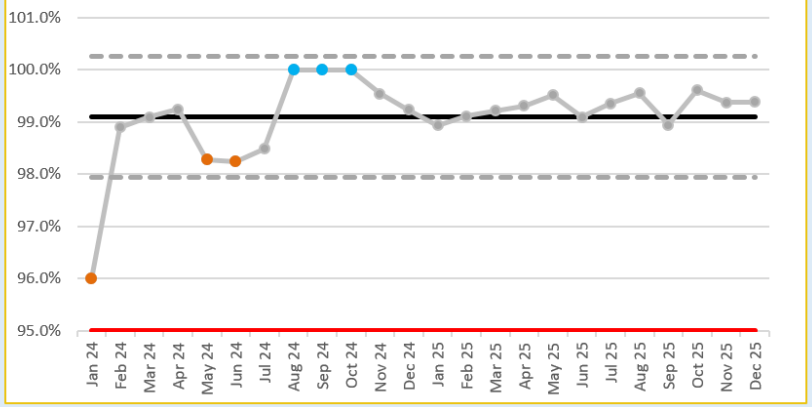
% Overall FFT Recommendation Rate



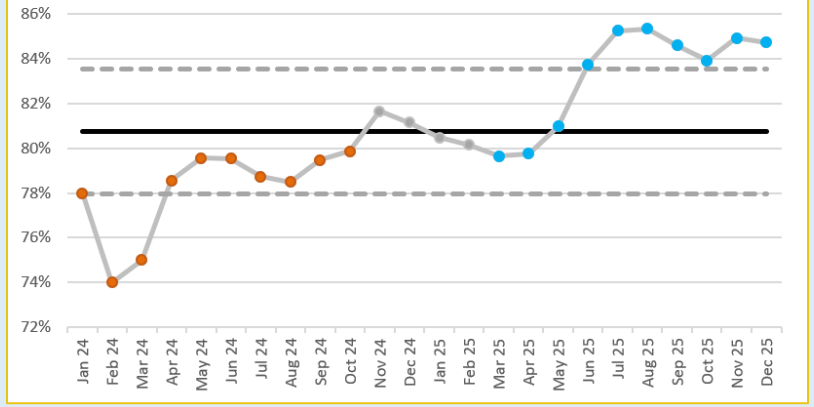
Overall FFT Response Rate



Smoking Status



Ethnicity Recording



Safer Staffing Compliance - Trust

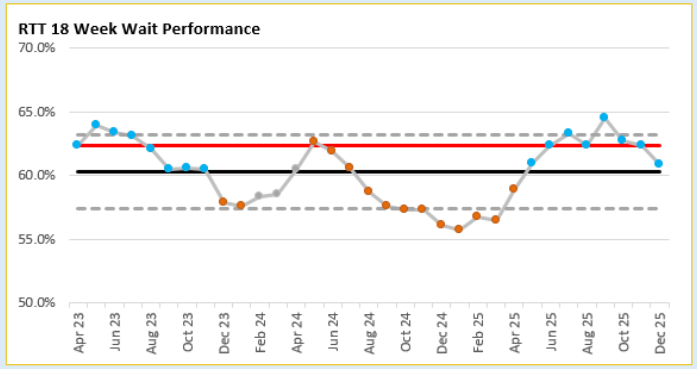
	Planned staff			Actual staff			December 2025
DAY	RN	NA	HCA	RN	NA	HCA	
	3,789.25	115.00	1,035.00	3,777.75	115.00	1,035.00	*Total Hrs Planned and Actual*
				99.7%	100.0%	100.0%	*% Planned Hrs Met*
			4,939.25			4,927.75	*Total Hrs Planned & Actual - Combined reg & support*
						99.77%	*% Planned Hrs Met - Combined reg & support*
NIGHT	Planned staff			Actual staff			
	RN	NA	HCA	RN	NA	HCA	
	3,237.25	57.50	736.00	3,214.25	57.50	713.00	*Total Hrs Planned and Actual*
				99.3%	100.0%	96.9%	*% Planned Hrs Met*
			4,030.75			3,984.75	*Total Hrs Planned & Actual - Combined reg & support*
						98.86%	*% Planned Hrs Met - Combined reg & support*
Combined	Planned staff			Actual staff			
	RN	NA	HCA	RN	NA	HCA	
	7,026.50	172.50	1,771.00	6,992.00	172.50	1,748.00	*Total Hrs Planned and Actual*
				99.5%	100.0%	98.7%	*% Planned Hrs Met*
			8,970.00			8,912.50	*Total Hrs Planned & Actual - Combined reg & support*
						99.36%	*% Planned Hrs Met - Combined reg & support*

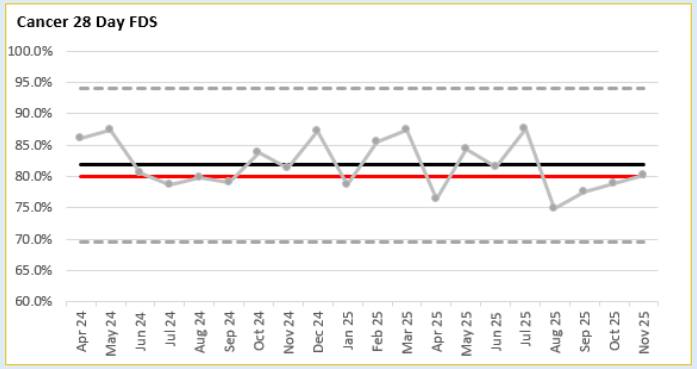
SPC Chart Key:

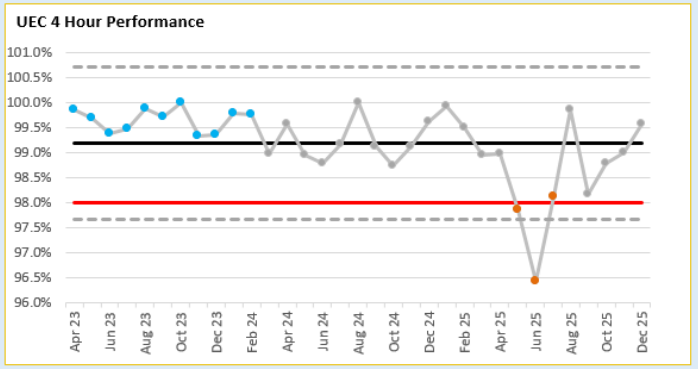
- Mean
- Target
- Process limits
- Special cause - concern
- Special cause - improvement

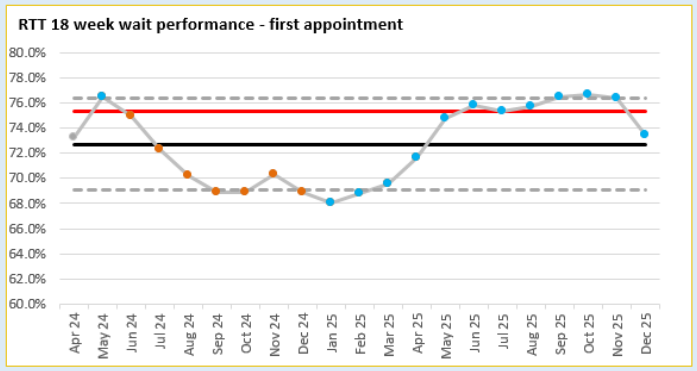
OPERATIONAL PERFORMANCE METRICS

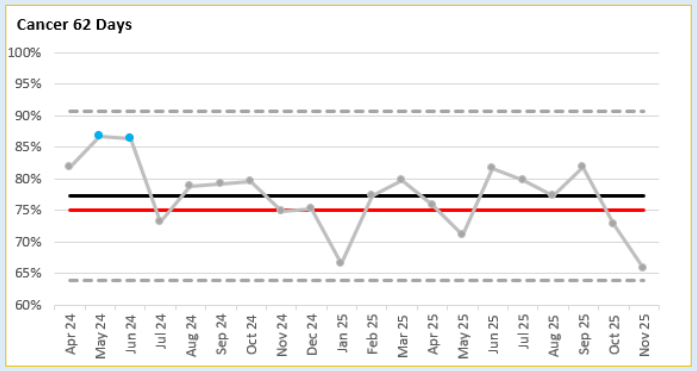
Queen Victoria Hospital
NHS Foundation Trust

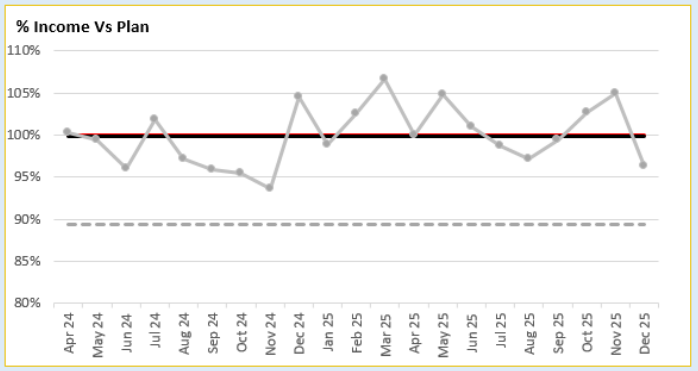


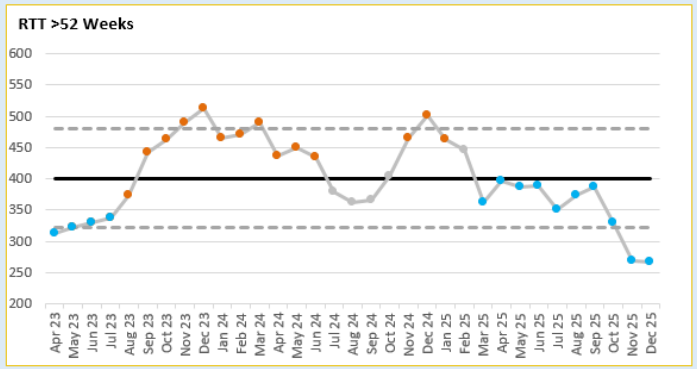


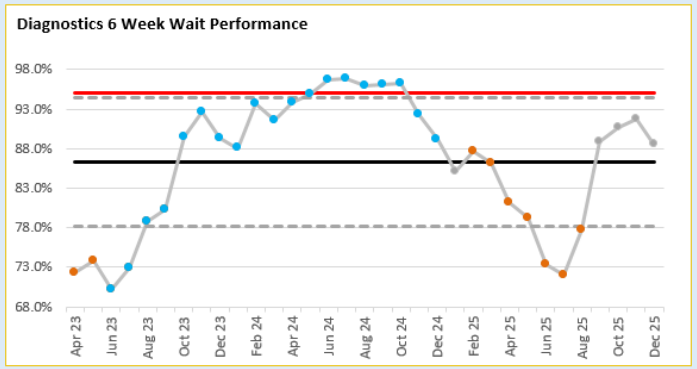


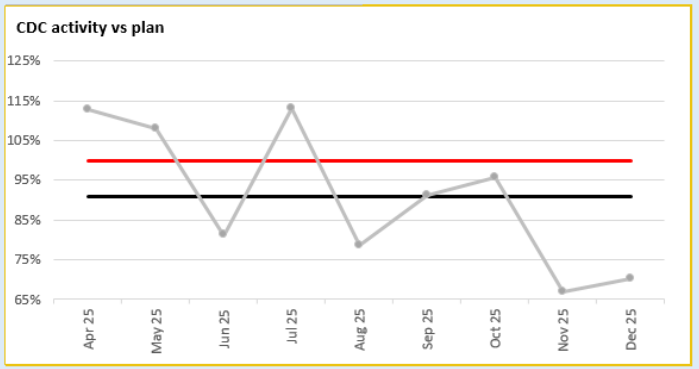












KSO1 AREAS OF FOCUS

Queen Victoria Hospital
NHS Foundation Trust

Area	Summary, impact and actions
Ethnicity Recording	Ethnicity data for December is 84.74% which is a slight decrease from November which was 84.92%, behind the Trust planned compliance of 95%. Work continues within the Health Inequalities Steering group to further improve compliance through training, focussed communication and the HI dashboard.
Smoking Status	Smoking status recording remains at 99% compliance.
Falls	Two witnessed falls within outpatient areas, both resulted in low or no physical harm.
Pressure ulcers	Zero pressure ulcers reported in M9.
% Complaints Responded On Time	Compliance with responding to complaints 88.8% in M9, this is reflective of one complaint not being responded to within the 30-day timeframe. Delays were noted in the response from staff to the complaint.
Safer Staffing Compliance	Safe staffing levels were maintained across all inpatient areas, with a fill rate at 99%.
Never Events	Zero never events reported this month. Patient Safety Incident Investigation (PSII) is underway for a major haemorrhage incident.
Mortalities	Zero mortalities reported this month.
% Overall FFT Recommendation Rate	The recommendation rate has dropped by 0.45% to 94.45% and reflects a special cause of variation. Data triangulated with other methods of feedback via our PALS service is underway to further understand the reduction noted.
VTE Risk Assessment	Compliance with VTE assessments has remained constant in M9 at 93%, however remains below our Trust compliance of 95%. Focussed work and policy review is in progress to address compliance.

KSO1 AREAS OF FOCUS

Queen Victoria Hospital
NHS Foundation Trust

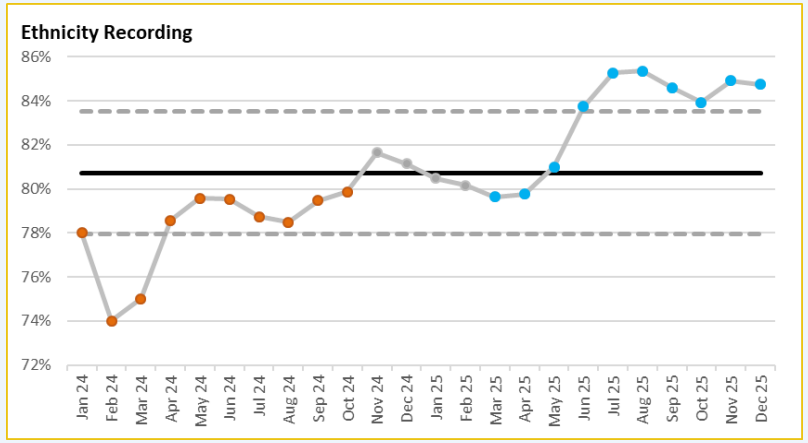
Area	Summary, impact and actions
RTT> 65 weeks	The Trust reported 53 patients waiting over 65 weeks at the end of M9, of which 12 patients were waiting over 78 weeks. Clinical harm reviews have been carried out on the long waiting patients. The trust is behind plan to ensure that there are zero patients waiting more than 65 weeks with the exception of breast reconstruction by December 2025 as agreed with NHSE and ICB. The total number of aggregate patients is in line with the trajectory, the number of breast reconstruction patients is ahead of plan however there remain a cohort of non-breast reconstruction patients that are behind plan due to a number of factors including cancer demand, late referrals and capacity. The trust is focussed on bringing forward treatment dates for these patients wherever possible.
RTT >52 Weeks %	The Trust achieved the planned trajectory in M9 and reported 266 patients waiting in excess of 52 weeks. The Trust is at risk of not achieving its trajectory for M10 trajectory due to pathway delays, late referrals and skin cancer demand. The Trust is part of the NHSE 52ww Q4 sprint and will be mobilising insourcing and outsourcing to reduce the number of patients waiting in excess of 52 weeks during Q4.
RTT - 18 week wait - first appointment	The Trust missed the internal trajectory by 1%, meaning there were more patients than anticipated waiting longer than 18 weeks for their first appointment. Outpatient capacity for first appointments is a constraint, and the trust will be focussing on standardising clinic templates in Q4 as part of the outpatient transformation programme in order to increase capacity.
RTT 18 Week Wait Performance	The Trust achieved the planned trajectory for M9, however performance has remained relatively stable and needs to improve to meet the year-end target. Teams are focussed on improving validation, strengthening oversight of the PTL and putting on additional activity wherever possible to improve performance.
RTT Waiting List	The RTT Waiting List showed an increase in month by 160 from 20,026 to 20,186. The Trust continues to participate in NHSE's 'Validation Sprint' exercise, and while statistically the growth is showing 'concerning variation' the waiting list remains within the trust overall plan.
Cancer 28 Day FDS	There was an improvement in FDS performance to 80.5% reaching the national FDS standard of 80% and internal trajectory of 80.5%. Service level performance for skin was 82.7% and head and neck 76%, both of which saw improvement compared to the previous month.
Cancer 62 Days	The Trust reported a decrease in performance in M8 from 72.78% to 65.8%. The increase in urgent suspected cancer referrals year-to-date has significantly challenged services, and the Trust is unlikely to meet M9 and M10 performance trajectory. Service level performance for skin deteriorated from 78.7% to 69.9% in month. The Trust is focused on strengthening oversight of the PTL, continued additional weekend sessions, and pathway improvement work supported by the Surrey and Sussex Cancer Alliance. Service level performance for head and neck improved by 6% in month to 64.7% driven by improved utilisation of capacity at spoke sites and the recruitment of a head and neck locum consultant. At the end of M9 85 patients (12.6% of the Cancer PTL) were patients waiting over 62 days. Of the 85 patients, 25 patients had been waiting over 104 days (5 breast patients, 4 Head and Neck patients and 16 skin patients). Clinical harm reviews are carried out on patients waiting over 62 days and in month no harm was identified.
Diagnostics 6 Week Wait Performance	DM01 performance showed an expected decrease in performance due to fewer diagnostic tests being carried out over the festive period. Performance is expected to improve for M10.
MIU 4 Hour Performance	The Trust performance in M9 was 99.57% exceeding the national standard (95%) and the internal trajectory.
% Income Vs Plan	The Trust reported 96.34% income vs plan for M9 driven in part by industrial action, sickness, and patient cancellations during the festive period.
% CDC activity vs plan	CDC activity was below plan in M9, delivering 72% Activity vs Plan. YTD the Trust delivered CDC activity (88% plan) and income (83% plan). . 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.
Theatre capped utilisation	Since the launch of Archie EPR, the trust reporting of theatre utilisation has been impacted, and new reports are being developed and review underway of reporting. In Q4 the Trust is planning to relaunch the theatre transformation work, focussed on activity throughput, utilisation and increasing activity through the Local Anaesthetic Unit.

HEALTH INEQUALITIES PRIORITY PROGRESS

Queen Victoria Hospital
NHS Foundation Trust

Area	Summary and actions
Data Improvement	The Trust ethnicity data collection for December is 84.74% which is a slight decrease from November which was 84.92%, and remains below the Trust target of 95% A communication plan is in place 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 Tuesday 27 January. 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)	Archie optimisation work continues to support better practice in relation to appropriate application of the Mental Capacity Act (MCA). The task and finish group continues to oversee progress and is exploring MCA in relation to outpatient experience and practice. Follow up audit following Archie EPR implementation is planned.

Queen Victoria Hospital
NHS Foundation Trust

KSO2

To innovate and improve

Ambition

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

Board Assurance Framework

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

2025/26 Annual Objectives

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

2025/26 Annual goals

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

KSO2 EXECUTIVE SUMMARY

Queen Victoria Hospital
NHS Foundation Trust

Research & Innovation (R&I):
Final NIHR funding for 2026/7 awaited following a refreshed data capture by NIHR in early January with confirmed allocation to be confirmed shortly. QVH has evidenced Capacity and Capability to progress four further new research studies, one of which commenced in December bringing our current number of active research studies to eleven.
Research collaboration opportunities continue to be explored including :

- University of Sussex who have submitted a bid for matched funding to undertake a pre-clinical study alongside us
- Sussex Community / QVH Plastics Consultants with view to partnering on a grant application to undertake a surgical clinical trial

Primary Care Network (PCN) Collaboration Project continues with weekly meetings – planning ongoing joint 'Research lunch and learn' sessions to be delivered by QVH research team members which will be open to both PCN and QVH Trust staff.

Quality priority: Evidence through measurable outcomes
Quarter 3 Quality Priorities progress report written for submission to Quality subcommittee in month 10. All quality priorities have developed into much wider projects of work so more has been achieved than the measures for improvement. Opportunities have arisen to develop work with parallel steering groups, for example process mapping where information is collected for accessible information requirements is now focusing on work in health inequalities and the collection of this data on the patient journey. Priority 1 national audits have been identified for inclusion into the Clinical Audit Plan for 26/27. A national report published in December 2025 was Emergency Paediatric Surgery (NCEPOD) - non-elective procedures, including emergency, urgent and expedited procedures. QVH contributed to this inquiry which highlights good practice at QVH around use of trauma co-ordination and our rollout of "sip to send" ensuring patients remain comfortably hydrated pre-operatively. Further recommendations are being considered as part of the Children's Model task and finish group.
The total of all registered projects continue to presented at Quality subcommittee for monitoring and discussion. Registrations of projects continue to increase.

Embed continuous improvement (CI):
Proposal to revise the plan for quarter 4 (Jan – March 2026) currently in discussion ensuring that outcomes expected by April are clear, sustainability methodology in place and a robust plan optimising our new CI capability to support delivery of key operational and strategic transformation is moving forward. Training options to support this will align 'The QVH Way' with other national training opportunities available via the 'NHS Impact' programme. Key members of staff are being identified by operational leadership teams who can benefit from this suite of training to support our qualified CI trained champions. Quality and Safety Board seminar planned in early February to explore our sustainability plan and socialise / agree how CI now remains business as usual across the Trust.

Medical Education:
On 9th December, the Anaesthetics and Plastics teams, supported by Medical Education, delivered multidisciplinary paediatric burns teaching for teams at SASH, as an outcome from the Clinical Learning Forum. The teaching was extremely well received.
The Head of School of Surgery for Kent Surrey and Sussex visited the Plastics team on 12th December to review progress for the KSS plastic surgery curriculum delivery at QVH, this is progressing well. The Plastics team will be supporting regional cadaveric teaching for KSS registrars in the new year.
A clinical librarian on secondment from SASH is now in post supporting QVH staff three days a week.

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

M9 whole time equivalent (WTE) is at 1078.09 minimally above plan (less than 0.1 WTE). Temporary staffing continues to decrease overall, with M9 bank usage decreasing from 62.5 WTE in M8 to 56.21 and agency from 6.3 in M8 to 4.36 in M9. We remain significantly under plan for temporary staffing for 2025-26 and one of the best performing Trusts in the South East Temporary Staffing Collaborative. Continued focus is through the temporary staffing reduction oversight groups and dedicated management by the Heads of Nursing and General Managers.

There were no grievances raised in M9.

Overall sickness absence levels saw no change in M9 at 4.1%. Long-term sickness continues to drive the overall sickness rate, with 2.12% long term sickness absence over the rolling 12-month period, with short-term sickness at 1.94%. The Trust anticipates an increase in sickness absence in M10 due to seasonal self-limiting colds, coughs and flu. The Trust (alongside NHSE) have moved to daily absence reporting for continual oversight. The Employee Relations team have been actively advising managers and supporting staff to help improve the position and have undertaken a deep dive for Q3 looking at reasons for absence and staff groups; which will be presented to the Health and Safety Group in January 2026. The system target is 4% in the national operational planning guidance with a keen focus on mental health and musculoskeletal problems.

Time to hire has slightly increased from 33.9 in M8 to 35.18 in M9 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 are rolling out a series of initiatives including the new Managers' Essentials programme, leading change, managing self through change, coaching skills for managers, resilience, appraisals (for managers and staff) and these will continue to be rolled out throughout 2026. Dates are currently being scheduled for 2026/2027.

Early analysis of the Staff Survey results are being undertaken and will be shared with the Executive Team. Data is embargoed in March/April 2026. Excel data tables, posters and other resources are being produced to support managers including a new workshop for managers to help them understand the results.

Focussed work is ongoing for specific areas of mandatory and statutory training (MAST) compliance. MAST rates increased for clinical, non-clinical and bank workers in M9. Overall appraisal completion saw an increase in M8, however those outstanding by >3months saw an increase from 86 in M8 to 101 in M9. 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

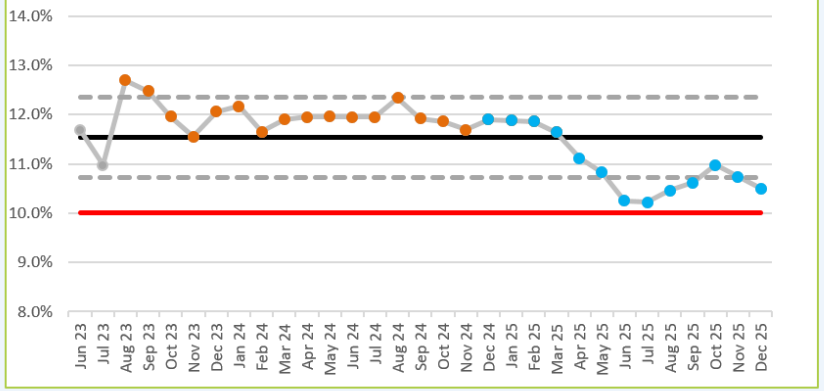
Queen Victoria Hospital
NHS Foundation Trust

Metric	Latest Month	Target	Variation	Assurance	Actual	Actual Previous Month	Mean	LCL	UCL	Summary
Trust vacancy rate (excluding bank and agency)	Dec-25	8%			4.9%	4.7%	6.9%	5.6%	8.2%	Special Cause - improving variation
Vacancies - Incl Bank & Agency	Dec-25	8%			2.4%	1.4%	1.8%	-0.3%	3.8%	Common cause - no signficant change
Average Time to Hire - Days	Dec-25	53			35.2	33.9	58.09	23.43	92.76	Special Cause - improving variation
Turnover rate - Rolling 12 months	Dec-25	10%			10.5%	10.7%	11.5%	10.7%	12.4%	Special Cause - improving variation
Sickness absence rate - Rolling 12 months	Dec-25	3%			4.1%	4.1%	3.8%	3.7%	3.9%	Special Cause - concerning variation
Appraisal Rate	Dec-25	90%			82.2%	81.8%	83.8%	81.1%	86.5%	Special Cause - concerning variation
Statutory & Mandatory Training Compliance	Dec-25	90%			92.3%	92.3%	92.0%	90.9%	93.1%	Common cause - no signficant change
Agency Usage in Month (WTE)	Dec-25	-			4.4	6.3	16.77	11.02	22.51	Special Cause - improving variation
Bank Usage in Month (WTE)	Dec-25	-			56.2	62.5	76.53	60.51	92.55	Special Cause - improving variation
Annual Leave Taken	Dec-25	-			70.8%	59.5%	40.8%	22.1%	59.6%	Special Cause - improving variation

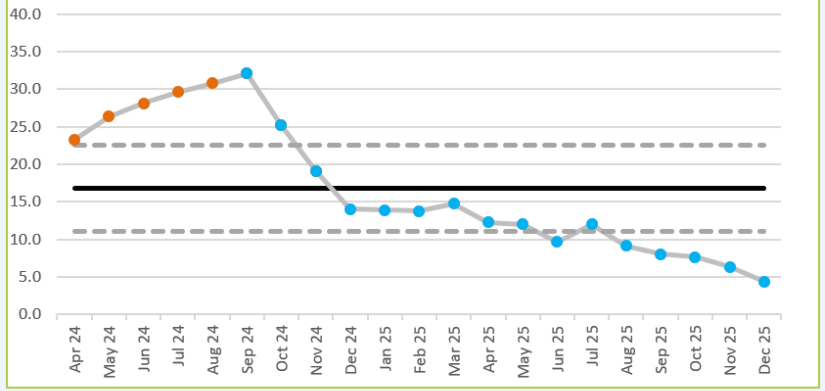
EXCELLENT EMPLOYER KEY METRICS

Queen Victoria Hospital
NHS Foundation Trust

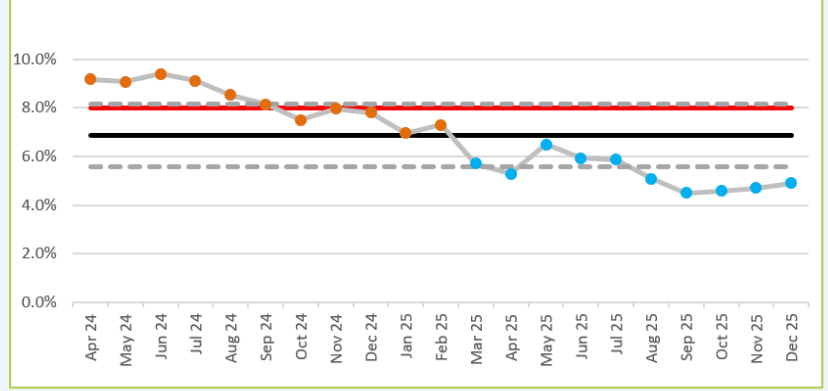
Turnover rate - Rolling 12 months



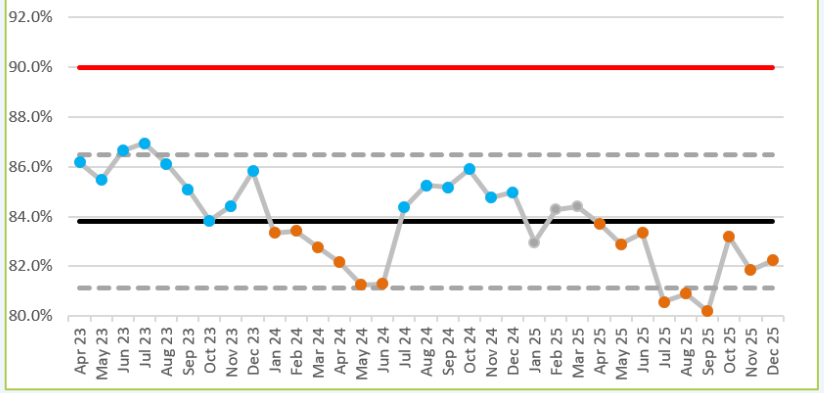
Agency Usage in Month (WTE)



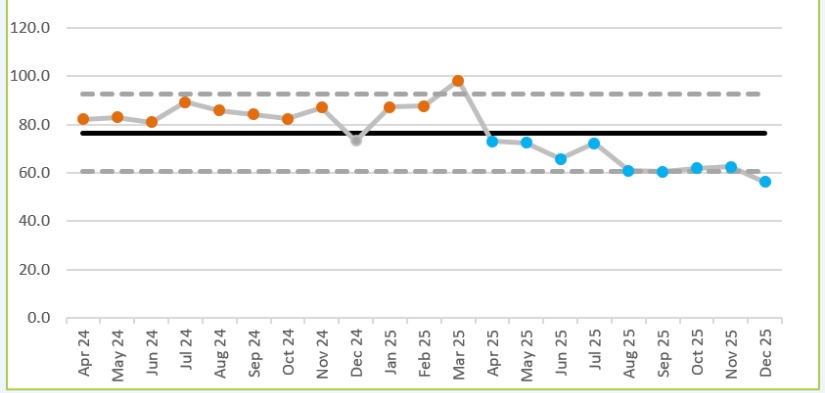
Trust vacancy rate (excluding bank and agency)



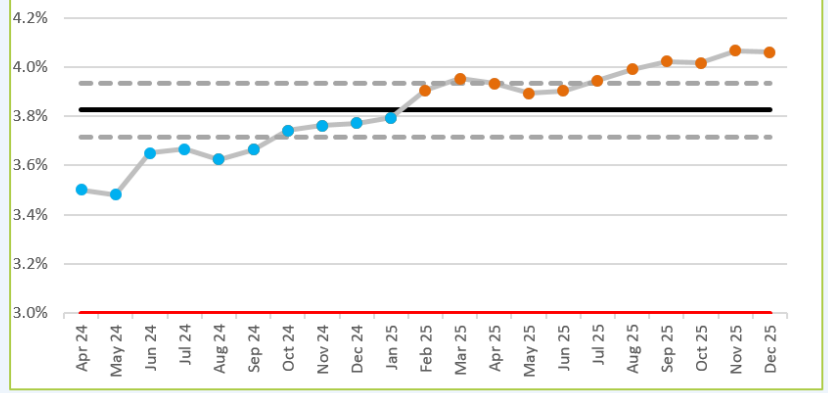
Appraisal Rate



Bank Usage in Month (WTE)



Sickness absence rate - Rolling 12 months



KSO3 AREAS OF FOCUS

Queen Victoria Hospital
NHS Foundation Trust

Area	Summary, impact and actions
Trust vacancy rate (excluding bank and agency)	M9 shows WTE at 1078.09 which is minimally above plan (less than 0.1 WTE) and with continued reduction in bank and agency QVH remain in a good position against plan.
Average Time to Hire - Days	Slight increase from 33.9 in M8 to 35.18 in M9. This ranged from 8 days average to 51 days due to an internal candidate taking 2 weeks for a start date to be confirmed by the appointing manager. A further 8 candidates took 13, 27, 31, 38, 39, 41, 42 and 46 days.
Sickness Absence Rate - Rolling 12 Months	This measure shows 'concerning variation' as performance has been above the mean for a period of time and remained the same as M8. The Employee Relations and Wellbeing & Inclusion teams have conducted a deep-dive for Q3 into reasons for absence and hot-spots which has identified the top 3 reasons as cold/coughs/flu, gastrointestinal problems and headaches/migraines; the highest number of working days lost were within the Admin & Clerical staff group (which makes up a third of the overall workforce) followed by Nursing; and approx. 18% of those absent due to mental health were undergoing or involved in a people management process – actions include updates to the Trusts' Managing Sickness Policy to be more supportive, clearer guidance on ill-health retirement processes, attendance toolkits and management/employee support hubs on Qnet, and proposed review of investigation and ER processes to gain insights from a wellbeing perspective. The ER team continue to support managers with absence management. Reporting is undertaken daily and cross-referenced with flu vaccination data.
Agency Usage In Month (WTE)	M9 has seen a further reduction in agency usage from 6.3 in M8 to 4.36 in M9 with all agency usage within Peri-Op between AHP and Nursing split between Day surgery at 0.38, Recovery at 0.93 and Theatres at 3.05 WTE.
Bank Usage In Month (WTE)	Bank usage has decreased from 62.5 in M8 to 56.21 in M9. Peri-op shows the highest use at 22.44 (decreased from M8). Nursing and Midwifery along with Admin and Clerical are the highest staff usage (14.68 and 14.40 respectively).
Grievances raised	0 grievances raised in M9.
% Job plans complete	88% of job plans are currently agreed / signed off, with focussed work underway to continue to improve the completion rate.
Turnover rate	Turnover decreased minimally to 10.5% in M9 from 10.7% in M8.
Statutory and mandatory training	M9 has seen no change in mandatory and statutory training (MAST) compliance from 92.3% in M8 to 92.3% in M9. Emergency Planning training and Fire Evacuation training have been areas of focus.
Appraisal rate	There is ongoing work to attain 90% appraisal completion rate, with continued focus with managers and highlighting outstanding areas. M9 had an increase from 81.8% in M8 to 82.2%. The number of appraisals outstanding >3 months has increased from 86 to 101 in M8, 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 December 2025, the Trust reported a year to date (YTD) Income and Expenditure position marginally favourable (£0.04m) to planned deficit (£0.3m) and had a cash balance of £11.9m. Whilst an on-plan position for the YTD remains positive, the YTD position is supported by c£0.5m of non-recurrent benefits. The Trust continues to report a forecast breakeven position.

Patient income is currently behind plan at M9 by £0.5m YTD, mainly due to £0.7m underperformance in CDC activity, £0.2m income loss from Industrial action (IA) and £0.1m device recharges income which is offset by additional commissioner digital funding. The main YTD areas of activity under-performance relate to Ophthalmology daycases and Plastics inpatients and outpatient procedures which is being offset by additional Plastics daycase weekend work. The £0.7m underperformance in CDC income YTD is also 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 adverse to plan in month and £0.1m adverse for the YTD with the YTD position driven by non-delivery of better value schemes (£0.7m), offset by underspends relating to CDC. The M9 Position includes estimated bank costs for IA (£20k) and December bank holiday enhancements (£25k). Agency spend continues to be within the 2% target of overall budget. Worked WTE reduced slightly compared to the YTD average and the last 3 month average.

Non-pay was adverse to plan in month (£0.1m) and underspent for the YTD (£0.6m), mainly within corporate areas and the CDC (£0.3m). In M9 non-pay was adverse to plan mainly due to higher than planned clinical supplies spend in theatre areas and equipment maintenance. Other Non-pay was broadly on plan in month, but there was an increase in trend in Digital areas, offset by an improved bad debt provision position.

At the end of M9, the Trust reported YTD delivery of £5.4m efficiencies which is on plan. Pay related schemes are off plan (£0.7m) and are being offset by over-delivery of non-pay items. 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 M9 against plan but is expected to catch up in later months.

Freedom of Information (FOI) requests responded to within 20 days has improved in the M9 report to 71.7% compared with 67.2% at M8. 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. Escalations will be sent to Executive Directors where information is not returned to the FOI team within the required timeframe.

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	Dec-25	£0.28m		F	-£0.24m	£0.09m	-0.42	-1.09	0.26	Common cause - no signficant change
Cash at Bank YTD	Dec-25	£11.90m	H	?	£11.90m	£11.90m	7.90	2.05	13.75	Special Cause - improving variation
Capital Spend YTD	Dec-25	£6.60m	H	?	£6.20m	£5.10m	3.62	-3.25	10.50	Special Cause - improving variation
Efficiencies YTD	Dec-25	£5.40m	H	?	£5.40m	£4.80m	3.61	0.70	6.51	Special Cause - improving variation
BPPC (NHS & Non NHS) - volume	Dec-25	95%	H	F	93.6%	92.1%	0.91	0.88	0.94	Special Cause - improving variation
BPPC (NHS & Non NHS) - value	Dec-25	95%		?	91.9%	87.2%	90.0%	84.7%	95.3%	Common cause - no signficant change
Agency spend <2% total pay bill	Dec-25	£1.15m	H	F	£0.60m	£0.50m	0.39	0.23	0.55	Special Cause - improving variation
Agency spend 40% less than 24/25 forecast	Dec-25	£1.12m	H	F	£0.60m	£0.50m	0.39	0.23	0.55	Special Cause - improving variation
Agency staff spend as % of total staff spend	Dec-25	2%		P	1.01%	1.07%	1.04%	0.33%	1.74%	Common cause - no signficant change
Bank spend reduction of 10% of Total Pay Bill	Dec-25	£3.36m	H	F	£2.50m	£2.20m	1.42	0.71	2.13	Special Cause - improving variation
Total Pay cost per Worked WTE	Dec-25				£5,502.06	£5,642.21	5668.68	5431.85	5905.51	Common cause - no signficant change
Subject Access Requests - Total Received	Dec-25				84	73	77.97	34.58	121.36	Common cause - no signficant change
Subject Access Requests - % Closed within 30 calendar days	Nov-25	100%	H	?	100.0%	100.0%	94.7%	78.7%	110.7%	Special Cause - improving variation
Freedom of Information requests – Total Received	Dec-25				51	46	50.39	16.31	84.48	Common cause - no signficant change
Freedom of Information requests – % Closed within 20 working days	Nov-25	80%	H	?	71.7%	67.2%	64.8%	38.8%	90.7%	Special Cause - improving variation

KSO4 EXECUTIVE SUMMARY

Queen Victoria Hospital
NHS Foundation Trust

Capital

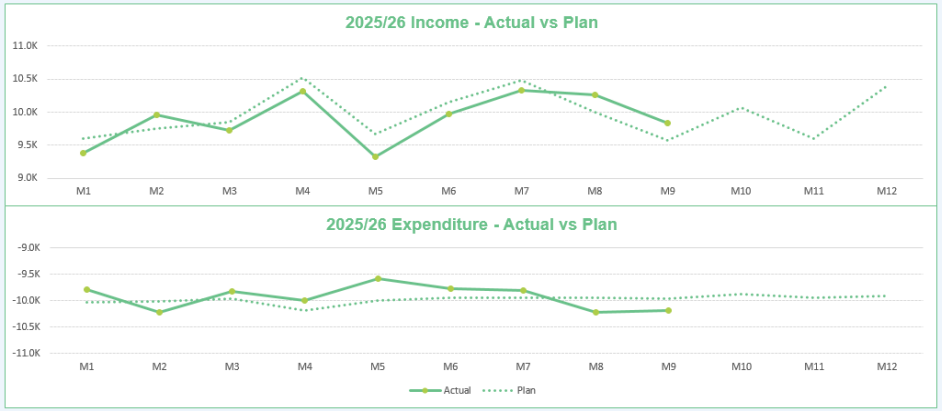
	In Month £'000			Year to Date £'000			Forecast Outturn £'000s		
	Plan	Actual	Variance	Plan	Actual	Variance	Plan	Actual	Variance
IT	0	65	65	131	148	17	131	142	11
Medical Equipment	83	0	(83)	249	47	(202)	1,000	517	(483)
Estates Maintainance	193	53	(140)	193	1143	950	1,907	1,907	0
Estates Other	0	0	0	750	0	(750)	750	-	(750)
EPR	248	240	(8)	744	1931	1,187	2,983	2,983	0
CDC	1,495	193	(1,302)	4485	1558	(2,927)	17,949	10,449	(7,500)
Other Capital	24	545	521	24	1374	1,350	1,640	5,671	4,031
Total	2,043	1,096	(947)	6576	6201	(375)	26,360	21,669	(4,691)

Income and Expenditure

	In Month £'000			Year to Date £'000			Forecast Outturn £'000s		
	Plan	Actual	Variance	Plan	Actual	Variance	Plan	Actual	Variance
Income									
Patient Activity Income	9,220	9,491	271	86,439	85,968	(471)	114,691	114,691	0
Other Operating Income	352	348	(4)	3,162	3,144	(18)	4,226	4,226	0
Total Income	9,572	9,839	267	89,601	89,112	(489)	118,917	118,917	0
Pay									
Substantive	(5,845)	(6,148)	(303)	(53,079)	(54,530)	(1,451)	(69,910)	(69,910)	0
Bank	(342)	(265)	77	(3,223)	(2,494)	729	(4,228)	(4,228)	0
Agency	(134)	(44)	90	(1,206)	(581)	625	(1,599)	(1,599)	0
Total Pay	(6,321)	(6,457)	(136)	(57,508)	(57,605)	(97)	(75,737)	(75,737)	0
Total Non-Pay	(2,935)	(3,045)	(110)	(26,192)	(25,556)	636	(34,943)	(34,943)	0
Total Non Operational Expenditure	(709)	(692)	17	(6,385)	(6,396)	(11)	(8,511)	(8,511)	0
Total Expenditure	(9,965)	(10,194)	(229)	(90,085)	(89,557)	528	(119,191)	(119,191)	0
Surplus/(Deficit)	(393)	(355)	38	(484)	(445)	39	(274)	(274)	0
Technical Adjustments	23	23	0	207	207	0	274	274	0
Adjusted Surplus / (Deficit)	(370)	(332)	38	(277)	(238)	39	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	213	130	667	1,546	879	922	2,048	1,126
Pay - Corporate Service and Digital Transformation	175	67	(108)	1,475	432	(1,043)	2,000	880	(1,120)
Pay - Clincal Service Redesign	134	56	(78)	909	504	(405)	1,310	672	(638)
Pay - Agency	39	26	(13)	351	417	66	463	529	66
Non-Pay - Procurement	58	15	(43)	462	335	(128)	641	518	(124)
Non-Pay - Other	-	118	118	-	1,099	1,099	-	1,208	1,208
Non-Pay Corporate Service and Digital Transformation	137	117	(20)	1,163	561	(602)	1,584	835	(749)
Non-Pay Clinical Service Redesign	13	56	43	117	504	387	153	672	519
Income - Non-patient care	31	3	(28)	279	35	(244)	376	98	(279)
Income - Other	1	-	(1)	9	-	(9)	11	2	(9)
Total	671	671	0	5,432	5,432	0	7,460	7,460	0

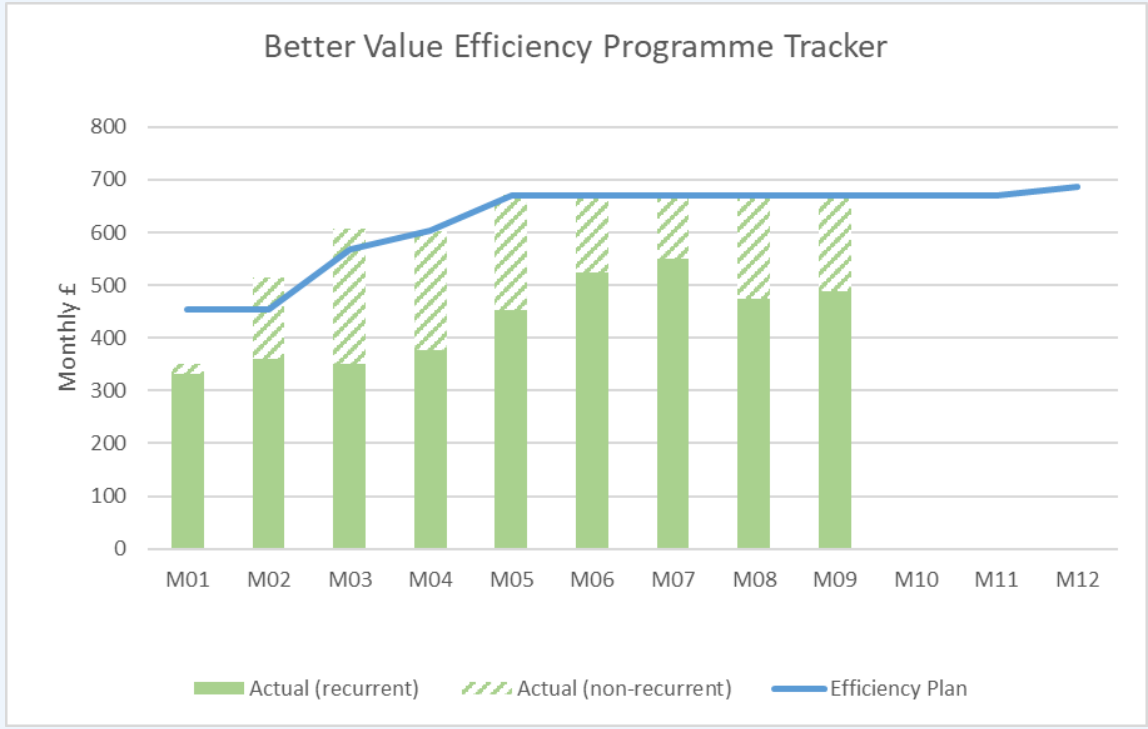


	Annual Target	Forecast Outturn
Income & Expenditure	£0.0m	£0.0m
Cash at bank	£1.9m	£1.9m
Capital Spend	£26.4m	£25.6m
Efficiencies	£7.46m	£7.46m
BPPC (NHS & Non-NHS)		
Volume	95.0%	91.9%
Value	95.0%	93.6%

Trust Best Value Efficiency Programme

Queen Victoria Hospital
NHS Foundation Trust

Financial Risk Rating	£000	M09 YTD	Current Forecast	Variance
Blue	2,413	1,690	2,431	18
Green	1,100	655	1,174	73
Amber/Green	1,982	1,067	1,510	(472)
Amber	832	216	355	(477)
Amber/Red	222	0	9	(213)
Red	994	0	0	(994)
Mitigating items		1,803	1,984	1,984
Total	**7,544**	**5,432**	**7,464**	**(80)**



KSO4 AREAS OF FOCUS

Queen Victoria Hospital
NHS Foundation Trust

Area	Summary, impact and actions
Breakeven YTD	In month position marginally favourable to planned £0.4m deficit for M9 and the Trust remains on plan YTD (£0.3m deficit). Patient income is £0.5m off plan YTD, due to the impact of industrial action (£0.2m), underperformance in CDC (£0.7m) and devices income £0.1m offset by pathway development funding for the Bleepa system used for CDC activity (£0.2m) and other digital funding. This is being offset by an underspend in non-pay. The Trust would be reporting a deficit of £1.4m without the inclusion of non-recurrent deficit support funding.
Cash at Bank YTD	Cash at M9 was £11.9m and cash levels remain supported by the slow start in capital spending.
Capital Spend YTD	The Capital Plan for M9 included £12.6m for CDC and £0.8m for boiler lease (which was contracted in 2024/25). Excluding these items planned spend was £4.9m in M9 with an underspend of £1.6m 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 £5.4m vs plan of £5.4m. 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 92.5% slightly increased from previous month.
BPPC (NHS & Non-NHS) Values	BPPC is slightly below target at 87.2% due to delays in processing requisitions.
Agency spend 40% less than 24/25 forecast	On target
Agency Spend Less than 2% of Total Pay Bill	On target
Bank spend reduction of 10% of Total Pay Bill	On target
Pay Spend	Pay is £0.1m adverse in month and for YTD with slippage in better value schemes (£0.7m) mostly offset by underspends mainly in CDC. M9 pay includes cost of IA and Bank holiday enhanced pay (£0.05m) combined. Pay spend will need to be maintained at the current trend to support delivery of control total.
Non-Pay Spend	£0.6m underspent for the YTD mainly due to underspends in CDC corporate areas. In addition, the underspend is also due to plan alignment between pay and non-pay. Non-pay must be maintained at normal run-rate level to support delivery of control total.

KSO4 PROJECT REPORT

Queen Victoria Hospital NHS Foundation Trust

Sussex Pathology Network

Exec Lead: CMO
Lead: PMO

Reporting Month: December-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 all Trusts and was taken through QVH Trust governance on 14 Dec with ELT agreement to proceed. Funding from NHSE to support ongoing costs for 2026/27 FY has been applied for through the SPN.on behalf of all organisations.
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 and PACS connectivity. Progress made with PACS connectivity and testing to commence mid Jan 26 and training scheduled for 9 Feb 26.
Order Comms (ICE) - Delivery of ICE will align with the revised timescales for WinPath Enterprise (LIMS). 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 but work is continuing and all Trusts are engaged.
Managed Service Contract (MSC) - All documents for round 3 were issued on the NHS commercial solutions platform on 6 Jan 26. Dialogue sessions with the remaining 2 bidders are scheduled for 13 and 14 Jan 26. Site visits are also scheduled during this period.
Network Formation and Laboratory Operating Model (LOM) - The Network Formation and Laboratory Operating Model projects are continuing with drafting the Outline Business Case. Workshops with the NHSE TU team are set for the 14/16 Jan with executive attendance confirmed for all Trusts. The timeline for activities remains challenging in the 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 outline business case (OBC) for approval	Sept 2025		Q4 2026	Additional resourcing has been added to assist delivery
Managed Service Contract – commencement of final stage	Jan 2026		Nov 2026	Completed and documents issued 6 Jan 26
Commencement of digital histopathology reporting	April 2025		Feb 2026	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 Digital Development and Connectivity Programme (DDCP) funding for FY 25/26. Planning underway for FY 26/27 and funding from NHSE DDCP for 26/27 has been applied for.
April 2025	Varying internal governance scheduling delays to programme timelines.	Assign Trust and Network Senior Responsible Officers (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 Chief Medical Officer (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: December-25

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

Archie EPR successfully went live on Tuesday 4 November and the system continues to bed in.

As of 15 January 2026, over two months post go live, there have been:

- 34,578 clinical documents created
- 14,626 medicines prescribed and 33,462 administered
- 131,690 patient context links to other clinical systems (Evolve – 78,054; Patientrack – 27,731; PACS – 17,678; Waba – 8,227)
- This equates to over 295,000 pieces of paper, which equates to 36 mature trees saved and avoiding approximately 1.5 tonnes of CO2. This directly supports the Trust's Green Plan and the NHS Net Zero commitments for 2040 and 2045

An optimisation exercise is underway and the programme team are planning to release additional functionality/modifications on a fortnightly/monthly basis. These include improvements to existing documents, improving our Critical Care Unit workflows and Theatres enhancements. The programme team are also supporting a number of other key productivity projects for the Trust. These include Patient Portal, G2 and AI initiatives. The team are also exploring other productivity opportunities including reduction in printing, reduction in scanning etc. A number of Plans on a Page were presented at the EPR Programme Board on January 20th where some decisions were made regarding which ones were approved, put on hold or where more discovery was required. The team will be working in collaboration with the Trust Efficiency Steering Group to ensure any cost benefits are approved and realised.

Funding has been secured from NHS England to extend the programme team until end March 2026. This is supporting stabilisation, optimisation and the commencement of the PAS project. Additional funding of approximately £1m is required for 26/27 and needs to be included as part of the capital planning. The team are working closely with NHS England to investigate whether there is national funding available via the Frontline Productivity programme as well as other potential funding sources.

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. Approximately £1m is required for 2026/27 and needs to be included in capital planning if there is no national funding available.

Date Raised	Risk Description	Mitigating Actions
Dec-25	There is currently no funding for programme team beyond end March for PAS implementation.	ELT and F&P notified of need for approximately £1m funding required from April-December 2026. Funding secured from NHS England from Jan-March 2026. Awaiting funding outcome from NHS England for 26/27 from the Digital Productivity funding. If no funding available, QVH will need to include in capital planning.

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
Within Month 9 the dedicated resource for the local offer programme concluded, with all actions and related meetings successfully transitioned, with leadership across the Triumvirate leadership team, with many being led by the Therapies Service Manager. Following engagement events across the community therapy teams, using digital questionnaires to support, staff feedback was received and analysed. After receiving this, learning was concluded from the working groups and final job planned templates were signed off by the clinical leads, staff and the Therapy Service Manager. This process has enabled job planning go live for 5 January 2026 as planned.

Provider Collaborative
Delivery plan circulated and discussed at Executive Leadership Team, with delivery requirements outlined from April 2026 as per Month 8 reporting. First Acute Alliance Board and Neighbourhood Alliance Boards have commenced.

Major Service Review
Following extensive clinical engagement across the system, key priorities have been agreed for 2026/27 . QVH will be participating in longer term transformational work to support the priorities, including work to establish a single point of access for specified elective services across Sussex.

Community Diagnostic Centre (CDC) – East Grinstead and Bognor
Groundworks have been completed and steel installation commencing 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 works started on site in East Grinstead including ground works and installation of the steel framework.
2. Continued engagement continues with University of Chichester regarding next steps for the Bognor site.
3. Activity against plan for East Grinstead was at 72% for December 2025 and income against plan (year to date) is 83%.
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 being agreed

Key areas for focus are 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 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.. Deadline of Feb 2026.
Construction completion on East Grinstead site	01/09/25		01/08/26	Steel installation commenced onsite.
Design of Bognor retro-fit	01/09/25		30/12/25	High level floor plan agreed December 2025 and detailed room planning has now commenced

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	99.57%	Dec-25	1	3	3	140
Cancer Treatment	62 days Performance	66.48%	Nov-25	12	13	96	137
	FDS Performance	80.45%	Nov-25	7	12	49	135
Diagnostics (DM01)	Under 6 Weeks Performance	91.73%	Nov-25	10	13	44	155
Referral To Treatment	Within 18 Weeks Performance	62.39%	Nov-25	10	13	70	149

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%
- ** In M8 and M9 the trust achieved the 65ww trajectory in terms of patient numbers, but was behind plan for the non-breast cohort of patients.

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:	12/03/2026		**Agenda reference:**	**148-26**	
Report title:	Research and Innovation Strategy update				
Sponsor:	Tamara Everington, Chief Medical Officer				
Author:	Mary Mason, Associate Director of Research, Innovation and Improvement				
Appendices:	None				
Executive summary					
Purpose of report:	To update the Board on Research and Innovation progress towards delivery of strategy				
Summary of key issues	• Progress in all 4 pillars of the Research & Innovation (R&I) Strategy • Strengthened governance in Research & Innovation through policies, processes and oversight • Research laboratory ready to start new in vitro laser study in partnership with University of Sussex supported by matched HEIF/QVH charity funding • Designers contracted to support £1.3m QVH Charity legacy donation planned refurbishment in location 40 in 2026/27 • 2 NIHR funded projects in 2025/26 and further funding approved for 2 in 26/27 including continued work with the PCN and commercial development • NIHR funding is reduced in 2026/27 and the Trust will need to commit Trust resource if R&I is to progress with pace • Developing innovation presents new challenges in governance but work is progressing supported by the KSS Health Innovation Network				
Recommendation:	The Board is asked to **note** the update.				
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:	GMC Good Clinical Practice				
Legal:	None				
Resources:	In order to progress research & innovation, the Trust must match central NIHR funding with commitment of integrated resource				
Assurance route					
Previously considered by:	ELT				
	Date:	3 March 2026	Decision:	N/A Update paper	
Next steps:					

Report to:	Board of Directors
Agenda item:	148-26
Date of meeting:	12 March 2026
Report from:	Tamara Everington, Chief Medical Officer
Report author:	Mary Mason, Associate Director of Research, Innovation and Improvement
Date of report:	26 February 2026
Appendices:	None

Research and Innovation update

Executive summary

The Research and Innovation Strategy has advanced across all four pillars with strengthened governance processes, infrastructure gains, including the planned £1.3m Research, Innovation and Education Centre and expanding partnerships in clinical research, AI and academia.

New policies, improved financial and research governance, and successful funding bids have positioned QVH for sustainable future growth, though the forthcoming NIHR funding model presents financial challenges and highlights the need to optimise performance metrics through sustainable commitment.

Internal and external collaborations are increasing at pace, and national directives reinforce the importance of fully resourcing research leadership, reinvesting external income, and excluding externally funded posts from headcount. The Board is asked to note progress and the strategic need for targeted Trust investment to secure long-term benefits for patients and the organisation.

Progress against Research Strategy

Progress against the Research and Innovation strategy is summarised against each of the key pillars below.

Pillar 1 – Develop Strategic leadership and culture of research

Significant progress has been made to develop the Research & Innovation team using a continuous improvement approach to map the end to end research set up process. This, along with clarity around roles and responsibilities, will support our newly strengthened governance processes. This will enable the next phase with outreach to departments and teams to showcase how integrated research can support developing excellence in patient care at QVH.

Research and Innovation Steering Group is convened monthly to receive and interpret performance against metrics and review of the study portfolio including a structured approach to new concepts in line with terms of reference.

A number of policies have been refreshed and a newly developed Research Sponsorship Policy is complete and awaiting final ratification to ensure consideration of organisational risk associated with home grown research.

An advertisement is currently active to recruit a new Clinical Director for Research & Innovation following Mohamed Elalfy's successful appointment as President of the Royal College of Ophthalmologists. We are immensely proud and grateful for the support that Mr Elalfy has given to the R&I agenda since his appointment, and look

forward to continuing to work with him through his presidency in his other key roles at the Trust.

Pillar 2: Workforce, Infrastructure and Governance

Our successful Charity bid in December 2025 secured £1.3m of legacy funding to design and redevelop an area in the centre of the hospital into a Research, Innovation and Education Centre. This is now moving into the next phase with designers in place and plans being developed with PMO programme oversight. Preparation for the governance infrastructure around the innovation aspects of the centre has been underway with support from the Kent, Surrey & Sussex Health Innovation Network Draft governance structures have been developed with contribution to the AI policy, which is currently under development in collaboration with the digital leadership.

A proof of concept collaborative partnership between the Department of Biomechanical Engineering at the University of Sussex and QVH has been established. Pump-prime funding from the QVH Charity bid has resulted in successful matched HEIF (Health Education Innovation Fund) funding being awarded to the University of Sussex. The project involves comparison of standard blood vessel suturing to laser anastomosis in an in vitro model with ‘surgery’ performed and samples processed in our new research laboratory facility. This will be a foundational project in developing our research strategy and contract negotiation is in progress.

Phase 1 of the REDCAP (research electronic data capture) implementation is also now complete with final development planned to extend access to this Trust-wide. The R-studio statistics software package has been successfully deployed as planned.

The R&I team continue to update and review standard operating procedures (SOPs) and policies prioritising those enabling progression with the strategy including development of a Research Governance Policy, Research Sponsorship policy.

Pillar 3: Sustainable growth

Significant progress has been made in development of strengthened governance processes around set up and contractual sign off of studies from expression of interest phase through to delivery through implementation of SOPs. As noted above, a new Research Governance Policy has been developed awaiting final ratification and strong financial governance systems and with agreed processes have now been adopted from feasibility stage to ensure that sign off meets our Standing Financial Instructions and contractual standards. A revised policy around commercial income redistribution is now active to inform how commercial income is redistributed in line with NIHR guidance.

Income this year has been bolstered by successful non-recurrent Strategic Funding Bids to:

- Expand our reach across boundaries with community partners within the PCN to support them to develop capability and capacity to undertake research. This is progressing well and completes at the end of March.
- Research Accelerator programme - Working with research colleagues across the wider system to help improve and achieve the national 150 days research set up ambition.

These programmes of work continue until the end of March after which a final report will be submitted to evidence the outcomes of funding. Whilst both initiatives support the wider strategic direction of research at QVH, secondments and associated challenges to backfill posts along with internal team challenges have contributed to a slower pace of change than we may have hoped for. Team members seconded into these roles move back to their substantive posts from April. This will improve sustainability of the delivery and governance teams to concentrate on the coming year's priorities within the strategy.

This pillar, therefore is one that offers greatest challenge currently around financial stability due to the overarching changes to the NIHR funding model commencing from April 2026. Indicative information (subject to final clarification at the end of February) notes that our award for 2026/7 will be decreased by 7% on last year. The NIHR funding model now combines historical allocation (50%) with research activity (30%) and a performance based element (20%) based on study set up to time and target including :

- Site opened within 60 days of HRA approval or site selection.
- First Participant, First Visit within 30 days of site readiness.
- Recruitment to Time and Target (commercial studies).
- Increase in recruitment to interventional commercial trials.
- Increase in the number of interventional commercial trials recruiting

A cap and collar system is in place preventing significant year on year fluctuations in funding which could affect staffing and business continuity. Work is ongoing to ensure that we optimise our opportunities with this new funding model however we are mindful that this year we are initially working on a projected reduction in funding.

Pillar 4: Collaboration and Partnerships

There are a steady stream of research pipeline opportunities coming to the team from an innovation perspective. As noted above, the collaboration with the PCN is due to complete at the end of March subject to further potential award of step down strategic funding if successful. In addition to the University of Sussex collaboration noted above, we have a potential EU collaboration with University Of Bath in planning relating to a project around hand trauma infection.

Internal collaborations around AI and other innovations are also being worked through including: -

- **HexAI** – A QVH employee (Fellow) has developed an AI start up pilot project proposed to be used in Burns subject to due diligence and full governance clearance.
- **AI for bone density** – A radiology consultant has been in early discussions to use routine data collected at CT Scan to identify patients at risk of fractures In later life. Our Clinical Academic has coded a pilot machine-learning model that can utilise data from a CT scanner and calculate bone density of the lumbar vertebrae. Potentially this is a computer science MSc project where QVH would hold the Intellectual Property.
- **Dental Reporting AI – DRAI** – Another radiology consultant at QVH has established a company and developed a business proposal for a medical software solution to report on Cone Beam Computed Tomography (CBCT) scans of complex dental impacted teeth utilising machine learning and

artificial intelligence reporting this immediately after imaging. This significantly helps with consultant reporting backlogs and automates letter and report production using appropriate language. This proposal will be tabled for fuller discussion at ELT in the coming weeks with a view to this being proposed to the League of Friends for funding if approved through internal governance channels.

- **Radiology AI** – We are also aware of planned deployment of another innovative AI solution for use in radiology which is currently in use across other Trusts local to QVH.
- **ELABS 2** – Another laser project is being developed with 8 other sites to explore the effectiveness of treatment of burn scars with pulse dye laser and fraction CO2 laser in early burns scarring.

Challenges

Over the past five months, sustained sickness absence and employment challenge has created significant service pressures within our small team with some effect on both research delivery and governance. With the new leadership now in place, intensive support has been deployed to ensure that business as usual has been maintained, however, the unavoidable result has been a temporary slowing in our strategic progress. Our emerging strategic partnership now offers a timely opportunity to regain pace given strengthened governance and closer alignment with established organisational processes.

A review of legacy trials has highlighted that previously these were initiated without the rigorous feasibility, costing, and resource planning required for high-quality delivery. Principal Investigator job-planned time, drug costs and resource implications were not always fully evaluated. We have now implemented strengthened approval processes that provide full visibility for all new trials. We have also begun retrospective review of ongoing studies to ensure they too meet the required standards and are fully costed and resourced. This work is essential to protect the Trust's operational, financial, and reputational position.

As we expand into AI-enabled research and innovation, the Trust is entering a strategically significant but complex landscape, particularly where staff innovators may also hold commercial interests. To harness this opportunity safely and constructively, we are developing robust governance and Intellectual Property frameworks with digital colleagues. Our aim is to enable innovation rather than constrain it, while ensuring clarity and protection from the outset.

The Trust-wide focus on 'Better Value' and cost control is both necessary and supported. At the same time, Research and Innovation remains one of the most promising areas for income generation and external investment, particularly given QVH's specialist reputation and strong national and international recognition. Commercial income is achievable at scale, but only where capacity is available to secure, resource, and deliver commercial trials effectively. NIHR funding provides an important platform for portfolio delivery, with the expectation that Trusts will contribute the internal capability required to realise its full benefit.

Although substantial funding opportunities exist, our current capacity limits our ability to pursue them and some clinical leads feel unable to progress research due to productivity challenges. Strengthening links with life sciences and industry partners is a high-value opportunity area, but one that requires dedicated focus. We therefore intend to systematically map existing clinical-industry connections to build a coherent and proactive engagement strategy.

Our recent success in the latest Strategic Funding call demonstrates the significant potential for growth having secured funding for two new bids:

• A six-month step-down programme supporting exit from the PCN partnership, and

• Part-funding for a Commercial Research Lead B7 (June 2026–June 2027)

This commercial role is pivotal in expanding commercial readiness, building an industry pipeline, and positioning the new QVH Research, Innovation and Education Centre for long-term sustainability. A proposal will shortly be submitted seeking QVH matched funding to unlock the full return on this opportunity, ensuring that this investment translates into measurable commercial income growth.

A critical success factor across all of this work is expanding Principal Investigator, Assistant PI, and broader clinical research leadership capacity. For the Trust to grow its' research portfolio sustainably, research activity must be fully job-planned, fully funded, and supported with protected time. This is essential to ensure high-quality portfolio delivery and compliance with Good Clinical Practice.

National policy direction strongly reinforces this need. Recent communications from DHSC and NHS England emphasise that Trusts must ensure adequate resourcing for commercial trial delivery—including protected PI time, adequate departmental support, and appropriate facilities. They also stress that external research income must be reinvested into research capability and capacity.

QVH will need to ensure consideration of these factors as we progress strategy delivery.

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

Report cover-page					
References					
Meeting title:	Board of Directors				
Meeting date:	12/03/2026		**Agenda reference:**	**148-26**	
Report title:	Estates Update				
Sponsor:	Simon Marshall, Interim Chief Finance Officer				
Author:	Adrian Lee, Associate Director of Estates and Facilities				
Appendices:	None.				
Executive summary					
Purpose of report:	To update the Board regarding the progress being made to improve the Trust's estate and critical infrastructure.				
Summary of key issues	• Further Fire Alarms and dampers funding is expected to be awarded in 2026/27 to complete the final phase of the multi-year fire improvement programme. The site inspection by West Sussex Fire Brigade on 3 February 2026, went well with the Brigade comfortable with the progress being made. **Mitigated risk score for alarms 9; Fire Dampers 15**. • Asbestos Management plan is in place. Funding is expected to be awarded in 2026/27 to eradicate our next highest risk areas. The Estates and Facilities building roof due to be replaced by the end of March 2026. **Mitigated risk score 12.** • Ventilation ductwork cleaning is on-going. There are currently no IPC concerns regarding infection incidents. Our AE is currently reviewing our ventilation infrastructure with a report due in June 2026. Estates Safety Funding linked to the MRI development and for Imaging has been bid for in 2026/27 with further bids in subsequent years. **Mitigated risk score 12.** • We are out to tender for Fixed Wire Testing, which is overdue. We inspect regularly and respond to any unforeseen issues. Our AE is currently reviewing our electrical infrastructure with a report due June 2026 **Mitigated risk score is 12**. • Internal Heating and Hot Water upgrades required across the site remain funding dependent. Currently, the main hospital is supplied via a mobile boiler system. The contractor is on permanent standby to support the estates on-call team if there are any failures. A long-term solution has been identified, and bidding for external funding is underway. **Mitigated risk score 15**. • The new design for the defective theatre roof has been started and we are in the process of covering the building with scaffolding and a temporary roof whilst further investigations take place and to allow the roof to dry out. A structural engineer is engaged and supporting estates team with this project but there is no requirement to close theatres. **Mitigated Risk Score 15**.				
Recommendation:	The Board is asked to **note** the progress being made to address the Trust's estate and critical infrastructure.				
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 3				
Corporate risk register:	All estates infrastructure risks are on the risk register				

Regulation:	Health and Social Care Act, Building Regulations, RRFSO, Health & Safety at work Regulations.			
Legal:	None			
Resources:	Both external funding and technical resources will be required to address these ongoing issues. We will continue to apply to NHSE for further critical infrastructure funding.			
Assurance route				
Previously considered by:	ELT			
	Date:	3 March 2026	Decision:	Noted.
Next step:	Significant works are currently underway to complete the majority of the Estate Safety Fund phase 1 and 2 works by the end of March 2026. Results of the next bidding exercise for 2026/27 are still awaited. Continue to monitor at estates and facilities sub-committee, report progress to ELT and F&PC bi-monthly.			

Report to: Board of Directors
Agenda item: 148-26
Date of meeting: 12 March 2026
Report from: Simon Marshall, Interim Chief Finance Officer
Report author: Adrian Lee, Associate Director for Estates and Facilities
Date of report: 28 February 2026
Appendices: None

Estates Update

Introduction & Background

There remain significant challenges regarding critical infrastructure issues at QVH, and although much progress is being made as a result of the Estates Safety Fund schemes, we must remain focused on the estate risks along with appropriate mitigations whilst seeking further opportunities for funding to address this.

Critical infrastructure improvements

- **Fire Alarms and dampers** progress. Funding is expected to be awarded in 2026/27 to complete the final phase of the multi-year fire improvement programme, Substantial progress has meanwhile been made, and the site remains safe as the fire alarm is working in all areas and improved fire segregation has been installed to the ward areas. The site inspection by West Sussex Fire Brigade on 3 February 2026, went well, with the brigade comfortable with the progress being made.
  Mitigated risk score for alarms 9; Fire Dampers 15
- **Asbestos Management** plan is in place. Funding is expected to be awarded in 2026/27 to eradicate our next highest risk areas. Roof deterioration is a concern but these are being monitored and replaced where necessary. Monitoring and

mitigation are in place. The Estates and Facilities building roof due to be replaced by the end of March 2026.
Mitigated risk score 12

- **Ventilation** – plan for ductwork on-going. IPC monitors infection levels, which could result from ventilation issues. However, there are currently no concerns regarding infection incidents. Our AE is currently reviewing our ventilation infrastructure with a report due in June 2026. Estates Safety Funding linked to the MRI development and for Imaging has been bid for in 2026/27 with further bids in subsequent years.
  Mitigated risk score 12

- **Electrical infrastructure testing** and panel replacement works. Out to tender for Fixed Wire Testing, which is overdue. We inspect regularly and respond to any unforeseen issues. We recently had a hire generator on site due to issue with our own back-up generator, repairs have been completed and the temporary generators have been returned. Our AE is currently reviewing our electrical infrastructure with a report due June 2026.
  Mitigated risk score is 12

- **Heating and Hot Water** – upgrades required across the site are funding dependent. Currently, the main hospital is supplied via a mobile boiler system. The contractor is on permanent standby to support the estates on-call team if there are any failures. A long-term solution has been identified, and bidding for external funding is underway.
  Mitigated risk score 15

- **Theatres** – the new design has been started for the defective roof but there is a need to cover the building with scaffolding whilst further investigations take place to agree a permanent solution and to allow the roof to dry. Structural engineer is engaged and supporting estates team with this project but there is no requirement to close theatres.
  Mitigated Risk Score 15

Other Updates

Premises Assurance Model Update
NHSE have shared the new Premises Assurance Model (PAM) for 2026. The model has been completely redesigned and the number of questions has increased significantly to over 700 individual Yes/No questions, accompanied by mandatory evidence-based documentation. In response we will shortly rolling out Concerto, a digital PAM solution designed specifically for NHS Trusts to manage their estates and facilities assurance requirements. It centralises compliance management, risk tracking, evidence submission and reporting—making the entire PAM process more efficient, transparent, and auditable.

PLACE Inspection – November 2025 This took place on Wednesday 12 November 2025 Overall feedback was positive and an action plan to address under-performing areas is being worked up.

Current Estate works programme updates
- The East Grinstead Community Diagnostic Centre build continues although some delays and additional costs have been incurred over recent months.

- The design for the Bognor CDC is progressing through RIBA stage 3, which is due for completion by the end of March 2026.
- Fire Alarm Upgrade works to Canadian Wing have now been completed. Location 51 has also been completed with the team moving onto location 56 which is on target to complete by the end of March 2026.
- CCTV Cabling works continue with completion on target for March 2026.
- Access Control Cabling works continue with completion on target for March 2026.
- The initial Fire Doors have been installed with further fire doors currently being manufactured for installation next year.
- Kitchen Boiler Replacement works are commencing.
- The theatre roof scaffold is progressing well.
- Electrical Upgrades - multiple distribution boards across site are being replaced with contractors appointed and installation dates confirmed for late March 2026.
- A new hydraulic waste compactor has been delivered and handed over to the waste team. A replacement electric tug to assist with refuse movement around site will be delivered at the end of February 2026, enabling works to the external corridor near the Hurricane café to accommodate this will commence imminently.
- Asbestos Removal. Following the successful demolition, a contractor has been appointed to replace the engineer's workshop. Plans have been finalised and contractor appointed to replace the estates building 20 asbestos roof.
- Window and Door replacement's - a contactor has been appointed and the physical works have commenced.
- A project to replace the external doors of our main theatre complex has been awarded and is due to commence in late March 2026.

Recommendation
The Board is asked to note the progress being made to address the Trust's estate and critical infrastructure.

Report cover-page					
References					
Meeting title:	Board of Directors				
Meeting date:	12/03/2026	**Agenda reference:**	**149-26**		
Report title:	Green Plan				
Sponsor:	Simon Marshall, Interim Chief Finance Officer				
Author:	Care without Carbon (the Trust's Green advisors)				
Appendices:	None				
Executive summary					
Purpose of report:	This report details the Trust's updated Green Plan for 2026 onwards.				
Summary of key issues	At Queen Victoria Hospital NHS Foundation Trust (QVH), we are always driven by our determination to provide the highest quality care, the best clinical outcomes and a safe and positive patient experience. Our Green Plan programme specifically aligns with this – every step improves the patient experience and brings us closer to a more resilient health care service, fit for a changing future. We have been delivering on our commitment to more sustainable healthcare since our first Green Plan came into being back in 2021, making progress on reducing the emissions from our anaesthetic gas use for example, completely eliminating use of desflurane, and decommissioning piped Nitrous Oxide use which has reduced carbon pollution from medical gases overall by 90%. Through this refreshed Green Plan, we are evolving our plan to focus on core emissions reductions across our estate, delivering clinical services that are more sustainable, switching from single-use to reusables and integrating sustainability into decision making. The new NHS 10-year Plan with its emphasis on moving care in community, more digitally enabled care and a care model of prevention is an important driver for the refreshed approach to our Green Plan. Our partnership approach with Care Without Carbon ensures we are aligned across the system, maximising the benefits of NHS scale and influence. Now, more than ever, the broader gains of sustainable choices are important to recognise. Through this Green Plan, we are supporting challenges linked to tighter resources and increasing demand on services by enabling innovations in care delivery that reduce costs, improve health and support our shared environment.				
Recommendation:	The Board is asked to **approve** the Trust's Green 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:	KSO 4 Sustainable healthcare provision				
Corporate risk register:	NA				
Regulation:	Net Zero by 2040 for emissions the NHS controls and Net Zero by 2045 for emissions we can influence.				

Legal:	H&SC ACT 2022			
Resources:	Will influence all future capital investment decisions.			
Assurance route				
Previously considered by:	Executive Leadership Team and Finance & performance committee			
	Date:	Nov 2025 Feb 2026 Mar 2026	Decision:	Forwarding to Trust Board
Next steps:	Board approval in March 2026. Post March Board to be shared externally with ICB.			

NHS

Queen Victoria Hospital

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care WITHOUT CARBON

Our Green Plan 2026

Our Environment | Our People | Our Commitment

NHS

Queen Victoria Hospital

NHS Foundation Trust

care WITHOUT CARBON

Our Green Plan 2026

Our Environment | Our People | Our Commitment

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Foreword

Creating a healthier future for our communities

At Queen Victoria Hospital NHS Foundation Trust (QVH), we are always driven by **our determination to provide our patients with the highest quality care, the best clinical outcomes and positive patient experience.** Our Green Plan programme specifically aligns with this – **every step improves the patient experience** and brings us closer to a more resilient health care service, fit for a changing future.

We have been delivering on our commitment to more sustainable healthcare since our first Green Plan came into being back in 2022, making progress on reducing the emissions from our anaesthetic gas use for example, completely eliminating use of desflurane, and decommissioning piped Nitrous Oxide use which has **reduced carbon pollution from medical gases overall by 90%.**

Through this refreshed five-year Green Plan, we're evolving our plan to focus on core emissions reductions across our estate, delivering clinical services that are more sustainable, switching from single-use to reusables and integrating sustainability into decision making.

The new 10 Year Health Plan with its emphasis on moving patient care in to the community, more digitally enabled care and a care model of prevention is an important driver for the refreshed approach to our Green Plan. Our partnership approach with Care Without Carbon ensures we're aligned across the system, maximising the benefits of NHS scale and influence.

Now, more than ever, **the broader gains of sustainable choices are important to recognise.** Through this Green Plan, we're supporting challenges linked to tighter resources and increasing demand on services by enabling innovations in care delivery that cut costs, improve health and support our shared environment.

Together we can create a healthcare system that supports our staff, patients and communities, and the environment on which our health depends.

Abigail Jago

Acting Chief Executive QVH

Case for change

It matters more than ever that we deliver sustainable healthcare

Taking urgent action to adapt to and mitigate our impact on climate change is critical to the health of our patient population at QVH, within Kent, Surrey, Sussex and beyond.

Global science[1] shows that climate change is faster and with deeper impacts than originally anticipated. Since our last Green Plan, the UK has faced two of the warmest years on record. In the South East, we're seeing more heatwaves, flooding and storms year-on-year and greater levels of air pollution; all impacting the health of our patient population.

Climate is impacting on our health

Climate change is already impacting health in the UK. The IPCC Sixth Assessment Report (2023) reports a 30% rise in heat-related mortality across Europe over the past two decades, with the South East having the highest number of heat-associated deaths in England. Warmer conditions are also **worsening air pollution and allergen exposure,** increasing risks of respiratory illness.

Rising temperatures and UV exposure are driving more severe skin injuries in the UK, with clinicians reporting pavement burns[4] during the 2022 heatwave and melanoma cases rising by around 33% over the past decade to 20,800 a year.[5]

Temperature extremes are also associated with **higher rates of surgical site infection and impaired wound healing[6].** There were 2,985 excess deaths recorded in the UK during the 2022 heatwaves[7]. Given our specialism as a Trust these figures are alarming and support our drive to deliver on our Net Zero target.

These threats will disproportionately **affect vulnerable populations,** either due to being more susceptible to health impacts, or living in areas most affected. This includes older residents, people with respiratory and cardiovascular disease, and people on lower incomes or in ethnic minority groups.

These extreme weather events are also impacting on our staff, infrastructure and the care we provide, through heat stress, service disruption, infrastructure strain and increased demand on clinical services.

↗ **2**

Of the warmest years on record in the UK since our Green Plan was published 3 years ago.

↗ **2/3**

Two-thirds of burn survivors experience temperature sensitivity, making heatwave conditions particularly challenging for people recovering from burns.[2]

↗ **33%**

Increase in melanoma cases over last 10 years.

> **"Given the global health imperatives, the NHS must stick to its Net Zero ambitions. There is no trade-off between climate responsibilities and reducing waiting lists."**
>
> **Darzi Report 2024**

Our own impact

Climate change and health are inextricably linked; at the same time, the way in which we are delivering care to our patient population across Kent, Surrey, Sussex and beyond – and across the NHS more broadly – is itself contributing to ill health.

The NHS is the largest public-sector emitter of CO_2, making up 4-5% of the UK's carbon footprint. And with 1 in 20 vehicles on the road associated with NHS business, plus huge amount of waste produced, our environmental impacts go far and wide.

This is an opportunity

- **Delivering more sustainable care presents an opportunity.** Improved air quality, healthy food, low-carbon travel and green space bring significant health benefits, and support a reduction in health inequalities, e.g. reducing respiratory and cardiovascular illness in lower-income communities most exposed to air pollution.
- **It can also save us money.** For example, installation of energy-efficient LED lighting cut our lighting energy demand – and costs – by around 70%.
- **By delivering care in a more sustainable way, we are enabling better health outcomes and long-term financial sustainability in Sussex,** the UK and globally (see figure 1 on the following page).

www.gov.uk/government/publications/chief-medical-officers-annual-report-2022-air-pollution

1 IPCC Sixth Assessment Report (AR6): Synthesis Report 2023, Intergovernmental Panel on Climate Change (IPCC)

2 https://www.ncbi.nlm.nih.gov/books/NBK430730/

3 Department of Health and Social Care (2022). Chief Medical Officers Annual Report 2022: air pollution.

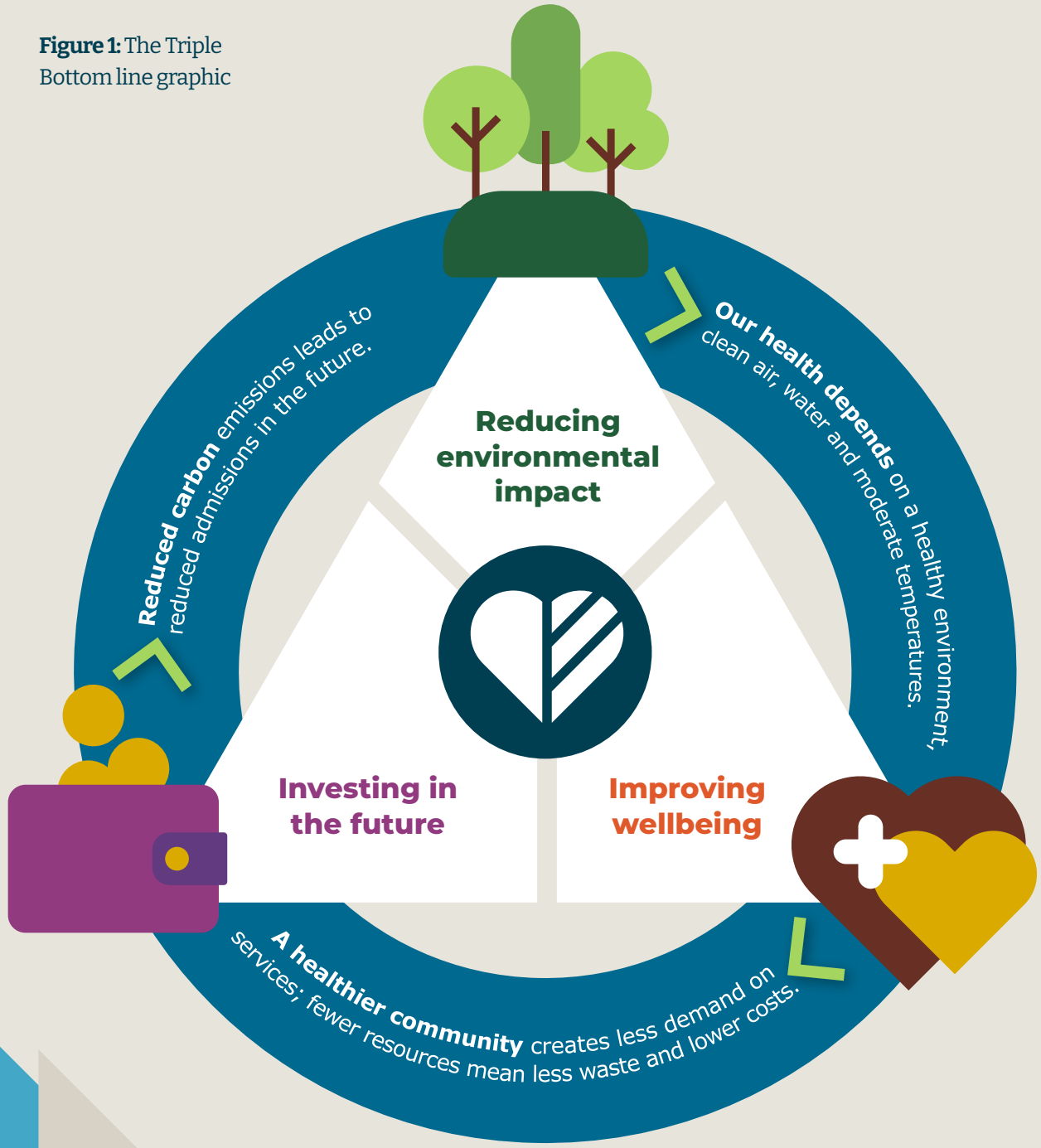
4 https://pmc.ncbi.nlm.nih.gov/articles/PMC10690489/

5 https://www.cancerresearchuk.org/health-professional/cancer-statistics/statistics-by-cancer-type/melanoma-skin-cancer

6 Kurz A, Sessler DI, Lenhardt R. Perioperative normothermia to reduce the incidence of surgical-wound infection and shorten hospitalization. New England Journal of Medicine. 1996;334(19):1209-15.

7 UK Health Security Agency. Heat mortality monitoring report: 2022. GOV.UK. Available at: https://www.gov.uk/government/publications/heat-mortality-monitoring-reports/heat-mortality-monitoring-report-2022

Figure 1: The Triple Bottom line graphic



Investing in the future

Delivering more sustainable care makes financial sense. Streamlining complex care for breathlessness patients is one such example, where 90% of referrals were managed without the need for in-person specialist appointments. Read the full case study on page 22.

KSO 2 To innovate and improve
KSO 4 To deliver sustainable services

Improving wellbeing

All our projects are focussed on supporting the health and wellbeing of our patients, staff and communities. Our investment in a specialist bone density scanner to reduce risk of fractures is explored in our case study on page 24.

KSO 1 To deliver outstanding care
KSO 3 To be an excellent employer

Reducing environmental impact

Prioritising lower carbon, environmental resources is key to maximising the health benefits of the programme. Projects designed to improve patient care demonstrate how this is possible, see our 'wide awake hand surgery' case study on page 23.

KSO 4 To deliver sustainable services
KSO 5 To collaborate with others

Why deliver a Net Zero NHS?

Legal duties and regulatory drivers

Since our last Green Plan, the NHS's commitment to deliver a Net Zero health service has been strengthened through the implementation of a range of legal and regulatory drivers.

The Health & Social Care (H&SC) Act 2022

Sets out legal requirements covering:

- **Reducing our carbon emissions to Net Zero by 2040** for emissions we control directly and by 2045 for emissions we can influence.
- **Adapting to current or predicted impacts** of climate change.
- **Targets within the Environment Act 2021** (air pollution, water, waste and biodiversity).

As part of the 'have regard to' duty set out in the H&SC Act 2022, NHS trusts, along with NHS England and ICBs, are mandated to consider statutory emissions and environmental targets when making decisions.

The **recent NHS 10 Year Health Plan** also reinforced the government's commitment to a Net Zero NHS, stating: we will prioritise the NHS's existing commitments set out in Delivering a Net Zero Health Service – **including achieving Net Zero by 2040 for the emissions the NHS controls and by 2045 for the emissions it can influence.**

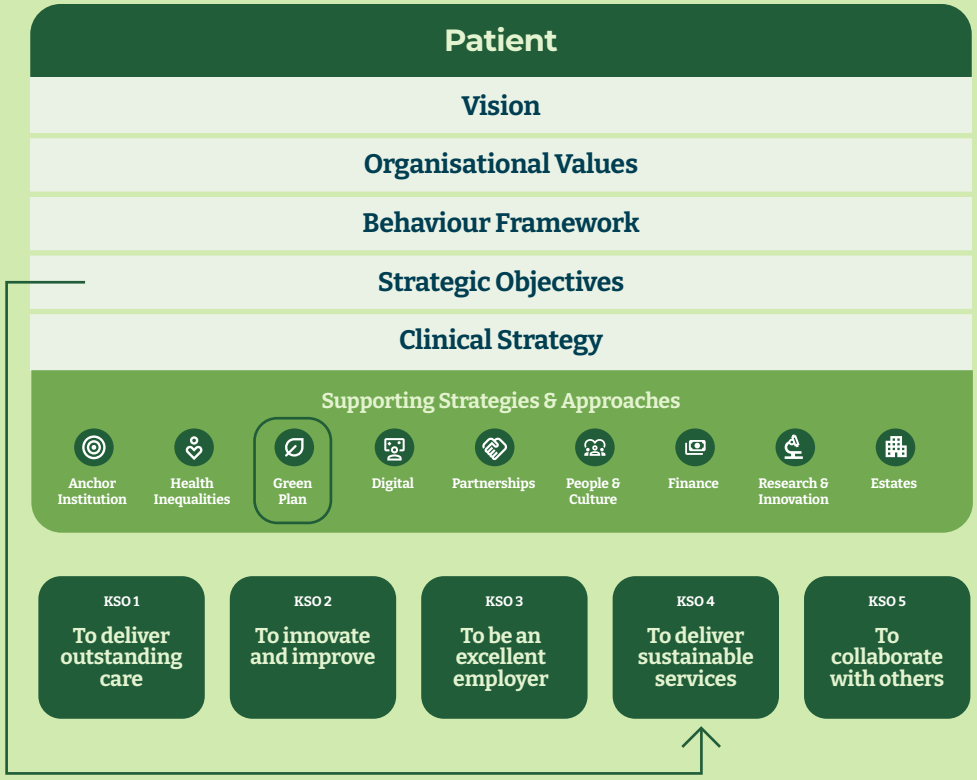
In setting out how the NHS must change to create a modern health service, the plan also aligned with three key trends required to support delivery of lower carbon care: shifting from hospital to community, sickness to prevention, and analogue to digital. All key aspects of this Green Plan refresh.

In addition and in support of this, additional requirements are outlined in the following:

- **Care Quality Commission (CQC) Quality Statement** - requiring staff and leaders to empower staff to understand health and climate links, its impact on services and how to deliver more sustainable healthcare.
- **NHS Standard Contract,** planning guidance and commissioning.
- **Public Sector Equality Duty:** must be considered when developing and implementing climate change-related policies and actions.
- **Net Zero and Social Value procurement requirements** PPN 002 and PPN 006 (Procurement Act).
- **NHSE climate change strategy 'Delivering a Net Zero NHS' and NHSE Green Plan refresh guidance,** along with a range of supporting strategies and guidance in place to meet the commitments of H&SC Act 2022. This includes the Net Zero Travel and Transport Strategy, Estates Net Zero Delivery Plan, NHS Net Zero Supplier Roadmap, NHS Clinical Waste Strategy etc.

Supporting our strategic direction

At its core, our Green Plan programme is about supporting the health of our patient population now and in years to come. This aligns directly with our vision to "Be a centre of excellence that rebuilds lives and supports communities for a healthier future."



Improving health for people and our shared environment

We updated our QVH Strategy 2025-2030 to better reflect the needs of our patient populations, in full consultation with the communities we serve. **Our approach directly recognises the importance of action on environmental sustainability.**

Our key organisational strategy objectives include the following:

- **Quality at the centre** of what we are and do for patients, families and communities
- **To reflect our future commitment and aspiration** to research, innovation and continuous improvement underpinning all that we do.
- **Our people are our greatest asset** and we need to work hard to develop and deliver our workforce for the future
- **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.
- **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 and commercial activities for the future

This Green Plan supports delivery of a number of these strategic objectives. It also supports delivery of the three core themes which underpin and unify our vision and areas of focus within our clinical strategy:

Centre of excellence: The commitment to high quality care is our core ambition and the innovations in care delivery that are enabled by making more sustainable choices directly delivers on this strategic goal; for example, our expansion of virtual appointments, with over 25% of outpatient appointments now delivered virtually, reducing waiting times for patients and improving outcomes.

Holistic needs: We will develop holistic services to support the repair and rebuild of our patients in regard to both physical and psychological needs, through our health psychology approach and surgical rehabilitation. This approach supports a de-escalation of care needs over time that is inherently sustainable and in line with our Healthier Lives sustainable healthcare principle.

Service integration: Our Streamlined processes and pathways sustainable healthcare principle directly aligns with our strategic focus to integrate our services with our healthcare partners, working together to support timely care, reduce waiting times and achieve best value.

Our expansion of virtual appointments, with over 25% of outpatient appointments now delivered virtually, reducing waiting times for patients and improving outcomes.

Guided by our stakeholders

In order to develop and deliver on our Green Plan effectively, we took learning from patients and clinicians, non-clinical teams, leadership and suppliers – **and we learned a lot.**

Our staff voice

In 2025 we participated in a Sussex-wide survey of NHS staff. **The majority (95%) of staff support more sustainable healthcare and 93% are willing to act within their role,** yet only 40% feel their Trust takes sustainability seriously.

We also met with stakeholders across the Trust to develop this Green Plan. Key learnings included:

- **Culture and engagement:** Clinical champions and active staff and patient involvement drive innovation and ensure sustainability reflects frontline priorities.
- **Our Estate**: An older estate and rural location present challenges for reducing emissions from buildings and travel.
- **Digital innovation:** Digital programmes (e.g. remote diagnostics, e-prescribing) support more sustainable care delivery.
- **Waste and circular economy:** Teams want practical, clinically safe support to reduce waste and increase reuse and recycling.
- **Governance and integration:** Embedding sustainability into The QVH Way and routine decision-making are essential.
- **Collaboration:** ICS and satellite site working enables more coordinated, system-wide action and shared benefits.

Patient feedback

In 2022, we engaged local communities to understand patient views on sustainable healthcare. Two thirds said sustainability should be an NHS priority, with strong support for a range of interventions. For more information, see the Care Without Carbon website.

Together To Zero: working across our system

At QVH, we recognise the value in partnership working. In line with this, we have been working with Care Without Carbon (CWC) to co-develop our sustainability programmes. **CWC are a multi-faceted team of sustainability experts and are now leading the way in the delivery of sustainable healthcare with NHS partners across the south-east.**

By working together in this way, we can:

- Maximise the impact of limited resource;
- Share learning, and the specialist expertise of our team; avoiding duplication;
- Deliver joint projects; bringing impact and efficiencies of scale;
- Use our influence to effect greater change;
- Show strength and leadership in the sector by setting joint commitments - and delivering on them;
- Communicate as one voice on sustainability to our patient community.

This strategy is aligned with our system-wide Green Plan in Sussex, Together to Zero (see Technical Appendix 6 for more info). Through partnership working we can drive the sustainability agenda more effectively within QVH and across the health and care system. For example:

- **Together to Zero staff engagement campaign:** delivered across all Sussex NHS trusts.
- **Low Carbon Skills Fund:** enabled delivery over 50 Heat Decarbonisation Plans across the Sussex estate including QVH sites.
- **Shared tools and processes:** supporting integration of sustainability into decision making through development of a user-friendly online Sustainable Healthcare Impact Assessment (SHIA) tool.

Reduced our carbon footprint by

500 tonnes CO_2e

A reduction of over 500tCO_2e.

N_2O

Cut our nitrous oxide emissions by

73%

Nitrous oxide piped supply decommissioned to eliminate wastage and leaks, cutting related emissions.

Saved

2.2 tonnes CO_2e

Replaced single-use anaesthetic trays with reusables, saving 2.2 tonnes CO_2e and 188,000 litres of water annually.

Appointments that are now virtual

25%

Improving access and reducing patient travel across Kent, Surrey and Sussex.

5 years of progress

Since our baseline year of 2019-20 we have...

cutting energy demand by around

70%

Installed energy-efficient LEDs across key areas, reducing emissions, and improving the workspace.

reduced in-person referrals by

90%

Introduced a Digital breathlessness pathway (Bleepa), enabling faster triage and lower travel-related emissions.

Bringing care closer to patients at

13 Spoke sites

Introduced our Hub-and-spoke outreach model to develop diagnostics and elective care across 13 spoke sites, **reducing patient travel and pressure on the main hospital.**

Reduced single-use PPE spend by

75%

(2020/21–2023/24) through smarter stock management and exploring reusable alternatives.

The data

Delivering care to our patients relies on significant use of natural resources, from surgery and medicines to staff and patient travel, and the energy and water used in our buildings. These activities contribute to our carbon footprint and wider pollution impacts.

We are working towards two key targets for carbon reduction set against a 1990 baseline, in line with the Health and Social Care Act requirements:

- **Net Zero by 2040** for the emissions the NHS controls directly (the NHS Carbon Footprint), with an 80% reduction by 2028 to 2032.
- **Net Zero by 2045** for the emissions the NHS can influence (the NHS Carbon Footprint Plus), with an ambition to reach an 80% reduction by 2036 to 2039.

Accurate measurement of our carbon footprint is essential to understanding where to prioritise action and how best to deliver our Green Plan within available resources.

For detailed information on how our carbon footprint is calculated, see Technical Appendix 1.

Our current environmental impact

In 24/25, in delivering specialist healthcare to patients from a wide geographical area at QVH:

Our estimated NHS Carbon Footprint Plus (direct + indirect emissions) was

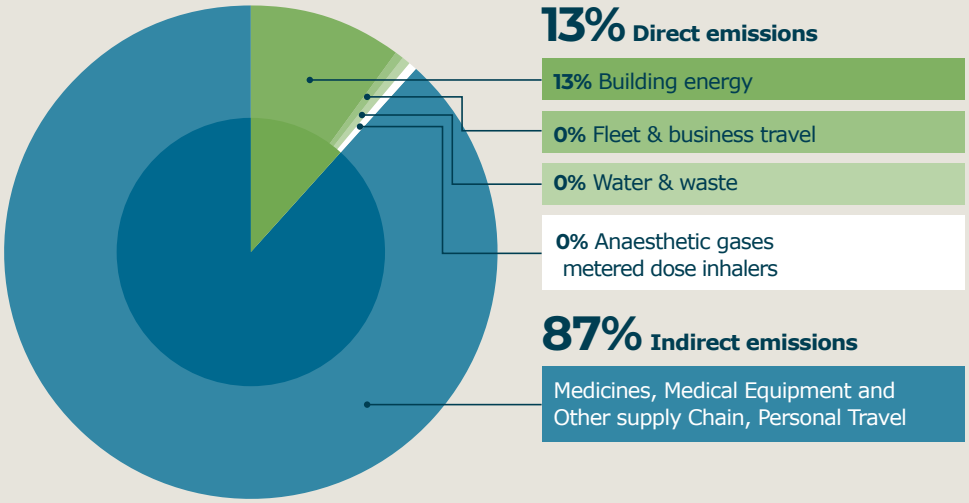
18,000 tCO_2e

9.75 million kWh
units of electricity/gas used.

410 tonnes
of waste produced.

67,000 miles
travelled.

Figure 2: Queen Victoria Hospital NHS Foundation Trust - estimated NHS Carbon Footprint Plus 2024/25



Our NHS Carbon Footprint:

These include energy and water use in our healthcare buildings, clinical waste, and travel for work and to patient homes. Together, these account for around 13% of our total carbon emissions.

Our estimated NHS Carbon Footprint Plus:

Around 87% of our impact comes from indirect emissions outside our direct control, including medicines, medical equipment, patient and visitor travel, supply chains and food. While harder to measure, these emissions are critical to achieving our Net Zero goal.

Net Zero: Our progress to date

NHS Carbon Footprint (direct emissions)

We've made significant progress since our 2022 Green Plan, with a particular focus on eliminating desflurane, cutting nitrous oxide emissions and streamlining our clinical processes. Improvements across our estate, however, remain extremely challenging. Our new Community Diagnostic Centre (CDC) currently being built will be low-carbon with high energy efficiency, however, the remainder of our site is made up of numerous ageing, inefficient buildings that are at, or beyond, end of life. These facilities are unsuitable for meaningful refurbishment or retrofit to the insulation and thermal performance standards required to support low-carbon heating. As a result, improvements to date have necessarily focused on essential safety and repair works, constrained by very limited internal capital.

Our progress towards our NHS Carbon Footprint targets is shown in Figure 3.

Since our baseline year of 2019/20, we've seen a reduction of 17% in our carbon footprint

Although we are required to measure our carbon emissions in absolute terms, in reality our level of service delivery has changed considerably since 2019/20. Using staff numbers as an indicator activity level, **our emissions per FTE staff member have decreased by 28% since 2019/20 baseline** – a significant achievement given the scale of frontline and financial pressures we face.

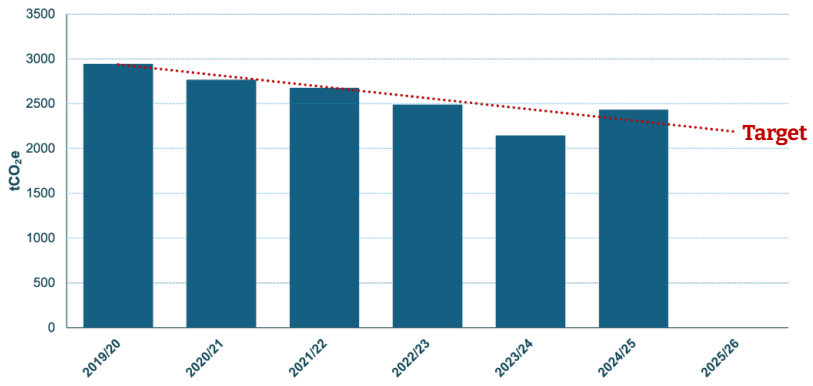
In 2019/20 our direct emissions were just under 3,000 tCO_2e. During the pandemic, emissions dropped across the NHS and at QVH as a result of more agile working and the use of online appointments and services. **This primarily impacted our business mileage, which remains 78% lower than 19/20 levels.**

Emissions associated with the energy used within our buildings have followed a downward trend since 2019, partly due to reduced energy consumption on site and the decarbonisation of the national grid. Data for our spoke sites was not available for this Green Plan.

We expect emissions from electricity and business travel to continue to reduce over the next five years as a result of grid decarbonisation and an increased use of electric vehicles. However, reducing our reliance on fossil fuels (gas) to heat our buildings poses a significant challenge.

Further reductions in gas use will not be possible without major investment. Replacing our current heating systems with heat pumps, alongside the extensive building replacement or deep refurbishment required to make them viable, is far beyond the Trust's current capital capacity. Without significant central or external funding, QVH will be unable to meet key decarbonisation milestones. Understanding the impacts of our 'spoke' sites will be another area of focus for our next phase of work.

Figure 3: Queen Victoria Hospital NHS Foundation Trust NHS Carbon Footprint against Green Plan target trajectory.



* 23/24 data has been checked and verified against all available sources. The reduction remains unexplained and is therefore subject to ongoing review and potential revision.

Sustainable Healthcare in practice: case studies

Streamlining care for breathlessness

Delivering on 'Streamlined processes and pathways'

QVH implemented Bleepa, a secure digital platform, to streamline the breathlessness pathway within the Community Diagnostic Centre. The system connects GPs and QVH clinicians, enabling diagnostic information to be shared and reviewed through asynchronous MDT working, reducing face-to-face appointments and optimising consultant time.

The pilot delivered a 63% reduction in referral -to-treatment waiting times, with 90% of referrals managed without an in-person specialist appointment. The model has since expanded to the non-specific symptoms pathway and won the Most Effective Contribution to Clinical Redesign Award at the HSJ Partnership Awards 2025.

The benefits

Patients receiving equitable access to care and early treatment, and staff travel time saved.

Reducing travel pollution from optimising patient appointment.

Reducing costs from consultant time and patient travel costs from streamlined pathway.

Green Spaces for Health

Delivering on 'Respecting Resources'

QVH adopted **WALANT (Wide Awake Local Anaesthetic No Tourniquet)** for hand and wrist surgery, used for procedures including carpal tunnel release, trigger finger, joint replacement and Dupuytren's contracture. The technique uses local anaesthetic instead of general or regional anaesthesia, **removing the need for tourniquets, sedation and operating theatre-based care.**

WALANT procedures can be delivered safely in clinics or community settings, increasing flexibility in where care is provided. This has **reduced waiting lists, freed theatre capacity and enabled treatment closer to home. Patients recover more quickly and avoid the risks associated with general anaesthesia.**

The benefits

Improved patient experience with no tourniquet or sedation.

Reduced use of anaesthetic drugs and operating theatres, lowering carbon impact.

Fewer hospital visits and shorter stays, reducing travel and pressure on NHS resources.

Bone density scanning to prevent fractures

Delivering on 'Healthier Lives' '

QVH introduced a **dual energy X-ray absorptiometry (DEXA) scanner** to support early diagnosis of bone-weakening conditions such as osteopenia and osteoporosis. The quick, painless scan accurately assesses bone strength, helping clinicians identify patients at risk of fractures.

Early diagnosis enables timely intervention, lifestyle advice and monitoring, reducing fractures from minor falls or everyday incidents. The scanner is part of QVH's **Community Diagnostic Programme,** increasing local capacity during a national shortage and improving access for patients across Kent, Surrey and Sussex.

The benefits

Early identification and management **reduces the risk of life-changing fractures.**

Scans delivered closer to home **reduce patient travel and associated carbon emissions.**

Preventing fractures avoids hospital admissions, inpatient stays and pressure on NHS resources.

Care Without Carbon framework

This Green Plan is based on our Care Without Carbon framework.

We spark change in healthcare; collaborating to protect health, our environment and create lasting value for our NHS.

To be a centre of excellence that rebuilds lives and supports communities for a healthier future.

Our Key Strategic Objectives:

- To deliver outstanding care.
- To innovate and improve.
- To be an excellent employer.
- To deliver sustainable services.
- To collaborate with others.

Our Green Plan aims

1. **Reduce our emissions** to Net Zero Carbon by 2040/45.
2. **Adapt our services and buildings** to the impacts of climate change.
3. **Address the environmental targets** within the Environment Act 2021.

Sustainable Healthcare Principles

Healthier lives
Making use of every opportunity to help people to be well, to minimise preventable ill-health, health inequalities and unnecessary treatment, and to support independence and wellbeing.

Streamlined processes and pathways
Minimising waste and duplication within the Trust and wider health system to ensure delivery of safe and effective care.

Respecting resources
Where resources are required, prioritising use of treatments, products, technologies, processes and pathways with lower carbon, environmental and health impacts.

We deliver this using our 7 elements

- Sustainable Clinical Practice
- Partnerships & Collaboration
- Places
- Culture
- Journeys
- Circular Economy
- Climate Resilience

Our refreshed approach

Sustainability is essential to delivering safe, high-quality care that protects both people and the planet. We know from national and global evidence that the next five years are critical for safeguarding health in a changing climate – **and we're feeling the impacts already at QVH.** At the same time, QVH is facing a period of significant operational and financial uncertainty, with increasing pressures across our specialist services and a very challenging estate that limits flexibility for improvement. Despite this, there is **real passion across the Trust, with staff-led innovation already helping to reduce waste and improve patient experience.** Our first Green Plan was launched in 2022. Since then, we have focused on embedding sustainability within our Strategy 2025–2030, eliminating harmful desflurane and improving energy efficiency.

Estates upgrades

Delivery of this Green Plan is **dependent on the upgrade of our ageing estate at QVH.** As such, a key focus for this Green Plan is not only to centralise our boilers, but also to work with our system partners and Department for Health and Social Care to tackle our ageing estate more broadly. In particular, putting a plan in place to upgrade current facilities to ensure they are fit for purpose, providing safe, high quality, low carbon patient care that is resilient to the impacts of climate change.

Using data to drive our decisions

Our refreshed approach is evidence-led and clinically informed. We have listened to staff; reviewed available data on our energy, waste, travel, and medical gases and identified data gaps; and aligned our priorities with national guidance and regulatory expectations. Improving our data and reporting will be a key aspect of this phase of Green Plan delivery, ensuring we are prioritising our resource use appropriately. Details of our prioritisation process are set out in Technical Appendix 5.

Clinical focus and integration

Our refreshed Green Plan strengthens our ambition to deliver sustainable, resilient, and high-quality specialist care. It makes sustainability more visible across all clinical areas of our work – from theatres and outpatient services to digital care and research. **By integrating sustainability into everyday clinical decisions, continuous improvement work and governance,** we can make our services more efficient, improve staff wellbeing, and enhance patient outcomes.

Collaboration

Delivering our goals will require **renewed focus on collaboration** – both within QVH and across the wider health system. Our plan builds on the Care Without Carbon (CWC) framework and aligns with our ICS Green Plan, Together to Zero (see Technical Appendix 4).

Through shared expertise and co-developed projects, we can build on what has worked well, expand innovation within our specialist services, and ensure QVH continues to contribute actively to system-wide Net Zero and resilience goals.

Roadmap to Net Zero

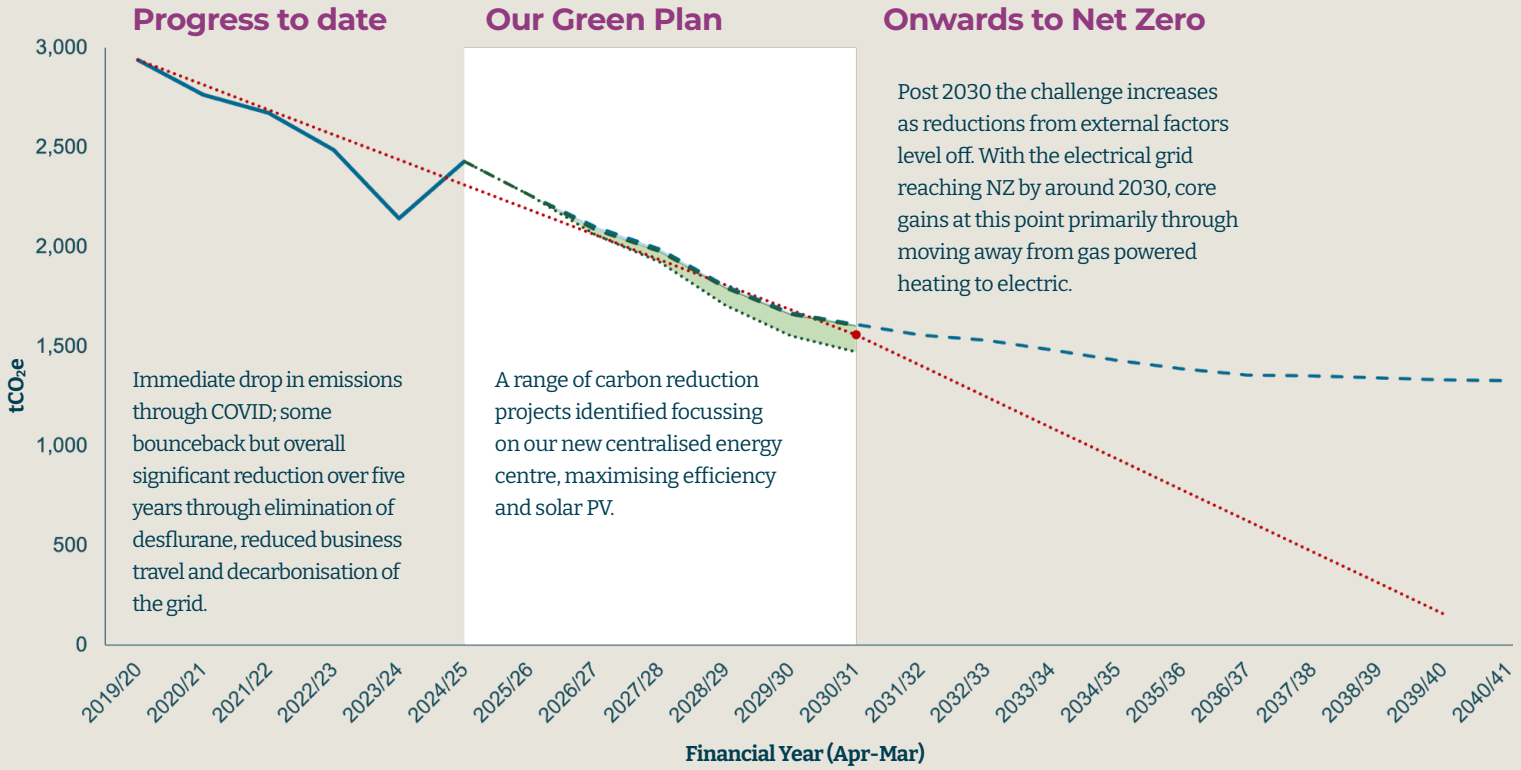
The next five years to 2030

Net Zero Roadmap: NHS Carbon Footprint
(direct emissions only)

Target: Net Zero by 2040

Our Net Zero Roadmap, set out in Figure 4, has been developed to meet our **interim target to reduce emissions by at least 47% by 2028-2032** from our baseline year of 2019/20, in line with the national commitment to Net Zero by 2040.

Between 2024/25 and 2030/31 we need to reduce our carbon emissions by 870 tCO_2e to meet this interim target. This target is ambitious, but deliverable based on the projects identified within our Delivery Plan. It will require tackling our significantly challenged estate to support our direct emissions reductions at the same time as increasing our focus on integrating into clinical practice with a particular focus on projects which deliver co-benefits, supporting patient outcomes, staff wellbeing or cost improvement. For more information about how we have developed our NZ Roadmap see Technical Appendix 2.



External factors include the carbon savings expected from factors outside of our control. This includes grid decarbonisation and the national transition to EVs.

External factors

Confirmed projects include projects recently completed but not yet captured as part of the Trust's annual carbon footprint reporting, or projects which are in progress.

Confirmed projects

Confirmed projects

Potential projects have been allocated a risk level, with high-risk carbon reduction projects including those which are reliant on external funding e.g. from an equivalent of the now terminated PSDS funding.

Low risk potential projects

Medium risk potential projects

High risk potential projects

Delivery Plan projects

The table to the right sets out the priority projects identified at this stage to support delivery of our Green Plan.

The Trust recognises that delivery of the confirmed projects alone will not be sufficient to meet our Net Zero targets. Achieving these targets will require the continued development and implementation of additional initiatives across both clinical and corporate functions. This includes further action in areas such as procurement and supply chains, medicines optimisation, virtualisation of clinical pathways, reducing avoidable attendances, and adopting proven best practice from elsewhere in the NHS and wider system.

As set out in the workstream sections (pages 33–48), this Green Plan establishes the frameworks, principles and priority areas through which further initiatives will be identified, prioritised and delivered over time. The programme will therefore continue to evolve, responding to emerging evidence, national guidance and opportunities to maximise carbon reduction while supporting high-quality, efficient patient care.

Figure 5: Delivery Plan projects

TOTAL SAVINGS TO MEET: 2032/33 TARGET: 870 tCO_2e | 2030/31 STRETCH TARGET: 1,769 tCO_2e		
Carbon reduction project	**Workstream**	**Carbon Savings (tCO_2e)**
Expected savings from external factors: including grid decarbonisation and national EV transition		**819**
Confirmed projects		
LED Lighting fit out across the site	Places	6
TOTAL confirmed carbon reduction projects		**6**
Potential projects		
New, Centralised Energy Centre, modernised pipework, insulation and controls	Places	121
New Car Park with Solar PV	Places	6
Transition Fleet Vehicles to Zero Emission	Journeys	4
TOTAL potential carbon reduction projects		**131**

Confirmed projects | Low risk potential projects | Medium risk potential projects | High risk potential projects

Dependencies and assumptions underpinning the Roadmap to Net Zero

The emissions reduction pathway in this Green Plan focuses on improving estate energy efficiency, reflecting what is realistically achievable over the next five years within the current national policy and funding landscape. Interim targets are expected to be met primarily through installation of a new centralised energy centre, continued decarbonisation of the national electricity grid, and delivery of smaller-scale local carbon reduction projects. Further decarbonisation of heating systems is more complex and dependent on significant capital investment and national funding. Over the next five years, the Trust will pursue external funding opportunities through system partners, local authorities and private partnerships, in line with NHS guidance. However, national and regional partners indicate that funding for large-scale heat decarbonisation projects is unlikely to be available at the scale required within this Green Plan period.

While this Plan sets out a credible pathway to achieving interim targets, longer-term progress depends on clarity regarding the future of the main hospital site and greater national policy and capital investment. These constraints are common across the NHS and sit outside the Trust's direct control. The Trust will continue to monitor policy and funding developments and refresh its Net Zero Roadmap as the external landscape evolves.

Net Zero Roadmap: NHS Carbon Footprint Plus

Target: Net Zero by 2045

NHS Carbon Footprint Plus accounts for our indirect emissions. This includes emissions from medicines, medical equipment, patient and visitor travel, supply chain etc.

Indirect emissions make up an estimated 87% of our total footprint and as such will be a key area of focus over the next five years. **The indirect emissions associated with our NHS Carbon Footprint Plus – 16,000 tCO_2e** - is the equivalent of a passenger flying from London to New York every day for 55 years.

The chart in figure X shows our estimated NHS Carbon Footprint Plus over the last five years, along with the trajectory required to meet our Net Zero target in 2045/46 and a breakdown of emissions sources. This is based on data for the NHS as a whole from the recently published "Five years of a greener NHS: progress and forward look" (see Appendices 1 and 2 for more detail on methodology).

The graph shows a considerable fluctuation over the last five years, with a significant increase in procurement during the pandemic, returning to pre-pandemic levels by 2024/25.

NHS Carbon Footprint Plus Strategy and Delivery Plan

Reducing our NHS Carbon Footprint Plus emissions will be a key focus for this Green Plan.

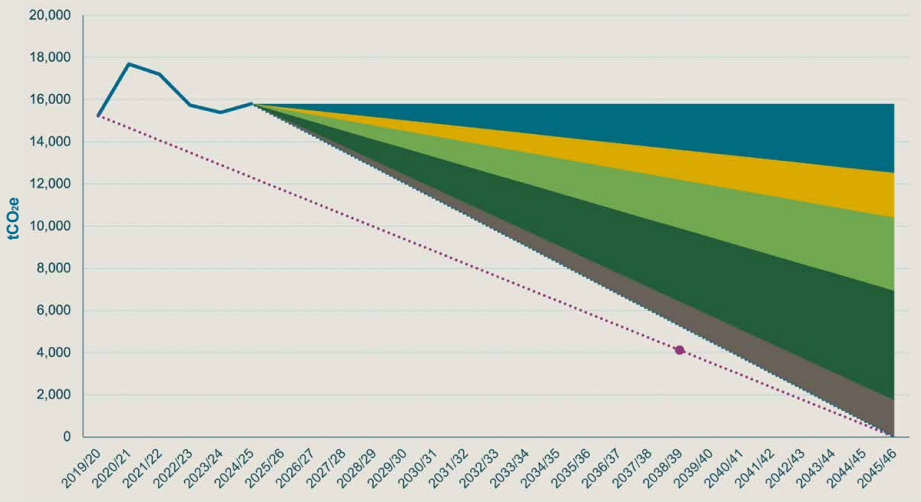
We know from our initial data analysis and research that some of the key areas we will need to focus on are:

- Clinical consumables – reducing waste and switching to reusables
- IT Hardware
- Staff and patient travel
- Food

Projects in these areas have been incorporated into our Sustainable Clinical Practice, Circular Economy and Journeys workstreams.

In order to support a greater level of details for our indirect emissions, **we are currently developing a NHS Carbon Footprint Plus Strategy and Delivery Plan.** This will more accurately measure our impact, set detailed interim targets and identify the key projects required to deliver over the next five years to 2030.

Figure 6: Queen Victoria Hospital NHS Foundation Trust Net Zero Carbon Roadmap to 2045: NHS Carbon Footprint Plus.



Estimated emissions

Target

Interim target

Revised trajectory to Net Zero

Medicines and prescribing	**21%**
Personal travel	**13%**
Staff commute	6%
Patient travel	6%
Visitor travel	1%
Medical supply chain	**22%**
Clinical consumables	12%
Clinical equipment	10%
Other supply chain	**33%**
Physical and digital infrastructure	12%
Other supplies and services	9%
Equipment	6%
Food and catering	4%
Corporate and administrative services	2%
Non-NHS commissioned services	**11%**
Voluntary and independent organisations	6%
Personal and continuing care	5%

Where we'll put our focus

As outlined in our CWC framework, the three core aims of this Green Plan are to:

- **Reduce** our emissions to Net Zero Carbon by 2040/45
- **Adapt** our services and buildings to the impacts of climate change
- **Address** the targets within the Environment Act 2021

We'll deliver on these – and support QVH Key Strategic Objectives – through our objectives and key priorities set out here.

To innovate and improve

To be an excellent employee

To collaborate with others

To deliver outstanding care

Deliver clinical services that are more sustainable

We will continue to **develop clinical sustainability leadership,** re-establishing and re-invigorating working groups and supporting governance/reporting and further **target reductions in medical gases** (Anaesthetics).

We will prioritise clinical teams with highest carbon impact to support **sustainability integration including theatres, pharmacy, critical care pathways, and virtual care pathway**s in the first instance.

Enhance the efficient and responsible use of our NHS estate

We will deliver our **Net Zero Roadmap** estates projects. Given the challenge of our ageing estate, this will focus on centralising our boilers, exploring new options for external funding and better understanding the impact of our 'spoke' sites.

For travel we will develop a **Sustainable Travel Plan** supporting improved air quality, vehicle electrification and reducing emissions from our staff and patient travel.

Implement practices that minimise waste, optimise reuse, and reduce our indirect emissions

We will target a reduction in single-use medical equipment and consumables over the next 3-5 years.

We will build capacity, tools and resources for sustainability within procurement teams to enable integration of sustainability into high impact procurements.

We will enhance food and catering approach and menus to reduce waste, cut indirect emissions and improve health.

Adapt to the impacts of climate change, enhancing resilience and well-being

We will develop a Trust level **Climate Risk & Vulnerability Assessment** to identify risks and help us build infrastructure and service climate resilience.

Embed sustainability principles into our day-to-day practices and decision making at QVH

We will integrate sustainability into trust decision making processes and **Continuous Improvement (CI)** programme with support of our Sustainable Healthcare Impact Assessment tool. This will include **The QVH Way, digital transformation programmes** and **capital planning processes.**

We will **engage with staff** (Board to frontline) and develop workforce capability with a focus on staff supporting high priority Green Plan activity.

Maintain focus on partnership working to support trust benefits

We will continue to **work in partnership with others locally through Care Without Carbon** to find collaborative solutions, economies of scale and share best practice

The seven elements: targeting action for optimum results

Delivery of our Green Plan is split across seven workstreams – or 'elements'.

Our elements have evolved over time and are aligned with the Greener NHS areas of work. They support appropriate allocation of work and resources and keep track of progress, ensuring we maintain the integrated and holistic approach required to reach Net Zero care by 2040.

The following pages set out a more detailed outline of each element, including key commitments, targets, and project areas over the coming five years.

Each element is directly aligned to delivery of the core aims and objectives of this Green Plan. See Technical Appendix 5 for further detail on how we have developed this.

Our seven elements are:

Sustainable Clinical Practice: Transforming clinical care to support health, reduce inequalities, and protect our shared environment.

Circular Economy: Respecting our health and natural resources by creating an ethical, resilient and circular supply chain.

Places: Ensuring our places are low carbon and protect local biodiversity whilst supporting wellbeing for staff, patients and visitors.

Journeys: Connecting care and communities through travel that is low carbon, cost-effective and conducive to good health and wellbeing.

Partnership & Collaboration: Optimising delivery and enhancing our impact through collaboration.

Culture: Empowering staff to deliver more sustainable healthcare and improve health outcomes.

Climate Resilience: Strengthening resilience to our changing climate in Sussex.

Areas for action:
Sustainable Clinical Practice

Transforming clinical care to support health, reduce inequalities, and protect our shared environment.

Commitments:

- **We will reduce the pollution and environmental impact associated with the care we provide, integrating sustainability into the way our services are designed and delivered.**
- **We will support our clinicians to apply our sustainable healthcare principles, enabling sustainable choices that are good for patients and our shared environment.**

Our approach:

With ~80% of our carbon footprint determined by clinical decisions, it's critical we deliver care in the most sustainable way possible. This element explicitly supports this, aiming to integrate sustainability into the fabric of the organisation through clinical services; to support health, target inequalities, and reduce impact on the environment.

As a specialist centre and leading centre for reconstructive surgery and rehabilitation, our priority areas are switching to reusables from single-use items particularly in our operating theatres, eliminating medicines wastage (including anaesthetic gases), and finding alternatives to travel (patients and staff) particularly where we provide regional and national services.

Our approach to tackling these areas is:

- **Integration:** Integrating sustainable healthcare principles into clinical projects, governance and change processes and ensuring ongoing clinical leadership.
- **High impact projects:** Maximise impact by delivering projects supporting pollution-reduction and more sustainable healthcare in priority areas.
- **Engagement, support and training for clinical staff:** Providing dedicated clinical sustainability support for teams.
- **Progressively strengthening our approach:** Ensuring interventions are as effective as possible by maintaining our understanding of key impact areas and continuously evolving our approach in line with new and emerging evidence.

Key targets:

- **Maintain our current reduction of medical gas pollution (75%) and reduce further nitrous oxide use or wastage by 2030/31 (compared to 2019/20 baseline).**
- **Where appropriate, meet the national NHS target of delivering at least 25% of outpatient appointments remotely, with a focus on supporting patients who travel further to reach us.**
- **By the end of 2026/27, identify our priority single-use items and set up processes to switch these to reusable alternatives.**

Key areas of work:

Integration into clinical processes:

Sustainable Healthcare Impact Assessment (SHIA): Use our local SHIA tool and sustainability metrics to integrate sustainability principles into key Trust projects (e.g. Electronic Patient Record).

Health Inequalities Strategy: Identify the main sustainability risks and opportunities of our health inequalities work, and develop a sustainability metric to support delivery of our Green Plan.

Health promoting hospital: Integrate sustainable healthcare principles into our work on developing a health promoting culture, and measure the sustainability benefits, particularly in priority areas.

High impact projects:

Anaesthetic gases: Continue to work with clinical services to reduce nitrous oxide waste and pollution. Review the use of anaesthetic gases in operating theatres to identify further opportunities to reduce waste and switch to alternatives (e.g. total intravenous anaesthesia).

Reusable clinical consumables and equipment: Identify priority single-use items to switch to reusable alternatives, working towards a reusable by default approach.

Medicines: Implement a programme to reduce medicines waste, eliminating unnecessary environmental and financial costs. Encourage more sustainable prescribing in high-impact areas (e.g. low-carbon inhalers, green social prescribing, oral nutritional supplements, anti-microbials). This should include developing a target to meet the medicines aspect of our NZCF+ trajectory.

Clinical Travel: Recognising we're a specialist centre for the region and nationally, develop our programme to optimise remote outpatient appointments to reduce patient and staff travel burden, and measure the sustainability impact. This will support the shift from analogue to digital, reduce air pollution, and improve wellbeing.

Sustainable food: Continue to improve access to healthy food for patients (e.g. more plant-based options) to support their nutrition and recovery (years 2-5).

Green spaces: Review opportunities for nature-based care projects that improve patient rehabilitation and recovery, (years 2-5).

Engagement, support and training

Support for clinical staff projects: Provide practical support for staff through toolkits, specialist guidance (e.g. Royal College of Anaesthetists Sustainability Resources) and hosting staff drop-in sessions.

Clinical sustainability networks: Building on our improvements in perioperative care, encourage peer-to-peer support for sustainability across clinical networks (years 2-5).

Clinical capacity: Identify key roles and responsibilities within clinical departments that support delivery in priority areas with protected capacity e.g. champion for re-use (years 2-5).

Progressively strengthening our approach:

Governance: Through our Clinical Lead for Sustainability and Clinical working group, prioritise teams to work with each year.

Developing our in-house knowledge: Continue to use and learn from specialist sustainability guidance on treating the conditions our patients (e.g. Green Theatre Checklist).

Carbon Footprint Plus Delivery Plan: Engage with key clinical stakeholders to agree approach and targets for medicines, switching to reusables, reducing travel burdens on patients, and other aspects of our indirect emissions (NHS Carbon Footprint Plus).

Areas for action:
Circular economy

Respecting our health and natural resources by creating an ethical, resilient and circular supply chain.

Commitments:

- **We will work closely with our suppliers to significantly reduce the environmental impact of our supply chain, ensure resilience and improve the health and wellbeing of the people and communities supporting it.**
- **We will keep products and materials useful for longer by creating circular systems of reuse, repair and recycling; whilst reducing waste.**

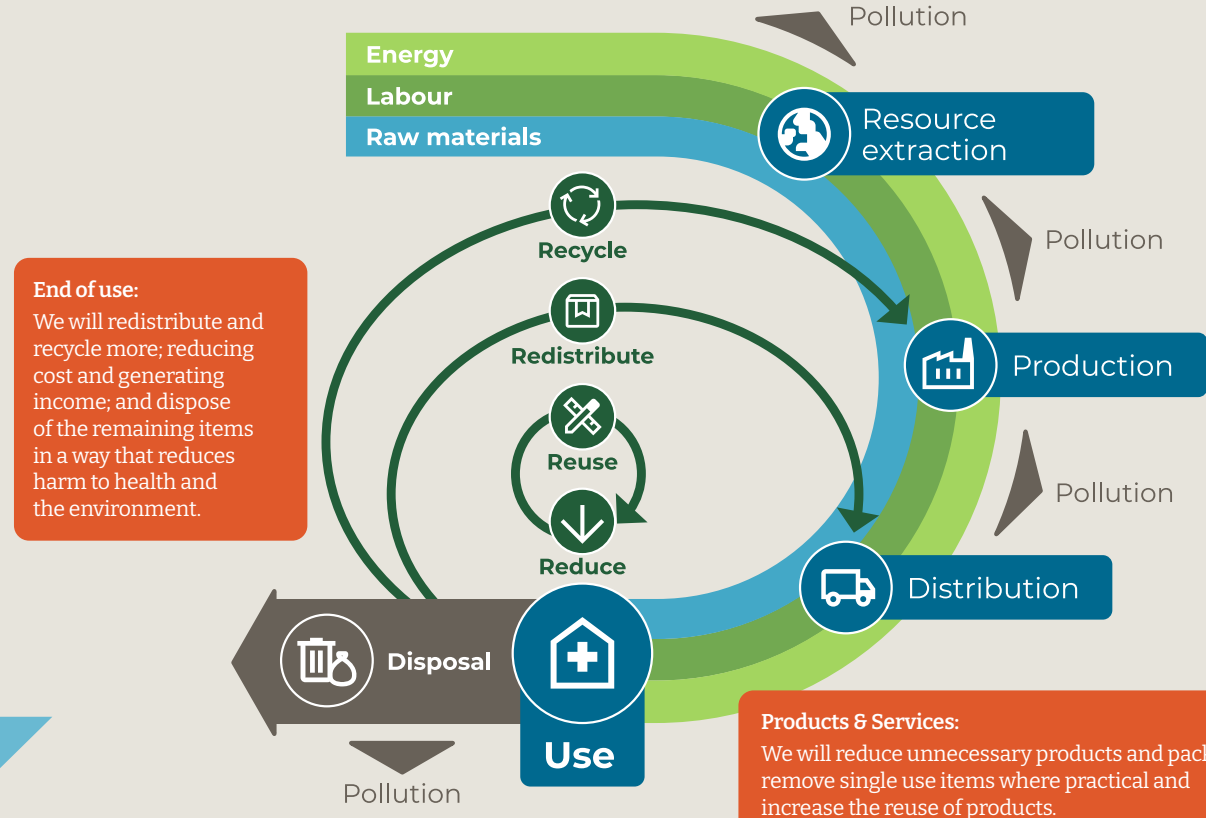
Our approach:

Our use of products and services to provide healthcare contributes to the largest part of our carbon emissions and impacts the health of workers, their communities and nature.

To avoid pollution, protect nature and improve health, we will keep products and materials useful for longer by creating circular systems of reuse, repair and recycling.

We will work with our suppliers and collaborate with other healthcare providers to create a net zero carbon, resilient and reliable supply chain that reduces costs and adds value to our patients and communities.

Purchasing & Supply Chains:
We will reduce pollution from our supply chains and assess the risk of climate, health and nature impacts from the products and services we use.



End of use:
We will redistribute and recycle more; reducing cost and generating income; and dispose of the remaining items in a way that reduces harm to health and the environment.

Products & Services:
We will reduce unnecessary products and packaging, remove single use items where practical and increase the reuse of products.

Key targets:

- **Develop SMART targets for each of our priority supply chain categories before 2027 in line with the Health & Social Care Act and Net Zero Carbon Footprint Plus trajectory.**
- **Full compliance with the requirements of the Net Zero Supplier Roadmap, including the Net Zero and Social Value Model.**
- **47% reduction in emissions related to our waste by 2030/31 from a 2019/20 baseline.**

Key areas of work:

Product level projects:

Net Zero Carbon Footprint Plus (Net Zero CF+) Delivery Plan: Based on our ICS Net Zero CF+ Strategy, produce a Delivery Plan to achieve our Net Zero CF+ targets, including identifying and setting targets for priority product areas for pollution reduction (e.g. Medical Devices).

Consumables – reduce and reuse: Work with other healthcare providers to develop and deliver an approach for switching to re-usable items to cut cost and pollution.

Sustainable food: Measure our sources of food waste in line with NHS standards, set targets and implement interventions to reduce waste, costs and pollution. Introduce more healthy food options (e.g. by providing more plant-based options), developing plans to adopt a "greener by default" approach to catering whilst contributing to improved patient health and recovery (years 2-5).

Digital hardware: Reduce the pollution associated with our digital hardware by extending the product lifespan of our assets, considering refurbished kit and improving our digital maturity assessment score (years 2-5).

End of use:

Healthcare waste segregation: Continue to work with Infection, Prevention and Control and clinical staff to monitor and improve our healthcare waste segregation through a programme of training, signage and staff engagement. Maintain the 60% Offensive, 20% Infectious and 20% High temperature incineration ratio for healthcare wastes in line with the NHS clinical waste strategy.

Waste disposal: Develop our approach to waste management to ensure we meet our three key waste targets: total waste reduction of 20% by 2030/31, zero waste to landfill for all waste streams, and 65% recycling rate before 2030/31.

Re-use platforms: Work with local partners to improve the reuse of unwanted furniture, equipment or supplies both internally and within Sussex, for example through digital re-use platforms (years 2-5).

New recycling streams: We will review opportunity for formalised reuse or recycling of high-volume items such as textiles and mattresses through innovation and external partnerships (years 2-5).

Purchasing and supply chains:

Procurement policy and key contracts: Update procurement processes and policies to align with the NHS Net Zero Supplier Roadmap and Net Zero & Social Value requirements. Focus delivery support on priority contracts and procurements that support our Net Zero CF+ Delivery Plan projects (see below).

Training: Upskill our procurement teams (and suppliers) with regional and national resources, webinars and procurement forums to ensure adherence to the Net Zero supplier roadmap; effectively manage sustainability KPIs through contracts; and include consideration of climate and nature-related risks and opportunities (years 2-5).

Tools and guidance: Expand our use of available tools and guidance such as Evergreen framework, product savings calculator, and social value playbook (years 2-5).

Supply chain risk: Through the Climate Resilience workstream we will assess and develop a plan to mitigate the most significant supply chain risks from the climate change and the degradation of natural systems (years 2-5).

Areas for action:
Places

Ensuring our places are low carbon, resilient and protect local biodiversity whilst supporting wellbeing for staff, patients and visitors.

Commitments:

- **We will minimise energy and water consumption across our estate.**
- **We will cut our carbon emissions in line with the national NHS Net Zero Carbon targets.**
- **We will improve our green spaces, so they are better able to support patient and staff wellbeing through resilience, nature connection and biodiversity.**

Our approach:

About Places

Improving our estate is key to delivery of our Green Plan aims. Emissions from electricity, gas and water used in our buildings make up 96% of our direct emissions; and our estate also provides an opportunity to support wellbeing through our green spaces. Delivering on this is, however, a significant challenge. Many of our buildings are in need of replacement or upgrade, and are lacking resilience to climate impacts such as heatwaves.

Our approach within this workstream is as follows:

- **Efficient use of our estate:** Minimising the energy we consume in our buildings; making use of more energy-efficient equipment.
- **Heat decarbonisation:** Transitioning from stand-alone, fossil-fuel based heating systems to a centralised, hybrid energy centre. Aim to reduce heat demand through improved building insulation and glazing wherever upgrades are required.
- **Renewables:** Installing on-site renewables as part of new construction works or car parks to generate energy for use within our buildings.
- **Biodiversity:** Improving quality and access to outdoor spaces to support biodiversity net-gain and improve wellbeing.

A key enabler for this workstream will be our **centralised energy centre project** delivering a more resilient, lower carbon heating system that will prepare the site for future new decarbonisation technologies.

Key targets:

- **47% Reduction in emissions from our estate by 2030/31, against a 2019/20 baseline.**
- **Increase the proportion of our electricity generated on site from renewable sources by 2030/31.**
- **Increase biodiversity and improve access to green spaces at each of our freehold sites by implementing at least 1 intervention annually until 2030/31.**

Key areas of work:

Planning and delivery

Sustainable estates planning: Embed sustainability and climate resilience principles into planning for the future of our estate; delivery of the major works required will enable delivery of our Net Zero targets.

Net Zero Carbon Building Standard: Ensure all future new developments and major refurbishments, including the new CDC building, comply with the NHS Net Zero Building Standard. New builds must also achieve a minimum BREEAM rating of 'Excellent' and major refurbishments much achieve a minimum of 'Very Good'.

Centralised Energy Centre: As the key project required to maintain patient safety and deliver on our interim Green Plan targets, continue to progress this including seeking central funding to ensure deliverability.

Net Zero Roadmap Delivery Plan projects: Work with capital projects to further develop our Delivery Plan projects in line with wider estates planning, and integrate into the trust capital programme each year.

Project pipeline: Work with capital projects to maintain a live pipeline of sustainability-focused, shovel-ready projects (with business cases developed) to enable rapid response to in-year funding or partnership opportunities.

Integrate sustainability into capital projects and business cases: Apply sustainability and climate resilience assessments (e.g. SHIA or equivalent) to all capital projects and wider E&F business cases, maximising opportunities for carbon reduction, nature recovery, and adaptation.

Efficient use of our estate

Energy and water performance reporting: Strengthen measurement and monitoring of energy and water consumption including understanding the fluctuation in our last two years of gas data, and improving understanding of energy use at our 'spoke sites'. Establishing regular performance reporting and ensure emissions savings from carbon reduction projects are accurately measured.

Water efficiency: Identify applicable water-saving technologies and review water metering to reduce consumption, leakage, and associated emissions (years 2-5).

Heat decarbonisation and renewables

Low Carbon Heating: With a focus on centralising our boilers in this first phase of work, continue to explore opportunities for the decarbonisation our gas-fired heating systems as part of all future works.

Renewable energy generation: Continue to identify and deliver opportunities for on-site renewable generation, including emerging technologies. Explore integration of battery storage and smart controls to maximise impact and enhance resilience.

Local energy collaboration: Work with local partners to explore alignment with Local Area Energy Plans as opportunities arise and the potential to connect to district or communal low carbon heat networks (years 2-5).

Biodiversity and green spaces

Green spaces and tree establishment: Review our approach to green spaces and tree establishment; develop a programme to develop this to promote patient and staff wellbeing, biodiversity and climate resilience. This should include a baseline site biodiversity survey and alignment with Local Nature Recovery Strategies.

Grounds management: Adopt sustainable grounds management practices that enhance biodiversity and reduce environmental impact, including supporting quick win biodiversity interventions e.g. planters, bird boxes.

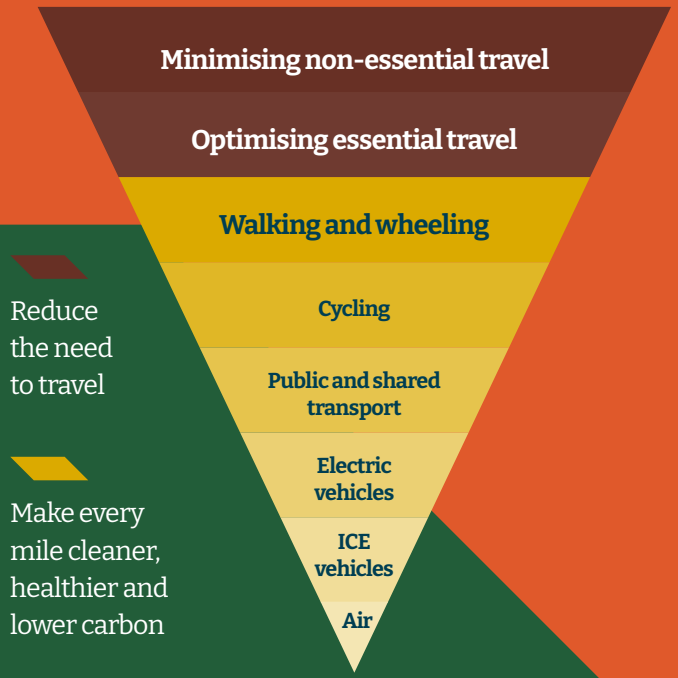
Areas for action: Journeys

Ensuring the transport and travel that connects our care and our communities is low carbon, cost-effective, inclusive, and conducive to good health and wellbeing.

Commitments:

- **We will design our services to minimise unnecessary travel for staff, patients and visitors, making access to care simpler, fairer and more sustainable.**
- **We will transition to a Zero-emission fleet and enable low-carbon travel choices, cutting pollution, improving health and reducing costs.**
- **We will work with our partners, staff and communities to embrace digital, active and shared travel solutions that deliver wider health and sustainability benefits.**

Our approach:



As a specialist hub, patients often have to travel significant distances to receive care – and we increasingly deliver care within our communities and in patients' homes. As a result, travel is an important source of emissions and local air pollution that directly affects the health of the people we care for. Reducing these emissions presents a significant opportunity for change, improving both environmental and population health outcomes.

Our practical, people-centred approach will make travel cleaner, fairer and more accessible for staff, patients and visitors. We will ensure sustainable travel options remain inclusive and affordable, avoiding financial or practical barriers to care or employment. As such, our three priority areas are:

- **Optimise essential travel:** Embed digital care and redesign pathways .
- **Minimise non-essential travel:** Support smarter working through hybrid and remote collaboration.
- **Make every mile cleaner, healthier and lower carbon:** Enable low-carbon commuting and business travel, prioritising active, shared and zero-emission modes.

Through this integrated approach, we can reduce travel demand while improving access and experience for patients, staff and visitors. Working with partners across Sussex and Surrey will be essential to align travel improvements with wider NHS, community infrastructure and health priorities, helping to reduce pollution, improve air quality and support healthier, more sustainable communities.

Key targets:

- **47% Reduction in business travel emissions by 2030/31, against a 2019/20 baseline (fleet and business travel).**
- **39% Reduction in staff commute emissions by 2030/31, against a 2019/20 baseline, in line with 2033 NHS Travel and Transport Strategy target of 50%.**
- **100% Zero-emission operational fleet by 2030/31.**

Key areas of work:

Optimise essential travel (digital care and service design):

Access to virtual consultations and tele-medicines: Expand successful virtual consultations programmes, where clinically appropriate, and explore other digital care models to improve patient choice by increasing access to digital care and remote monitoring technology to support earlier intervention and reduce patient and staff travel, carbon and costs.

Optimise clinical travel: Work with high mileage clinical teams to explore smarter ways of working to optimise clinical travel through hub and spoke outreach models, route optimisation and smarter staff scheduling - saving staff time, costs and carbon (years 2-5).

Minimise non-essential travel (smarter working):

Smarter working and collaboration: Support hybrid and remote working where appropriate, providing staff with the tools, training and guidance needed for effective remote collaboration. This should aim to optimise estate use, reduce unnecessary travel and business mileage, and support staff flexibility and wellbeing.

Make every mile cleaner (enable low-carbon commuting and business travel):

Sustainable Travel Plan: Develop a Sustainable Travel Plan by December 2026 aiming to increase the use of active, public and zero emission travel modes. Align our approach with the principles of the Clean Air Hospital Framework to ensure we are reducing the impacts of air pollution on our staff and patients.

Travel survey: Introduce staff travel surveys to help us to better understand travel behaviours, set targets and measure progress more effectively.

EV charging infrastructure: Expand EV charging infrastructure across our occupied sites to enable expansion of zero-emission fleet vehicles, and support staff, patients and visitors to use EVs to travel to sites.

Electrifying the fleet: Maximise the use of electric vehicles for staff travel. This includes transitioning our small fleet of vehicles to 100% Zero-emission and expanding the availability of electric pool cars and e-bikes for staff travel.

Salary-sacrifice scheme: In line with NHSE requirements, offer only zero-emissions vehicles through vehicle salary sacrifice schemes from December 2026.

Patient and visitor travel measurement and targets: Complete the development of our methodology and introduce annual reporting on our patient & visitor travel and integrate into our targets as appropriate (2-5 years).

Areas for action:
Culture

Empowering staff to deliver more sustainable healthcare and improve health outcomes.

Commitments:

- **We will engage with staff to promote a greater understanding of sustainable healthcare and support development of skills to deliver improvements.**
- **We will support leadership with the confidence in championing the importance and relevance of sustainability in the context of current healthcare challenges.**
- **We will promote specialist resources, tools and best practice to inspire others, share learning and drive change.**

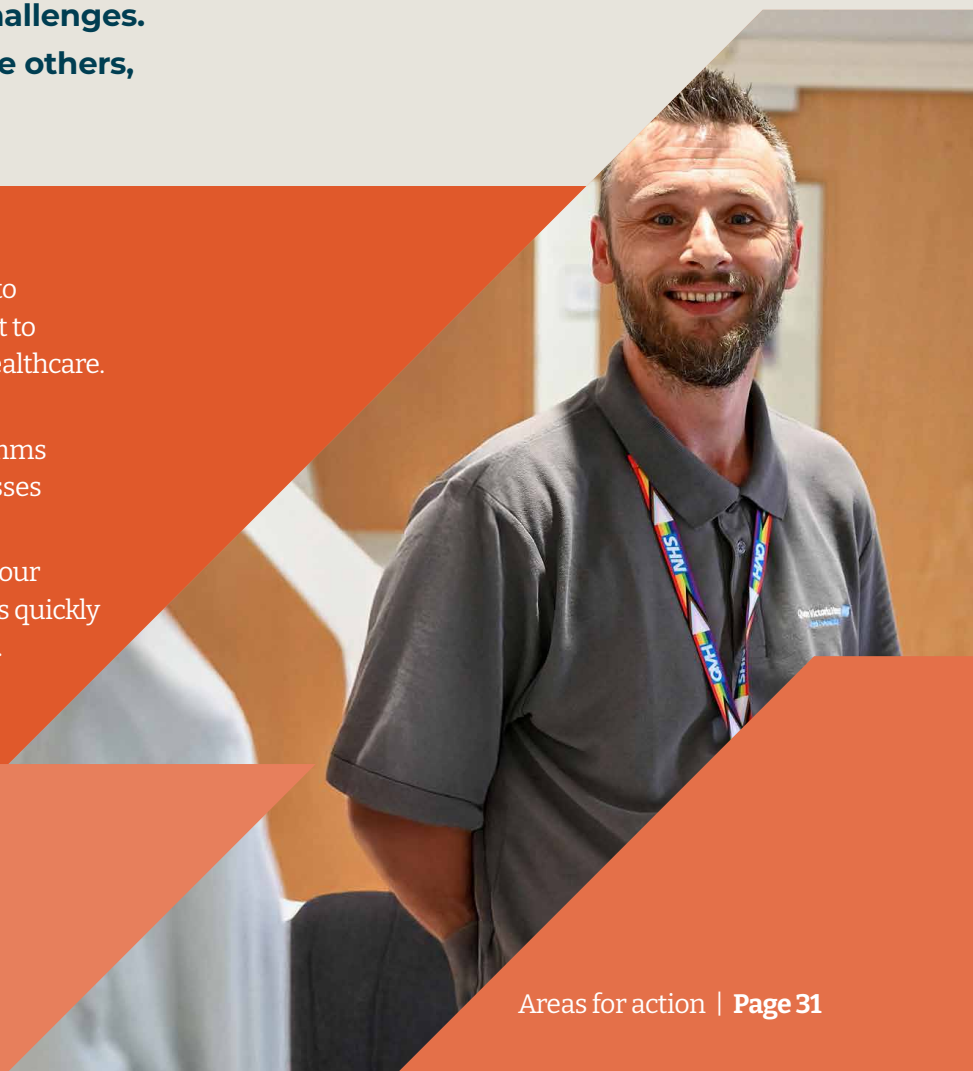
Our approach:

Culture is one of our enabling workstreams, linking in closely with Partnerships and Collaboration and Sustainable Clinical Practice, and supporting delivery across the programme. Through this workstream we are aiming to embed sustainability into everyday practice through empowering our staff.

We do this by:

- **Increasing awareness:** Building awareness and understanding with staff to give them the confidence to act.
- **In-depth engagement:** Engaging with staff and patients in a focussed way to ensure most effective delivery of Green Plan programme activity.
- **Capability and capacity:** Enabling staff to acquire the necessary skills and support to deliver improvements in sustainable healthcare.
- **Integration into people processes:** Embedding sustainability into trust comms and engagement and our people processes and projects.

By working in this way, we're maximising our impact and improving health outcomes as quickly as possible within the resources available.



Key targets:

- **Increase in staff understanding of sustainable healthcare by 10% by 2030.**
- **Establish a network of CWC Envoys or similar by 2027.**
- **Specialist training delivered to top five priority teams by 2027.**

Key areas of work:

Increased awareness

Green Plan refresh launch: Develop comms to support updated Green Plan focussing on key messages and call to action for staff.

Communications and engagement planning: Develop a more detailed comms plan to support delivery of this workstream over the coming 12-18 months.

Ongoing comms: Sharing of relevant information via internal comms and CWC website blog posts on link between health and climate, sustainable healthcare, and the ability to make a difference.

Case studies: Share good practice carbon reduction projects that also demonstrate co-benefits such as patient outcomes, staff wellbeing and cost.

In depth engagement

Board and senior leaders awareness: Develop an engagement programme to support leadership with the confidence to champion sustainability in the context of current healthcare challenges.

Targeted engagement: Liaise with priority teams to support action required for Green Plan delivery and develop bespoke campaigns as required (years 2-5).

Patient engagement: Link into existing patient engagement mechanisms such as Sussex Net Zero Patient Engagement Group, to understand what matters to patients and accelerate project delivery (years 2-5).

Capability and capacity

Capacity: Assess workforce capacity and skill requirements for delivering this Green Plan and develop approach to ensure deliverability.

Envoy network: Develop our approach to supporting staff that wish to champion sustainability for example through the Sussex-wide CWC Envoy network.

Training: Champion national Net Zero NHS e-learning. Review opportunity to integrate sustainability principles into existing training e.g. IPC and deliver specialised sustainability training to staff in priority areas (years 2-5).

Integration into people processes

Internal comms: Integrate sustainability messaging into wider trust comms pieces e.g. highlighting sustainability as a co-benefit of other areas of work, using chief exec message to focus on sustainability etc.

Staff development and recruitment: Review our Personal Development Review (PDR) and recruitment processes and identify opportunities to integrate sustainability (years 2-5).

Conferences and events: Develop a Sustainable Events Checklist for organisational conferences and events, and consider how to integrate sustainability principles into agendas e.g. through presentations, stalls etc (years 2-5).

Staff wellbeing: Measure staff wellbeing impacts of Green Plan projects through the SHIA tool and integrate sustainability principles into staff wellbeing projects and processes (years 2-5).

Staff Star Awards: Ensure sustainability is reflected in categories for organisational Star Awards (years 2-5).

Areas for action:
Partnerships & collaboration

Optimising delivery and enhancing our impact through collaboration.

Commitments:

- **We will ensure effective Green Plan delivery through our governance processes, reporting, risk management and robust measurement.**
- **We will integrate and embed sustainability principles into core processes and decision making.**
- **We will collaborate with partners outside of the trust to reduce duplication, share expertise and increase impact.**

Our approach:

We cannot achieve Net Zero Carbon working in isolation. Working collaboratively – both within Queen Victoria Hospital, across our system and more broadly – enables us to integrate into day-to-day business more effectively, maximising our impact and patient benefit.

In working together as NHS organisations we can share learning and reduce duplication, deliver joint projects that bring efficiencies of scale and communicate as one voice on sustainability to our patient community.

This workstream delivers on this through:

- **Optimisation and assurance of delivery:** Focussing on effective governance reporting, risk management and prioritisation.
- **Integration:** Making sustainability part of our every day at Queen Victoria Hospital by embedding sustainability principles into core Trust processes and decision making.
- **Collaboration with external partners:** Working in partnership with Sussex Integrated Care System partners through collaborative projects and approaches; and collaboration outside of Sussex including to learn from others and share our learning.

Key targets:

- **Report annually on delivery of Green Plan requirements.**
- **Identify our approach to integrating sustainability into Trust decision-making in line with Health and Social Care Act requirements and develop a SMART target to reflect this before 2027.**
- **Share learning from our Green Plan projects outside of Queen Victoria Hospital, covering each of our workstreams every two years.**

Key areas of work:

Optimisation and assurance of delivery

Prioritised action plan and reporting: Develop, deliver and report against a prioritised Green Plan action plan and KPIs each year, with a focus on continuous improvement of our approach.

NHS Carbon Footprint Plus Delivery Plan: Develop Delivery Plan to tackle our indirect emissions, incorporate into Green Plan action plan and implement new targets to ensure delivery.

Risk: Review requirements for climate risk reporting and integrate into organisational risk reporting structure as appropriate.

Net Zero Roadmap to 2040: Develop Net Zero Roadmap to 2040 for direct emissions, working at a strategic level to ensure decisions made during the timeframe of this Green Plan do not preclude delivery (years 2-5).

Integration into core business/decision making

Integrating sustainability into Trust decision-making: Develop and deliver an agreed programme to integrate sustainability into decision-making processes trust wide, using our SHIA tool. This should cover Trust strategic improvement projects, strategy, Quality Impact Assessment (QIA) process, business cases, charity funding, policies etc. Set a target to deliver on this.

Taskforce for Climate-related Financial Disclosures (TCFD): Improved completion of our climate related financial disclosures, and consideration of nature related financial disclosures submission as requirements develop.

Key meetings: Consider how best to incorporate sustainability into key meetings e.g. through cover sheets, as a standing agenda item or within annual workplan (years 2-5).

Working with enablers: Embed sustainability principles into estates, transformation, CI and digital team project processes and training (years 2-5).

Collaboration with external partners

System working: Continue to collaborate with NHS Sussex and local partners on system-wide projects to enhance delivery of this Green Plan (e.g. re-use network).

Care Without Carbon: Continue to work through our specialist sustainability partners, Care Without Carbon, to maximise efficiency and ensure a joined-up approach.

Sharing our learning: Share learning from our projects with other NHS organisations (e.g. through case studies on the CWC website, conferences etc) as well as relevant professional bodies and decision makers.

Areas for action:
Climate Resilience

Strengthening resilience to our changing climate in Sussex.

Commitments:

- **We will protect and improve patient care and outcomes by understanding climate and nature-related risks to our services and communities.**
- **We will increase the resilience of our services, estates, and supply chains to ensure safe, equitable, and high-quality care in a changing environment.**

Our approach:

Climate change is already impacting our patients and services at QVH. More frequent heatwaves, increasing air pollution and new health risks will continue to test the continuity of our services and change health needs over the coming years.

We're also becoming more aware of the dependence of our healthcare delivery on healthy natural systems and the impact of nature degradation. In particular, our supply chains are becoming increasingly impacted by ecosystem degradation and biodiversity loss, and closer to home our clean air, water and food.

Through our climate resilience workstream, we are proactively working to tackle these risks, aiming to maintain safe, effective, and equitable care, protect patient and staff health, and minimise disruption to services.

Our approach is to:

- **Deliver quick wins:** Working with emergency planning and wider teams, implement immediate changes where we can.
- **Understand environmental risks and respond to them:** Assess climate and nature-related risks across our services, workforce and estate to identify vulnerabilities; develop a prioritised action plan which activates change and embeds within trust processes.
- **Collaborate with our system partners:** To ensure a joined-up approach, work with others to improve preparedness and protect those most at risk.

In strengthening our resilience to climate and environmental change, we not only reduce risk but also realise wider benefits – from improved health outcomes to operational efficiencies – that enable us to continue caring for our patients now and in the years ahead.

Key targets:

- **Climate risks and vulnerabilities across patients, services, estates and supply chains assessed by end 2026/27.**
- **Climate Resilience Plan developed by 2027/28.**

Key areas of work:

Deliver quick wins

Monitoring: Establish and enhance monitoring and surveillance of key estate and clinical/operational indicators (e.g. heat, PSIs etc).

Emergency Preparedness, Resilience and Response (EPRR): Ensure compliance with EPRR Core Standards for climate adaptation.

Governance: Formalise our governance around climate resilience to support mitigation of Trust level climate risk. This should include a named Trust adaptation lead and link into wider Trust level governance as appropriate.

Understand climate risks and respond to them

Climate risk assessment and resilience planning: Undertake a Trust-wide assessment of climate and wider environmental risks to identify key vulnerabilities across our estate, services, supply chain and digital infrastructure. Based on this assessment, develop and implement a proportionate Climate Resilience Plan to mitigate priority risks, protect continuity of high-quality care, and embed climate resilience within Trust governance and risk management frameworks.

Training: Deliver climate resilience awareness training to all senior decision-makers and to senior managers across all identified high-risk services (years 2-5).

System-wide collaboration

Risk and planning approach: Collaborate with system partners including public health to ensure joined up approach to service planning and commissioning to identify evolving and future service needs (years 2-5).

Governance

At QVH, everything we do is informed by our passion for providing the highest quality care, the best clinical outcomes and a safe and positive patient experience. Effective governance is critical to delivering on this Green Plan and our Trust Vision and Key Strategic Objectives.

Board lead for Sustainability and Net Zero and SRO for the programme is our Chief Finance Officer.

Clinical sustainability responsibilities are currently shared across **theatres, outpatients and divisional leadership,** providing distributed clinical input into the delivery of the Green Plan. In line with national requirements, the Trust will appoint a named Clinical Sustainability Lead to provide clear clinical leadership and oversight of the programme.

Delivery of the Green Plan is reported and monitored through the Trust's new quarterly Green Plan Group, chaired by our SRO. The group brings together clinical, non-clinical and system partners to track progress against each of our workstreams. It is attended by Trust representatives covering each of our seven workstreams as well as enabling functions, and the CWC team.

Delivery of the Green Plan programme is supported by our CWC team. They are responsible for coordination and day-to-day delivery of the Green Plan programme alongside trust leads, providing specialist sustainability expertise to the trust.

The Trust's ability to resource sustainability activity beyond the five-year planning horizon will be reviewed as part of the development of future Green Plans.

Board Oversight and Reporting

In line with NHS requirements, this Board approved **Green Plan outlines our core aims, objectives and commitments** across seven workstreams.

The Trust and Board will be kept up to date on progress of Green Plan delivery through: six-monthly updates to Estates and Facilities Steering Committee, reporting into Executive Leadership Team and Finance and Performance Committee. In addition, an annual update to Board will be provided directly through the Trust Annual Report.

This governance structure provides assurance on delivery of our Green Plan commitments.

Risk Management

A key focus for this Green Plan is to develop our understanding of and approach to climate change risks to our patients and service delivery. Through our newly updated Climate Resilience workstream, we aim to ensure we are equipped to respond to the impacts of a changing climate.

In order to strengthen our governance and risk oversight in relation to climate change, we will follow the principles of the Task Force on Climate-related Financial Disclosures (TCFD) to for our Trust annual report. By reporting in line with HM Treasury's TCFD-aligned guidance for the public sector, the Trust enhances transparency on how climate risks and opportunities are managed within our strategic and financial planning.

Metrics, targets and reporting

A core set of Green Plan targets have been developed to track progress, aligned with Health and Social Care Act 2022 requirements, NHSE guidance and Trust priorities. See Technical Appendix 3 for a full breakdown of these targets, also detailed in the workstream sections of this document.

Each year, a detailed action plan and KPIs will be developed for each workstream based on this Green Plan, and reported through our Green Plan Group. Progress is also published externally through our Trust Annual Report.

Finally, we will also participate in external reporting through Greener NHS returns, the Greener NHS Fleet return, ERIC, PAM, and through our regional NHS England team as required.

The following acronyms are used throughout the report

CDC – Community Diagnostic Centre

CF – Carbon Footprint

CF+ - Carbon Footprint Plus

CI – Continuous Improvement

CWC - Care Without Carbon

E&F - Estates and Facilities

EPR – Electronic Patient Record

EPRR - Emergency Preparedness, Resilience and Response

EV - Electric Vehicle

FTE - Full Time Equivalent

GP – General Practice

GPOG - Green Plan Oversight Group

H&SC – Health and Social Care

HEARTH - National Hub on Net Zero, Health and Extreme Heat

ICB - Integrated Care Board

ICS – Integrated Care System

KPI - Key Performance Indicator

kWh - Kilowatt Hour

LCSF - Public Sector Low Carbon Skills Fund

NHSCF - NHS Carbon Footprint

NHSCF+ - NHS Carbon Footprint Plus

NHSE - NHS England

NZ - Net Zero

NZC - Net Zero Carbon

PDR – Personal Development Review

PSDS - Public Sector Decarbonisation Scheme

QIA – Quality Impact Assessment

QVH – Queen Victoria Hospital NHS Foundation Trust

SHIA - Sustainable Healthcare Assessment Tool

SMART targets - Specific, Measurable, Achievable, Relevant, and Time-bound targets

tCO_2e - Tonnes of Carbon Dioxide equivalent emissions

WTT - Well to Tank

NHS

Queen Victoria Hospital

NHS Foundation Trust

care WITHOUT CARBON

Find out more

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See the QVH website at:
www.qvh.nhs.uk

For more information on Care Without Carbon visit:
www.carewithoutcarbon.org

NHS
Queen Victoria Hospital
NHS Foundation Trust

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Technical Appendices to QVH Green Plan

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Appendix 1

Carbon Footprint Method Explained

Our carbon footprint reporting boundary

The NHSE climate change strategy, *"Delivering a Net Zero National Health Service"*, defines NHS emissions in two groups:

NHS Carbon Footprint – Emissions we control directly

NHS Carbon Footprint Plus – Emissions we can influence

The Greenhouse Gas (GHG) Protocol Corporate Accounting and Reporting Standard **Control Approach** sets out defined scopes for emissions:

Scope 1: direct emissions. These occur from sources owned or controlled by the reporting organisation.

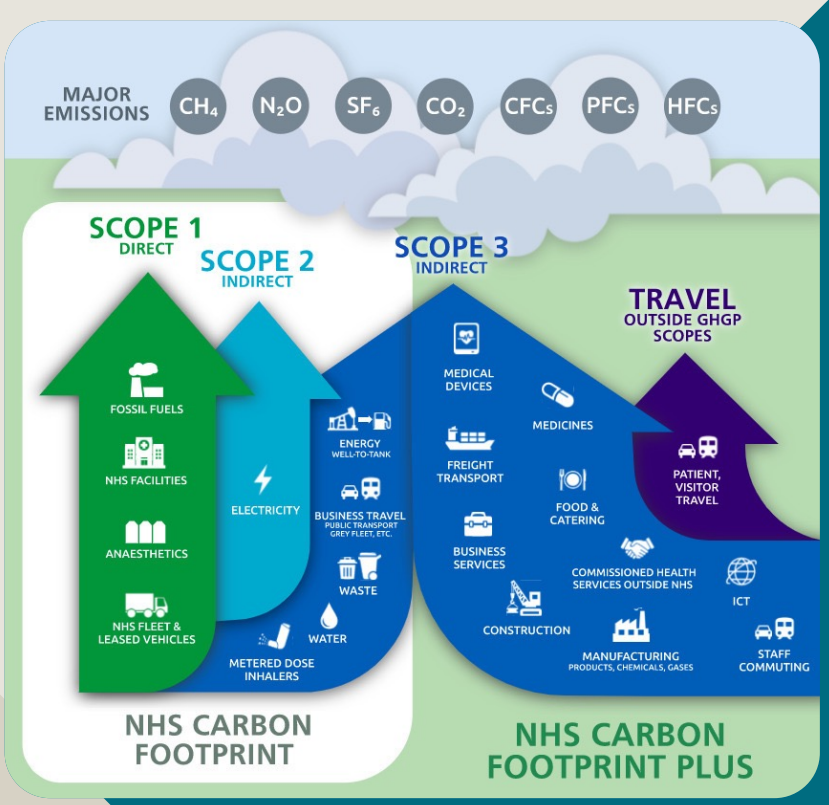
Scope 2: (indirect) purchased energy emissions occurring as a result of purchased energy consumed by the reporting organisation, but where the emissions occur from another organisation (mostly electricity).

Scope 3: other indirect emissions. All other emissions that occur as a consequence of organisational activity, but which are not reportable in Scope 1 or 2.

The NHSE climate change strategy also commits to net zero for emissions relating to patient and visitor travel which falls outside of these scopes.

The approach adopted by Queen Victoria Hospital NHS Foundation Trust is to report on emissions from the activities over which it exerts operational control. In other words, the accounting boundary is drawn around the clinical services that the Trust is commissioned to deliver, and which are therefore delivered in accordance with Trust policies and procedures.

Our carbon footprint reporting boundary



Measuring Our Carbon Footprint

When measuring our carbon footprint, we use a baseline year of 2019/20, in line with national NHS guidance. The data included in our carbon footprint is associated with the main Queen Victoria Hospital site only. We do not yet include emissions from our 'spoke' sites in our footprint but will look to do so in future. We use the following methodology for calculating emissions relating to each source:

Energy and Water

Energy and water consumption figures are generally calculated from supplier data as follows:

- Invoices and half-hourly meter reads from our utility suppliers provide consumption data.
- Consumption figures are then converted into carbon emissions using UK Government Greenhouse Gas Conversion Factors.

Medical Gases

The volume of Nitrous Oxide purchased by the trust is provided by the supplier. This is then converted to carbon using UK Government Greenhouse Gas Conversion Factors.

Emissions from fluranes are calculated using the volume and Dr Tom Pierce's RCoA tool.

Waste

The weight of waste for each category is calculated from supplier reports. In order to convert waste consumption to carbon impact, we use UK Government factors for general, and recycled waste. Government factors are not available for clinical waste; in place of these we use factors from the National Atmospheric Emissions Inventory.

Travel

Travel emissions are calculated as follows:

- Trust fleet emissions are calculated from the litres of fuel purchased using fuel cards relating to each trust vehicle. These are converted to carbon impact using UK Government Greenhouse Gas Conversion Factors based on the type of fuel used.
- Business mileage vehicle claims have been converted to carbon impact using UK Government Greenhouse Gas Conversion Factors based on the fuel type and engine size of the vehicle.
- Public Transport business mileage claims have been converted to carbon impact using UK Government Greenhouse Gas Conversion Factors based on mode of transport used. In 19/20 and 20/21 the separate travel modes were not available and so a proportional split was used against the total claims based on data from subsequent years.

Measuring Our Carbon Footprint Plus

At Queen Victoria Hospital NHS Foundation Trust, our focus to date has been implementing data collection to support regular measurement of our NHS Carbon Footprint. We are currently undertaking work to allow us to be able to confidently expand this to include emissions sources within our NHS Carbon Footprint Plus.

Greener NHS provide estimated figures for the NHS Carbon Footprint Plus for all NHS trusts through their Green Plan Support Tool data, covering the baseline year of 19/20. This includes data covering the following emission sources

- Medicines and prescribing
- Personal travel (staff commute, patient travel, visitor travel)
- Medical supply chain (clinical consumables, clinical equipment)
- Other supply chain (physical and digital infrastructure, equipment, food and catering, corporate and administrative services and other supplies and services)
- Non-NHS commissioned services (voluntary and independent organisations, personal and continuing care)

NHS England's recently published "Five years of a greener NHS: progress and forward" estimates that 24/25 indirect emissions have seen a small increase since 19/20. As such, we have then used 19/20 figures as an estimate for our 24/25 impact for indirect emissions for both our carbon footprint figures, and our Net Zero NHS Carbon Footprint Plus Roadmap.

More information about the approach to carbon footprinting developed by the Greener NHS team can be found in www.thelancet.com/journals/lanplh/article/PIIS2542-5196(20)30271-0/fulltext

NHS Carbon Footprint emissions by source and per FTE

Using the above methodology, our calculated NHS Carbon Footprint by emission source is set out below. We have set this against the number of Full Time Equivalent (FTE) staff in each year to give an indication of level of service delivery.

Annual carbon emissions (tCO_2e)						
Source	**2019/20**	**2020/21**	**2021/22**	**2022/23**	**2023/24**	**2024/25**
Fossil Fuels	1,178	1,213	1,178	1,006	876	1,030
NHS Facilities	0	0	0	0	0	0
Medical Gases	173	162	126	165	131	43
NHS Fleet and Leased vehicles	0	1	4	3	3	4
Purchased Electricity	1,007	926	806	765	687	853
Energy WTT	392	376	501	441	370	451
Business Travel	129	38	11	20	22	28
Waste	27	27	30	71	40	7
Water	17	15	12	11	8	8
NHS Fleet & Leased Vehicles WTT	0	0	1	1	1	1
Business Travel WTT	16	5	3	3	4	4
Metered Dose Inhalers	0	0	0	0	0	0
Total Emissions (NHS Carbon Footprint)	**2,938**	**2,762**	**2,673**	**2,486**	**2,141**	**2,428**
% change against baseline year (tCO_2e)	0%	-6%	-9%	-15%	-27%	-17%
Year on year % change		-6%	-3%	-7%	-14%	13%
FTE staff	863	897	913	915	935	997
Emissions per FTE	3.4	3.1	2.9	2.7	2.3	2.4
% change against baseline year (tCO_2e/FTE)	0%	-10%	-14%	-20%	-33%	-29%

Appendix 2

Net Zero Carbon Roadmap: our approach

Target Emissions

The recent *"Delivering a Net Zero National Health Service"* report, sets out two clear targets for the NHS, as follows:

- Net zero carbon by 2040 for the emissions we control directly (NHS Carbon Footprint).
- Net zero carbon by 2045 for the emissions we can influence (NHS Carbon Footprint Plus).

The strategy also sets out interim ambitions to:

- Reach an 80% reduction in NHS Carbon Footprint by 2028 to 2032 (based on 1990 emission levels). This equates to reducing emissions by at least 47% by 2028-2032 based on our 2019/20 baseline.
- Reach an 80% reduction in NHS Carbon Footprint Plus by 2036 to 2039 (based on 1990 emission levels). This equates to reducing emissions by at least 73% by 2036-2039. based on our 2019/20 baseline.

Our Net Zero Carbon Roadmap for direct emissions uses an interim target of 47% reduction by 2030/31.

Reductions due to external factors

Some carbon savings are expected from external factors outside of organisational control, for example expected grid decarbonisation and transition to EVs. To account for these within the Net Zero Roadmap, we have calculated the impact of these factors from 2024 to our interim target. This is based on the following assumptions:

- **Grid decarbonisation:** Expected electricity grid decarbonisation calculated from expected emissions factors set out in the HM Treasury 2022 Green Book guidance. These are aligned to published emission factors to give the estimated impact of grid decarbonisation to 2030.
- **Natural gas:** Assumed 5% reduction in natural gas emissions by 2040 based on assumptions around new tech/Hydrogen.
- **Water:** Assumed 5% reduction in water emissions by 2040 based on assumptions around new tech and grid decarbonisation.
- **EV transition:** From 2030, new petrol and diesel cars will no longer be available for sale in the UK. For this Roadmap, we have assumed 1% reduction per year for business travel emissions based on current trends of the uptake of Electric Vehicles.

Delivery Plan projects

The estimated additional carbon savings as a result of confirmed and potential projects are calculated to 2030. In most cases these are a direct carbon reduction per year (often phased in its implementation in line with the project timeline). Note the following caveats:

- For projects that involve transition from gas to electricity there may be an expected increase in electricity but overall, these will have a net reduction in emissions.
- For any project with electricity savings, the expected impact is calculated in line with expected grid decarbonisation savings using the same methodology as detailed in the External Factors section.

NHS Carbon Footprint Plus Roadmap

Our NHS Carbon Footprint Plus Roadmap sets out our trajectory to 2045 from the 19/20 baseline year using NHS England data as set out in Appendix 1.

The roadmap used an interim target of 73% reduction by 2038/39 which gives an almost straight line reduction trajectory to 2045/46.

The 'estimated emissions' shown are estimates based on 19/20, and on NHS England's recently published "Five years of a greener NHS: progress and forward" report. The chart in figure 6 indicates the estimated proportion reductions required in each of the key areas calculated.

More information about the approach to carbon footprinting developed by the Greener NHS team can be found in: www.thelancet.com/journals/lanplh/article/PIIS2542-5196(20)30271-0/fulltext

Appendix 3

Targets

A summary of the Green Plan targets from across our workstreams is provided below. These – alongside more detailed KPIs – are or will be measured and reported on through our Sustainability Programme Board.

Targets will also be developed over time, for example where targets run only to halfway through the plan period (e.g. climate resilience workstream), or where we don't yet have enough information to set targets (e.g. NHS Carbon Footprint Plus). This will ensure we are able to keep track of progress over time effectively.

Core Green Plan aim	Measure	Target	Target Date	Unit
Net Zero Carbon Footprint Targets	NHS CF (direct) emissions	47% reduction on 2019/20 baseline	2030/31	tCO_2e
	NHS CF+ (indirect) emissions	42% reduction on 2019/20 baseline	2030/31	tCO_2e
Climate resilience	NHS Climate Change Risk Assessment completed	Yes	2027/28	Y/N
Environment Act. Focus on: air pollution and biodiversity	**Air pollution**			
	Emissions from fleet and business travel	47% reduction on 2019/20 baseline	2030/31	tCO_2e
	Biodiversity			
	Number of biodiversity interventions per year	1	Each year to 2030/31	#

Workstream	Measure	Target	Target Date	Unit
Sustainable Clinical Practice	Emissions from Nitrous Oxide	Reduction on 2019/20 baseline	2030/31	tCO_2e
	% of outpatient appointments delivered remotely	25%	2030/31	%
	% of priority single use items with clearly defined processes to switch to reusable alternatives	100%	2026/27	%
Circular Economy	Emissions from waste	47% reduction on 2019/20 baseline	2030/31	tCO_2e
	% of requirements of the Net Zero Supplier Roadmap met	100%	Each year to 2030/31	%
	% of NHSCF+ priority supply chain categories with smart targets	100%	2027/28	%
Places	Emissions from estate	47% reduction on 2019/20 baseline	2030/31	tCO_2e
	kWh of electricity generated on site from renewable sources	50% increase on 24/25 level	2030/31	kWh
	Number of biodiversity interventions per year	1	Each year to 2030/31	#
Journeys	Emissions from fleet and business travel	47% reduction on 2019/20 baseline	2030/31	tCO_2e
	Emissions from staff commute	39% reduction on 2019/20 baseline	2030/31	tCO_2e
	Percentage of trust operational fleet which are EVs	100%	2030/31	%

Workstream	Measure	Target	Target Date	Unit
Culture	% of staff responding to staff survey who indicate an understanding of sustainable healthcare	10% increase	2030/31	%
	CWC Envoy network or similar eatablished?	Yes	2027/28	Y/N
	% of top 5 priority teams who have had team member attend specialised training (cumulative)	100%	2027/28	%
Partnerships and Collaboration	Report annually on delivery of Green Plan requirements	Yes	Each year to 2030/31	Y/N
	SMART target developed demonstrating approach to integrating sustainability into Trust decision-making in line with Health and Social Care Act requirements	Yes	2026/27	Y/N
	% of workstreams having learning from Green Plan projects shared outside of QVH within the last two years	100%	2027/28	%
Climate Resilience	NHS Climate Change Risk Assessment completed	Yes	2026/27	Y/N
	Climate Resilience Plan developed	Yes	2027/28	Y/N

Appendix 4

Together to Zero: NHS Sussex green plan refresh

Key objectives and priorities for the next 3 years

Deliver clinical services that are sustainable, efficient, and equitable	**In 2025/26 we will launch the Sustainable Healthcare Impact Assessment tool** in a partnership with Care Without Carbon with the aim of ensuring that all new business cases across the system have due regard for environmental sustainability by April 2028.
Enhance the efficient and responsible use of our NHS estate	**We will rapidly increase the availability of local renewable energy** in 2025/26 by delivering an additional 2m kwh through the GB Energy funding for Solar PV and saving £500k p.a. in electricity costs across the system from 2026/27.
Implement practices that minimise waste, optimise efficiency, and reduce emissions	**We will target a reduction in single-use medical equipment and consumables over the next 3 years** by agreeing policy across the system which supports reusing wherever it is clinically feasible and appropriate to do so.
Adapt to the impacts of climate change, enhancing resilience and well-being	**We will develop proposals in 2026/27 for a collaborative research and innovation hub** in partnership with local academic institutions, aimed at developing and implementing sustainable solutions that enhance the climate resilience of health services.
Foster awareness of sustainable practices in our workforce and in services	**In 2026/27 we will promote and agree uptake targets** with NHS organisations for targeted staff groups to access the core training offers set out on the Greener NHS Training Hub.
Strengthen partnership working within and outside of the NHS	**In 2026/27 and enabled by flexibilities under the 2022 Act for ICBs to transfer their statutory duties,** the Care Without Carbon Team will assume responsibility for system wide strategic planning, collaboration and delivery.

Appendix 5

How we will prioritise our efforts

The landscape for sustainable healthcare is complex and evolving, with critical pressures on resource across the NHS. Delivery of our Green Plan is dependent on effective use of our limited resource; as such prioritisation of our work to the most material areas of impact is key.
We have taken the following approach to the development of this Green Plan.

A data driven approach

In order to ensure effective delivery, we have taken a data-lead approach to our Green Plan programme. We use our annual carbon footprint and workstream level data to understand our impacts, identify hotspot areas, set clear targets for change and measure the impact of our work over time.

This has been our approach to development of our Net Zero Roadmap and Delivery Plans for our NHS Carbon Footprint and NHS Carbon Footprint Plus. It has also determined our approach to delivery, for example identifying and prioritising high impact clinical services such as operating theatres for workstream support on reusables projects.

In this way we can use data to focus our efforts on the highest impact areas and ensure change is improvement.

Guided by our stakeholders

As set out in this Green Plan, stakeholder engagement has also been key to developing this Green Plan and will also support our more detailed delivery planning.

We gathered qualitative data from staff 1-2-1s, staff survey data and wider stakeholder engagement to identify the key challenges to and opportunities for delivery.

We used this information to corroborate key areas of focus, develop our core objectives and support additions or nuances to workstreams. We will also use this data to support more detailed delivery planning as we develop our detailed action plans for 26/27 and beyond.

National legislation, guidance, best practice and experience

In addition to trust level data and insight, we have also sought learning from elsewhere to develop our Green Plan programme. This includes:

- The core aims of this Green Plan are aligned with the legal requirements of the Health and Social Care Act 2022.
- Our Green Plan refresh is also in line with the recently published NHSE Green Plan refresh guidance as well as their original Delivering a Net Zero NHS strategy. This provides us with a good grounding in terms of materiality and prioritisation.
- Legal and regulatory requirements set out earlier in this Green Plan.
- NHSE or specialist guidance (e.g. NHS Travel and Transport Strategy).
- Best practice examples (for example learning from Circular Economy Healthcare Alliance, Centre for Sustainable Healthcare or other leading NHS trusts).
- Our learning at CWC from working across a number of Trusts in Sussex and Surrey, which brings a depth of knowledge and experience to the programme.

Taking a CI approach – aligned around legal requirements

The core aims of this Green Plan are aligned with the legal requirements of the Health and Social Care Act 2022.

We've used learning from our data, stakeholder engagement and review of guidance and best practice to develop an overarching driver diagram based around these core aims and to identify our key objectives.

More detailed driver diagrams have then been developed for each of our core areas of work (our workstreams). These have helped us to produce our workstream level plans – including key commitments, targets and priority project areas.

Following development of this Green Plan, detailed action plans will be developed and delivered through our Green Plan Group.

Next steps: ongoing review and risk

Climate change is evolving at pace – as is our knowledge and understanding around how to mitigate and adapt within the healthcare sector. In addition our context within the NHS evolves each year, providing new challenges around resource and capacity to deliver.

In light of this, our Green Plan programme will be reviewed and re-prioritised each year to reflect the most recent context, and with priorities confirmed through the Green Plan Group.

This prioritisation will also support the development of our approach to climate change risk assessment and reporting at QVH. As set out in the Partnerships and Collaboration workstream, a key action for 26/27 is to review our approach to and requirements for climate risk reporting and integrate into Trust risk reporting structure accordingly.

In order to achieve our Green Plan aims	We need to ensure	Which requires work in these areas
Reduce our emissions to **Net Zero by 2040/45**	**Reduce direct emissions to net zero by 2040** (interim target of 47% by 2030/31)	Sustainable Clinical Practice
	Reduce indirect emissions to net zero by 2045 (interim target of 73% by 2036-39)	Circular Economy
		Places
		Journeys
Address the **targets within the Environment Act 2021**	**Improve** biodiversity, air quality, reduce waste, conserve clean water	
Adapt our services and buildings to the impacts of climate change	**Identify key impacts,** assess risk to patients and service delivery and develop mitigations.	Climate resilience
'Have regard to' legal duty (our enablers)	**Staff awareness of climate change** and capacity/skills to integrate into day-to-day work	Culture
	Integration of sustainability into decision making	Partnerships and Collaboration
	Assurance of Green Plan delivery and maximising impact of the programme through partnerships	

Appendix 6

NHSE Green Plan Targets

	2025	2026	2027	2028	2029	2030
Journeys 		**Sustainable Travel Strategies** Sustainable travel strategies will be developed and incorporated into NHS organisations' Green Plans. **Salary Sacrifice Schemes** All vehicles offered through NHS vehicles salary sacrifice schemes will be electric.	**Electric Vehicles** All new vehicles owned or leased by the NHS will be zero emission (excluding ambulances).			**Staff Commute** Reduce emissions by 39% by 2030/31 in line with Net Zero Travel & Transport Strategy target to reduce by 50% by 2033.
Circular Economy 		**Waste** NHS trusts and NHS foundation trusts to eliminate waste sent to landfill.	**Net Zero Supplier Roadmap** All suppliers required to publicly report targets, emissions and publish a Carbon Reduction Plan for global emissions.	**Net Zero Supplier Roadmap** New requirements will be introduced overseeing the provision of carbon footprinting for individual products supplied to the NHS.		**Net Zero Supplier Roadmap** Suppliers should only qualify for NHS contracts if they can demonstrate progress through published progress reports and continued carbon reporting.
Places 		**Water Efficiency** NHS trusts to review options to install leak detection systems.		**Fossil Fuel Heating** Remove coal and oil-led primary heating systems. **Energy Efficiency** NHS trusts and primary care to review options to install energy metering at all sites (floor level). **Drainage** NHS trusts to carry out sustainable urban drainage system assessments		
Climate Adaption 	**Emergency Planning** NHS trusts must have specific plans for flooding and overheating.					

Reach net zero carbon footprint by 2040, reducing emissions by at least 47% against 2019/20 emissions by 2030-31
Reach net zero carbon footprint plus by 2045, reducing emissions by at least 73% against 2019/20 emissions by 2036-39

The following acronyms are used throughout the report

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CF+ - Carbon Footprint Plus

CI – Continuous Improvement

CWC - Care Without Carbon

E&F - Estates and Facilities

EPR – Electronic Patient Record

EPRR - Emergency Preparedness, Resilience and Response

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HEARTH - National Hub on Net Zero, Health and Extreme Heat

ICB - Integrated Care Board

ICS – Integrated Care System

KPI - Key Performance Indicator

kWh - Kilowatt Hour

LCSF - Public Sector Low Carbon Skills Fund

NHSCF - NHS Carbon Footprint

NHSCF+ - NHS Carbon Footprint Plus

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PSDS - Public Sector Decarbonisation Scheme

QIA – Quality Impact Assessment

QVH – Queen Victoria Hospital NHS Foundation Trust

SHIA - Sustainable Healthcare Assessment Tool

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WTT - Well to Tank

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Find out more

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See the QVH website at:
www.qvh.nhs.uk

For more information on Care Without Carbon visit:
www.carewithoutcarbon.org

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Meeting title:	Board of Directors				
Meeting date:	12/03/2026	**Agenda reference:**	**150-26**		
Report title:	Board work programme 2026/27				
Sponsor:	Leonora May, Company secretary				
Author:	Leonora May, Company secretary				
Appendices:	Appendix one- Board work programme 2026/27				
Executive summary					
Purpose of report:	To present the Board work programme for 2026/27 for review and approval.				
Summary of key issues	The Board work programme for 2026/27 has been drafted in line with the Board's responsibilities and has been aligned to its sub-committee work plans. The Quality and safety committee, Finance and performance committee and Audit and risk committee have reviewed their work programmes at their February and March 2026 meetings. The Strategy and culture committee will review its work programme at its meeting at the end of March 2026. The Board work programme 2026/27 will be flexible as priorities emerge for next year.				
Recommendation:	The Board is asked to review and approve its work programme for 2026/27, noting that there may be further iterations.				
Action required	**Approval**	Information	Discussion	Assurance	Review
Link to key strategic objectives (KSOs):	**KSO1:**	**KSO2:**	**KSO3:**	**KSO4:**	**KSO5:**
	Outstanding patient experience	***World-class clinical services***	***Operational excellence***	***Financial sustainability***	***Organisational excellence***
Implications					
Board assurance framework:	None				
Organisational risk register:	None				
Regulation:	Standing Orders Code of governance for NHS Provider Trusts				
Legal:	None				
Resources:	None				
Assurance route					
Previously considered by:	Executive leadership team				
	Date:	Feb 2026	Decision:		
Next steps:	Work plan used to inform 2026/27 Board meeting agendas				

Agenda item	14 May 2026	24 June 2026 (ARA)	09 July 2026	10 September 2026	12 November 2026	21 January 2027	11 March 2027	Lead
Standing items								
Welcome, apologies and declarations of interest	✓	✓	✓	✓	✓	✓	✓	Trust Chair
Patient story	✓		✓		✓	✓		Chief nursing officer
Staff story				✓			✓	Chief people officer
Minutes of the previous meeting	✓		✓	✓	✓	✓	✓	Trust Chair
Matters arising and actions pending from previous meetings	✓		✓	✓	✓	✓	✓	Trust Chair
Chair's report	✓		✓	✓	✓	✓	✓	Trust Chair
Chief Executive Officer's report: - Risk - Key strategic priorities - Partnership working (CiC assurance)	✓		✓	✓	✓	✓	✓	Chief executive officer
Strategy								
Partnership implementation update			✓	✓				Chief executive officer
Key Strategic Objectives 2026/27 - approval	✓							
Key Strategic Objectives 2027/28 - approval							✓	Company secretary / exec leads
R&I strategy update						✓		Chief medical officer
Governance & Risk								
Board assurance framework and Organisational risk register	✓		✓	✓	✓	✓	✓	Company secretary
Freedom to Speak Up guardian report	✓				✓			FTSU guardian
Guardian of Safe Working report	✓				✓			GoSW guardian (Jennifer O'Neill)
Company secretary's report: - Compliance with Code of governance for NHS provider trusts 2025/26 - Compliance with licence conditions 2025/26 - Compliance with governing documents	✓							Company secretary
Risk management framework inc. risk appetite			✓					Company secretary
Annual review of SOs, SFIs, and SoD RoP			✓					Company secretary / Chief finance officer
Audit committee annual report			✓					Committee Chair
Annual Board effectiveness review incl. Board self assessment							✓	Trust Chair / Company secretary
Annual review of committee ToR	✓							Committee Chair's / Company secretary
Board work programme 2027/28							✓	Company secretary
Annual review of register of sealings							✓	Company secretary
Finance and performance								
Integrated quality and performance report: key strategic projects, KSO1, KSO2, KSO3, KSO4 and KSO5	✓		✓	✓	✓	✓	✓	Chief operating officer
Business planning 2026/27 - approval	✓							Chief finance officer / Chief operating officer
Business planning 2027/28 - update (provisional dates subject to business planning guidance)					✓	✓		Chief finance officer / Chief operating officer
Business plan 2027/28 - approval (provisional dates subject to business planning guidance)							✓	Chief finance officer / Chief operating officer
Annual items								
Quality annual reports: - learning from deaths - safeguarding - Infection, prevention and control - complaints - research & innovation - consultant revalidation			✓					Chief nursing officer & chief medical officer
Workforce annual reports: - WRES and WDES annual reports 2025/26 - Gender pay gap as at 31 March 2026 - Ethnicity pay gap as at 31 March 2026				✓				Chief people officer
- EDI annual report 2025/26 and action plan					✓			Chief people officer
Operational annual reports: - Emergency planning, response and resilience							✓	Chief operating officer
Annual review of learning from patient stories			✓					Chief nursing officer
6 monthly safe staffing review			✓			✓		Chief nursing officer
National inpatient survey results				✓				Chief nursing officer
Cancer patient survey				✓				Chief nursing officer
National staff survey results	✓							Chief people officer
Annual review of raising concerns						✓		Chief people officer Chief nursing officer
Annual assessment of organisational culture					✓			Chief people officer
Bi-annual assessment of addressing health inequalities	✓				✓			Chief operating officer
Premises assurance model - approval				✓				Chief executive offcer

Bi-annual digital update			✓			✓		Chief people officer
Committee assurance								
Quality & safety committee assurance	✓		✓	✓	✓	✓	✓	Committee chair
Finance & performance committee assurance	✓		✓	✓	✓	✓	✓	Committee chair
Audit & risk committee assurance	✓		✓	✓	✓	✓	✓	Committee chair
Strategy & culture committee assurance	✓		✓	✓	✓	✓	✓	Committee chair
Annual report & accounts								
Annual report 2025/26		✓						Company secretary
Audited annual accounts 2025/26 incl. external audit opinion		✓						Chief finance officer
Quality account 2025/26		✓						Chief nursing officer
Ad-hoc items								
Trust Constitution updates								Company secretary
Private business								
Strategic partnership implementation	✓		✓	✓	✓	✓	✓	Acting Chief executive officer

Report cover-page					
References					
Meeting title:	Board of Directors				
Meeting date:	12/03/2026		**Agenda reference:**	**151-26**	
Report title:	Annual report on the use of the Trust seal 2025/26				
Sponsor:	Leonora May, Company secretary				
Author:	Leonora May, Company secretary				
Appendices:	Appendix one: entries to register of sealing 2025/26				
Executive summary					
Purpose of report:	To provide the Board with an annual report on the use of the Trust seal, in line with the requirement within the Trust's standing orders.				
Summary of key issues	Since 1 April 2025, the Trust seal has been affixed to four documents as authorised by the Chief executive officer and Chief finance officer. The seal was attested by the Trust Chair and Chief executive officer. The entries to the register of sealing are appended to this report and were related to the East Grinstead Community diagnostic centre (CDC), the Bognor Regis CDC and the land sale: 1/25 21 July 2025: Agreement between (1) Queen Victoria Hospital NHS Foundation Trust and (2) Logan Construction (South East) Ltd for works related to the East Grinstead Community Diagnostic Centre 2/25 21 October 2025: Lead Designer Deed of Appointments relating to the construction of a Community Diagnostic centre at the University of Chichester, Upper Bognor Rd, Bognor Regis PO21 1HR between (1) Queen Victoria Hospital NHS Foundation Trust and (2) AK Design Partnership LLP 3/25 23 October 2025: Deed of Variation related to the land sale between (1) Queen Victoria Hospital NHS Foundation Trust and (2) Macar Partnerships (QVH) Limited 4/25 23 October 2025: Deed of Release of covenants related to the land sale between (1) Queen Victoria Hospital NHS Foundation Trust and (2) Macar Partnerships (QVH) Limited				
Recommendation:	The Board is asked to **note** the contents of this 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:	BAF regulation- ensures compliance with the Trust's standing orders
Organisational risk register:	None
Regulation:	Ensures compliance with the Trust's standing orders
Legal:	None
Resources:	None

Assurance route				
Previously considered by:	NA			
	Date:		Decision:	
Next steps:	NA			

Report to: Board of Directors
Agenda item: 151-26
Date of meeting: 12 March 2026
Report from: Leonora May, Company secretary
Report author: Leonora May, Company secretary
Date of report: February 2026
Appendices: Appendix one: entries to register of sealing 2025/26

Annual report on the use of the Trust seal 2025/26

Introduction

The purpose of this paper is to provide the Board with an update on the use of the Trust seal, in line with the requirement in section 10 of the Trust's Standing Orders.

Background

S.10 of the Trust's Standing orders state:

Sealing of Documents

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

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

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

Register of sealing

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

Annual report

Since 1 April 2025, the Trust seal has been affixed to four documents as authorised by the Chief executive officer and Chief finance officer. The seal was attested by the Trust Chair and Chief executive officer. The entries to the register of sealing are

appended to this report and were related to the East Grinstead Community diagnostic centre (CDC), the Bognor Regis CDC and the land sale:

1/25 21 July 2025:
Agreement between (1) Queen Victoria Hospital NHS Foundation Trust and (2) Logan Construction (South East) Ltd for works related to the East Grinstead Community Diagnostic Centre

2/25 21 October 2025:
Lead Designer Deed of Appointments relating to the construction of a Community Diagnostic centre at the University of Chichester, Upper Bognor Rd, Bognor Regis PO21 1HR between (1) Queen Victoria Hospital NHS Foundation Trust and (2) AK Design Partnership LLP

3/25 23 October 2025:
Deed of Variation related to the land sale between (1) Queen Victoria Hospital NHS Foundation Trust and (2) Macar Partnerships (QVH) Limited

4/25 23 October 2025:
Deed of Release of covenants related to the land sale between (1) Queen Victoria Hospital NHS Foundation Trust and (2) Macar Partnerships (QVH) Limited

Recommendation
The Board is asked to **note** this annual report of sealings.

NHS
Queen Victoria Hospital
NHS Foundation Trust

REGISTER FORM

To be completed for each use of the Trust's seal electronically, except for signature

Date	Description	Authorised Signatory CEO and DoF or nominee Those who attested seal
21/07/2025	Agreement between (1) Queen Victoria Hospital NHS Foundation Trust and (2) Logan Construction (South East) Ltd for works related to the East Grinstead Community Diagnostic Centre	Chief Executive officer (Abigail Jago): AJago. Chief Finance Officer (Simon Marshall): SMarshall Jackie Smith (Trust Chair):

1/25

NHS
Queen Victoria Hospital
NHS Foundation Trust

REGISTER FORM

To be completed for each use of the Trust's seal electronically, except for signature

Date	Description	Authorised Signatory CEO and DoF or nominee
21/10/2025	Lead Designer Deed of Appointment relating to the construction of a Community Diagnostic Centre at the University of Chichester, Upper Bognor Rd, Bognor Regis PO21 1HR between (1) Queen Victoria Hospital NHS Foundation Trust (2) AK Design Partnership LLP	Chief Finance Officer (Simon Marshall): Marshall Chief Executive Officer (Abigail Jago): AJago Trust Chair (Jackie Smith):

2/25

NHS
Queen Victoria Hospital
NHS Foundation Trust

REGISTER FORM

To be completed for each use of the Trust's seal electronically, except for signature

3/25

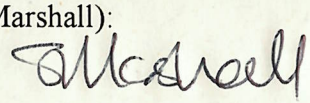
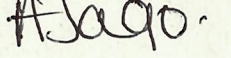
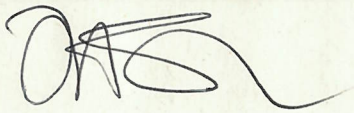
Date	Description	Authorised Signatory CEO and DoF or nominee
23/10/2025	Deed of Variation related to the land sale between (1) Queen Victoria Hospital NHS Foundation Trust (2) Macar Partnerships (QVH) Limited	Chief Finance Officer (Simon Marshall): Chief Executive Officer (Abigail Jago): Trust Chair (Jackie Smith):

NHS
Queen Victoria Hospital
NHS Foundation Trust

REGISTER FORM

To be completed for each use of the Trust's seal electronically, except for signature

4/25

Date	Description	Authorised Signatory CEO and DoF or nominee
23/10/2025	Deed of Release of convenants related to the land sale between (1) Queen Victoria Hospital NHS Foundation Trust (2) Macar Partnerships (QVH) Limited	Chief Finance Officer (Simon Marshall):  Chief Executive Officer (Abigail Jago):  Trust Chair (Jackie Smith): 

Report cover-page					
References					
Meeting title:	Board of Directors				
Meeting date:	12/03/2026	**Agenda reference:**	**152-26**		
Report title:	Trust Constitution				
Sponsor:	Leonora May, Company secretary				
Author:	Leonora May, Company secretary				
Appendices:	Appendix one: Trust Constitution				
Executive summary					
Purpose of report:	To seek approval of changes to the Trust's Constitution.				
Summary of key issues	There are a number of governors coming to the end of their first or second terms in 2026. The Trust's Constitution currently allows governors to serve up to two terms of three years. Staff and public governor elections are being held during 2026 to fill the vacancies that will arise during 2026 to ensure that governor statutory duties can be fulfilled and ensure that the Council of Governors can hold quorate meetings. It will also be important to ensure continuity and stability for the Council of Governors during a time of significant change. Current governors wishing to serve a further term will need to go through re-election in order to be elected for a further term. Given the need for continuity and the likelihood of not all vacant roles being filled given the ten year plan, it is proposed that the Trust's Constitution is updated to allow governors to serve up to three terms of three years. This would allow governors coming to the end of their second term to put themselves forward for re-election.				
Recommendation:	The Board is asked to **approve** the change to the Trust's Constitution as outlined in this report and as appended.				
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- regulation				
Organisational risk register:	None				
Regulation:	Code of governance for NHS provider trusts				
Legal:	None				
Resources:	None				
Assurance route					
Previously considered by:	Council of Governors				
	Date:	Feb 2026	Decision:	Approved	
Next steps:	Updated Constitution to take effect immediately				

Report to:	Board of Directors
Agenda item:	152-26
Date of meeting:	12 March 2026
Report from:	Leonora May, Company secretary
Report author:	Leonora May, Company secretary
Date of report:	February 2026
Appendices:	Appendix one: Trust Constitution

Trust Constitution

Introduction

This report seeks approval from the changes of changes to the Trust's Constitution. Changes to the Trust's Constitution require approval from the Council of Governors and the Board of Directors. The Council of Governors approved these changes at its meeting on 25 February 2026.

Background

There are a number of governors coming to the end of their first or second terms in 2026. The Trust's Constitution currently allows governors to serve up to two terms of three years.

Staff and public governor elections are being held during 2026 to fill the vacancies that will arise during 2026 to ensure that governor statutory duties can be fulfilled and ensure that the Council of Governors can hold quorate meetings. It will also be important to ensure continuity and stability for the Council of Governors during a time of significant change.

Current governors wishing to serve a further term will need to go through re-election in order to be elected for a further term.

Given the need for continuity and the likelihood of not all vacant roles being filled given the ten year plan, it is proposed that the Trust's Constitution is updated to allow governors to serve up to three terms of three years. This would allow governors coming to the end of their second term to put themselves forward for re-election.

The Code of governance for NHS provider trusts states that 'Elected foundation trust governors must be subject to re-election by the members of their constituency at regular intervals not exceeding three years…**Best practice is that governors do not serve more than three consecutive terms** to ensure that they retain the objectivity and independence required to fulfil their roles'.

The NHS ten year health plan 'fit for the future' sets out the intention to remove the requirement for NHS foundation trusts to have governors. To date, no further guidance has been received from NHSE, other than to continue as business as usual until such time that new legislation is passed removing governors statutory powers. The legislation is expected in April 2027 and until that time governors continue to have important statutory duties to fulfil. Other foundation trusts across the country have continued with elections to fill roles.

Constitution

17.2 of the Trust's Constitution has been updated to read 'all governors may hold office for a maximum of three terms', This is the only change proposed to the Constitution.

Recommendation
The Board is asked to **approve** the change to the Trust's Constitution as outlined in this report and as appended.

Queen Victoria Hospital
NHS Foundation Trust

Queen Victoria Hospital
NHS Foundation Trust

(A Public Benefit Corporation)

Constitution

(updated as per the Health and Social Care Act 2012)

Document control sheet		
Document title		Queen Victoria Hospital NHS Foundation Trust Constitution
Version	1	Agreed by the Council of Governors at a meeting held in public on 16 April 2013
Version	2	Amended by the Council of Governors at a meeting held in public on 19 June 2014
Version	3	Amended to incorporate the 2014 Model Election Rules, as notified to the Council of Governors at a meeting held in public on 11 December 2014
Version	4	Amended by the Council of Governors at a meeting held in public on 8 October 2015 • Provisions 18.1.5 and 18.1.7 Council of Governors – disqualification and removal • Provision 38.1 Board of Directors – disqualification
Version	5	Amended by the Council of Governors at a meeting held in public on 21 April 2016 • Annex 1 – The public Constituency
Version	6	Approved by the Board of Directors at its meeting on 6 July 2017 and by the Council of Governors at the Trust's AGM on 31 July 2017 • References to Chairman are now shown as Chair • Reference to both male and female gender shown throughout the documentation. • Following agreement by the Council of Governors at its meeting on 20 October 2016, the title Governor Representative to the Board has been changed to Lead Governor. • At the same meeting, Council agreed that the roles of Lead governor and Vice-Chair should be amalgamated; the Constitution has been revised to reflect this change.
Version	7	Approved by the Board of Directors at its meeting on 07 November 2019 and by the Council of Governors at its meeting on 13 January 2020. • Wording of S18.1 amended to reflect wording of S.11, making it clear that an individual who satisfies criteria for membership of one constituency shall not become or continue as a member of any other constituency
Version	8	Approved by the Board of Directors at its meeting on 07 January 2021 and by the Council of Governors at its meeting on 11 January 2021. • Amendment to S16.6 and Annex 3 (CoG vacancies) • Amendments to 17.1 and 17/2 to ensure consistency • Amendment concerning processing of membership applications • Amendment to GSG Terms of Reference (S.25) • Amendment to wording of paragraph 4.2 'exercisable' from 'exercised' • Updating of pronouns.

Version	9	Approved by the Board of Directors at its meeting on 05 August 2021 and by the Council of Governors at its meeting on 19 July 2021. • Rescinding amendments to GSG Terms of Reference (S.25) agreed in January 2021.
Version	10	Approved by the Council of Governors at its meeting on 21 February 2022 and by the Board of Directors at its meeting on 3 March 2022. • Lead governor: amendment to interpretation and definitions. • Lead governor: amendment to section 26.1 • Lead governor: amendment to sections 26.2 and 26.3 • Lead governor attendance at Board of Directors meetings: Amendment to section 39.6 • Chairing of Council of governor meetings: Amendment to section 21.14
Version	10a	Correction of administrative error, numbering of section 18
Version	10b	Correction of administrative error to remove the text in section 21.15 and correct numbering of section 21.15 to section 22
Version	11	Approved by the Council of Governors at its meeting on 15 July 2024 and by the Board of Directors at its meeting on 12 September 2024. • Amendments to S18.1.7amendment to make clear that a person may not become or continue to be a governor if they have previously been removed as a QVH governor • Amendments S18.17 to include express provision for Chair to suspend a governor • Addition S18.18 to include a provision which states a governor may not stand for re-election or be reappointed whilst they are suspended • Amendments S21.6 to make clear that the Chair may call a meeting of the Council of Governors • Amendments S25 to update the name of the Governor steering committee • Amendments S26 to include reference to Deputy Lead Governor role
Version	12	Amendment to 17.2 to confirm that all governors may serve up to three terms of three years

Preamble

This document is the Constitution for the Queen Victoria Hospital NHS Foundation Trust.

An NHS Foundation Trust is a Public Benefit Corporation authorised under the National Health Service Act 2006 (the 2006 Act) to provide goods and services for the purposes of the health service in England. A Public Benefit Corporation is a body corporate which is constituted in accordance with Schedule 7 of the 2006 Act. The Constitution provides, inter alia, for the Trust to have Members, Governors and Directors, and determines who may be eligible for Membership and how Governors and Directors are appointed and defines their respective roles and powers. Further, Members of the Trust may attend and participate at public meetings of the Trust, vote in elections of, and stand for election for, the Council of Governors, as provided in this Constitution.

The NHS Constitution is a Department of Health publication and establishes the principles and values for staff and patients. It sets out the rights to which patients, public and staff are entitled, and pledges which the NHS is committed to achieve. It also sets out responsibilities which the public, patients and staff owe to one another to ensure that the NHS operates fairly and effectively.

TABLE OF CONTENTS

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1 Interpretation and definitions

Unless a contrary intention is evident or the context requires otherwise, words or expressions contained in this Constitution shall bear the same meaning as in the 2006 Act or as amended by the Health and Social Care Act 2012.

References in this Constitution to legislation include all amendments, replacements or re-enactments made and include all subordinate legislation made thereunder.

Headings are for ease of reference only and are not to affect interpretation.

Words importing the singular shall import the plural and vice-versa.

All annexes referred to in this Constitution form part of it.

In this Constitution:

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

the 2012 Act is the Health and Social Care Act 2012;

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

Affiliate Member means anyone under the age of 18 or who lives outside the areas specified in Annex 1 as the area for the Public Constituency who shall receive information about the Foundation Trust but who shall not be entitled to vote in Governor elections;

Annual Accounts means those accounts prepared by the Foundation Trust in accordance with paragraph 25 of Schedule 7 to the 2006 Act;

Annual Governors' Meeting is defined in paragraphs 21.3 and 27.1 of this Constitution;

Annual Members' Meeting is defined in paragraph 28 of this Constitution;

Annual Report means a report prepared by the Foundation Trust in accordance with paragraph 26 of Schedule 7 to the 2006 Act;

Appointed Governors means a Local Authority Governor or Partnership Governor;

Appointments Committee means a committee comprised of Governors for the purpose of carrying out activities and functions in accordance with its terms of reference;

Area of the Foundation Trust means an area specified in Annex 1 as an area for a Public constituency;

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

Auditor means the Auditor of the Foundation Trust appointed by the Council of Governors in accordance with paragraph 46 of this Constitution;

Board of Directors means the Board of Directors of the Foundation Trust, constituted in

accordance with this Constitution;

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

Chief Executive means the Chief Executive of the Foundation Trust;

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

Close Family Member means either a:

a) Spouse;

b) Person whose status is that of "Civil Partner" as defined in the Civil Partnerships Act 2004 or a co-habitee;

c) Child, step child or adopted child;

d) Sibling;

e) Parent; or

f) Nephew, niece or cousin;

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

Constitution means this Constitution and all annexes to it;

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

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

Director means a member of the Board of Directors;

Directors' Code of Conduct means the Code of Conduct for Directors of the Foundation Trust, as adopted by the Foundation Trust and as amended from time to time by the Board of Directors, to which all Directors must subscribe;

Disclosure and Barring Service means the Executive Agency of the Home Office to which the Secretary of State has delegated his/her functions under Part V of the Police Act 1977 in relation to applications for criminal records certificates and enhanced criminal record certificates as established by section 87(1) of the Protection of Freedoms Act 2012;

Elected Governor means a Public Governor or a Staff Governor;

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

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

Forward Plan means the document prepared by the Foundation Trust in accordance with paragraph 27 of Schedule 7 to the 2006 Act;

Foundation Trust means the Queen Victoria Hospital NHS Foundation Trust;

Governor means a member of the Council of Governors;

Governors' Code of Conduct means the Code of Conduct for Governors of the Foundation Trust, as adopted by the Foundation Trust and as amended from time to time by the Council of Governors, to which all Governors must subscribe;

Lead Governor means the governor nominated by the Trust to fulfil the role described in Appendix B to The NHS Foundation Trust Code of Governance (Monitor, December 2013) or any later version of such code and as set out in the role description and personal specification.

Governors Steering Group means a group of Governors chosen by the Council of Governors and chaired by the Vice-Chair of the Council of Governors that supports the work of the Council of Governors and the phrase "GSG" shall be construed accordingly;

Health Service Body shall have the meaning ascribed to "NHS Body" in Section 275 of the 2012 Act;

Interested Director shall have the meaning ascribed to "Interested Director" in paragraph 40.11.1 of this Constitution;

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

Local Authority Governor means a member of the Council of Governors appointed by one or more Local Authorities whose area includes the whole or part of the area of the Foundation Trust;

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

Member means a Member of the Foundation Trust and the term "Membership" shall be construed accordingly;

Membership Strategy means the document of that name which describes the Foundation Trust's strategy to set up systems and processes to establish, maintain and develop its Membership;

Model Election Rules means the rules set out in Annex 4 of this Constitution;

Monitor is the body corporate known as Monitor, as provided by Section 61 of the 2012 Act;

Nomination and Remuneration Committee means a committee constituted in accordance with paragraph 37;

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

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

Partnership Governor means a member of the Council of Governors other than a Public Governor, a Staff Governor or a Local Authority Governor;

Partnership Organisation means an organisation that may appoint a Partnership Governor and which is listed in Annex 3 of this Constitution;

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

Public Constituency is defined in paragraph 8 of this Constitution;

Public Governor means a member of the Council of Governors elected by Members of the Public Constituency;

Registered Dentist means a fully registered person within the meaning of the Dentists Act 1984 who holds a licence to practise under that Act;

Registered Medical Practitioner means a fully registered person within the meaning of the Medicines Act 1983 who holds a licence to practise under that Act;

Registered Midwife means a fully registered person within the meaning of the Nurse and Midwifery Order 2001 (SI 2001/253);

Registered Nurse means a fully registered person within the meaning of the Nurse and Midwifery Order 2001 (SI 2001/253);

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

Replacement Governor is defined in paragraph 16.4 of this Constitution;

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

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

Sex Offenders' Order means either:

a) a Sexual Offences Prevention Order made under Section 104 or Section 105 of the Sexual Offences Act 2003; or

b) an Interim Sexual Offences Prevention Order made under Section 109 of the Sexual Offences Act 2003; or

c) a Foreign Travel Order made under Section 114 of the Sexual Offenders Act; or

d) a Risk of Harm Order made under Section 123 of the Sexual Offences Act 2003; or

e) an Interim Risk of Sexual Harm made under Section 126 of the Sexual Offences Act 2003;

Sex Offenders' Register means the notification requirements set out in Part 2 of the Sexual Offences Act 2003, commonly known as the Sex Offenders' Register;

Staff Constituency is defined in paragraph 9 of this Constitution;

Staff Governor means a member of the Council of Governors elected by the Members of the Staff Constituency; and

2 Name

2.1 The name of the Foundation Trust is the Queen Victoria Hospital NHS Foundation Trust (the "Foundation Trust").

3 Principal Purpose

3.1 The Principal Purpose of the Foundation Trust is the provision of goods and services for the purposes of the health service in England.

3.2 The Foundation Trust does not fulfil its Principal Purpose unless, in each Financial Year, its total income from the provision of goods and services for the purposes of the health service in England is greater than its total income from the provision of goods and services for any other purposes.

3.3 The Foundation Trust may provide goods and services for any purposes related to:

3.3.1 the provision of services provided to individuals for or in connection with the prevention, diagnosis or treatment of illness, and

3.3.2 the promotion and protection of public health.

3.4 The Foundation Trust may also carry on activities other than those mentioned in the above paragraph for the purpose of making additional income available in order to better carry on its Principal Purpose.

4 Powers

4.1 The powers of the Foundation Trust are set out in the 2006 Act.

4.2 All the powers of the Foundation Trust shall be exercisable by the Board of Directors on behalf of the Foundation Trust.

4.3 Any of these powers may be delegated to a committee of Directors or to an Executive Director.

4.4 In performing its NHS functions, the Foundation Trust shall have regard to the NHS Constitution. For the purpose of this paragraph, "NHS functions" means functions under an enactment which is a function concerned with, or connected to, the provision, commissioning or regulation of NHS services and "NHS services" means health services provided in England for the purposes of the health service under Section1(1) of the 2006 Act.

5 Other purposes

5.1 The Foundation Trust shall operate for the public benefit and aspire to the highest standards of public service, including respect for the rights of individuals and the environment. The Foundation Trust will operate effectively, efficiently and economically and invest any surpluses in its future.

5.2 The Foundation Trust shall, as appropriate, involve itself in education, training and research activities, in furtherance of its Principal Purpose.

6 Membership and constituencies

6.1 The Foundation Trust shall have Members, each of whom shall be a Member of one of the following constituencies:

6.1.1 the Public Constituency; or

6.1.2 the Staff Constituency.

7 Application for Membership

7.1 An individual who is eligible to become a Member of the Foundation Trust may do so on application to the Foundation Trust.

7.2 Subject to paragraph 9.5 below, applicants for Membership of the Foundation Trust must complete a form prescribed by the Chief Executive or the Secretary.

7.3 All Members of the Foundation Trust shall be under a duty to notify the Secretary of any change in their particulars which may affect their entitlement as a Member.

7.4 It shall be the responsibility of Members to ensure their eligibility and not that of the Foundation Trust.

7.5 Anyone under the age of 18 or who lives outside the area specified in Annex 1 as the area for the Public Constituency and who wishes to become a Member of the Foundation Trust shall become an Affiliate Member of the Foundation Trust. An Affiliate Member shall receive information sent to all Members about the Foundation Trust but shall not be entitled to vote in Governor elections.

8 Public Constituency

8.1 An individual who lives in the area specified in Annex 1 as the area for the Public Constituency may become or continue as a Member of the Foundation Trust.

8.2 Those individuals who live in the area specified for the public constituency are referred to collectively as the Public Constituency.

8.3 The minimum number of Members in the Public Constituency is specified in Annex 1.

8.4 The Secretary shall, on receipt of an application and subject to being satisfied that the applicant is eligible, ensure the applicant's name is entered into the Foundation Trust's register of Members at which point they shall become a Member of the Foundation Trust.

8.5 The Secretary may require any individual to supply supporting evidence to confirm eligibility.

8.6 The Secretary will endeavour to complete the membership application process within 20 working days; when a governor election has been announced membership applications will be processed within 5 working days of all supporting evidence being made available by the applicant.

9 Staff Constituency

9.1 An individual who is employed by the Foundation Trust under a contract of employment with the Foundation Trust may become or continue as a Member of the Foundation Trust provided:

9.1.1 he/she is employed by the Foundation Trust under a contract of employment which has no fixed term or has a fixed term of at least 12 months;

9.1.2 he/she has been continuously employed by the Foundation Trust under a contract of employment for at least 12 months; and

9.2 Those individuals who are eligible for Membership of the Foundation Trust by reason of the previous provisions are referred to collectively as the Staff Constituency.

9.3 The minimum number of Members in the Staff Constituency is specified in Annex 2.

9.4 For the purposes of paragraph 9.1 above, Chapter 1 of Part 14 of the Employment Rights Act 1996 shall apply for the purposes of determining whether an individual has been continuously employed by the Foundation Trust.

9.5 An individual who is eligible to become a Member of the Staff Constituency under paragraph 9.1 above, and who is invited by the Foundation Trust to become a Member of the Staff Constituency, shall become a Member of the Staff Constituency without an application being made, unless he/she informs the Foundation Trust that he/she does not wish to do so.

10 Membership

10.1 The Foundation Trust shall at all times strive to ensure that, taken as a whole, its actual Membership of the Public Constituency is representative of those eligible for Membership of the Foundation Trust.

10.2 The area set out for the Public Constituency shall have regard to the need for those eligible for such Membership to be representative of those to whom the Foundation Trust provides services.

11 Restriction on Membership

11.1 An individual who is a Member of a constituency shall not, while Membership of that constituency continues, be a Member of any other constituency.

11.2 An individual who satisfies the criteria for Membership of the Staff Constituency shall not become or continue as a Member of any constituency other than the Staff Constituency.

11.3 An individual must be at least 18 years old to become a Member of the Foundation Trust.

11.4 An individual shall not become or continue as a Member of the Foundation Trust if:

11.4.1 he/she has been confirmed as an habitual and/or vexatious complainant in accordance with the Foundation Trust's policy for handling complaints; or

11.4.2 he/she has been deemed to have acted in a manner detrimental to and

contrary to the interests and values of the Foundation Trust or has failed to agree to and abide by the values of the Foundation Trust.

12 Expulsion from Membership

12.1 If a Member is found to be in contravention of paragraph 11 above, a resolution to expel them shall be considered by a committee comprising the Chair, the Lead Governor and the Secretary.

12.2 The committee (as set out above) shall consider the complaint, taking such steps as it considers appropriate to ensure that the Member's point of view is heard.

12.3 Where a Member is deemed by the committee to be in contravention of paragraph 11, the Member shall be suspended immediately and the committee's recommendation shall be taken to the next general meeting of the Council of Governors for approval. The Member shall be duly informed.

12.4 At the general meeting of the Council of Governors at which the committee's recommendation to expel a Member is considered, the Council of Governors shall be at liberty to either:

12.4.1 agree with the committee's recommendation, by a three quarters majority vote of those Governors present, and expel the Member immediately; or

12.4.2 remove the Member's suspension with immediate effect should the Council of Governors not agree with the committee's recommendation.

12.5 In either case, the Member shall be duly informed of the decision of the Council of Governors.

12.6 No person who has been expelled from Membership in accordance with these provisions shall be re-admitted as a Member except by a resolution carried by the votes of three quarters of the members of the Council of Governors present and voting at a general meeting in favour of the individual concerned being re-admitted.

13 Termination of Membership

13.1 A Member shall cease to be a Member on:

13.1.1 death; or

13.1.2 resignation by notice in writing to the Secretary;

13.1.3 ceasing to fulfil the requirements of paragraphs 8, 9 or 11 of this Constitution or being expelled in accordance with in paragraph 12 above.

14 Council of Governors – composition

14.1 The Foundation Trust is to have a Council of Governors, which shall comprise both Elected Governors and Appointed Governors.

14.2 The composition of the Council of Governors is specified in Annex 3.

14.3 The members of the Council of Governors, other than the Appointed Governors, shall

be chosen by election by their constituency.

14.4 The number of Governors to be elected by each constituency is specified in Annexes 1 and 2.

14.5 More than half of the members of the Council of Governors shall be Governors from the Public Constituency.

15 Council of Governors – election of Governors

15.1 Elections for elected members of the Council of Governors shall be conducted using the first past the post method in accordance with the Model Election Rules.

15.2 The Model Election Rules, as published from time to time by the Department of Health and which may be varied from time to time, form part of the Constitution. The current Model Election Rules are attached at Annex 4.

15.3 A subsequent variation of the Model Election Rules by the Department of Health shall not constitute a variation of the terms of the Constitution for the purposes of paragraph 53 of this Constitution (Amendment of the Constitution).

15.4 An election, if contested, shall be by secret ballot.

15.5 A person may not vote at an election or stand for election as an Elected Governor unless, within the specified period in the Model Election Rules, he/she has made a declaration in the form specified in paragraph 15.6. It is an offence to knowingly or recklessly make a declaration which is false in a material particular.

15.6 The specified form of declaration referred to in paragraph 15.5 above regarding the declaration to stand for election as an Elected Governor shall be as set out on the nomination paper referred to in rule 12 of the Model Election Rules and shall also state as follows:

15.7 *"I declare that, to the best of my knowledge, I am eligible to stand for election to the Council of Governors for the seat named in Section 2 of this form. I declare that, to the best of my knowledge, I am not de-barred from standing for election by any of the provisions detailed at Section 3 of this form. I declare that I have stated details of any political membership and financial interests I have in the Foundation Trust at Section 4 of this form. I declare that I am a member of the Foundation Trust and that I have attended a pre-election Governor awareness training session or equivalent, as agreed by the Company Secretary. I understand that if any of these declarations are later found to be false, I will, if elected, lose my seat on the Council of Governors and may also have my Membership withdrawn."*

16 Council of Governors – vacancies

16.1 Where a vacancy arises on the Council of Governors for any reason other than expiry of a term of office, the provisions set out below will apply.

16.2 Where the vacancy arises amongst the Elected Governors, the Council of Governors shall be at liberty either:

16.2.1 to call an election to fill the remainder of the unexpired term of office where it is in excess of one year; or

16.2.2 to invite the next highest polling candidate for that seat at the most recent election or (where relevant) by-election, who is willing to take office, to fill the seat for the remainder of the unexpired term of office where it is in excess of one year. If that candidate does not accept to fill the vacancy, it may be offered to the next highest polling candidate until the vacancy is filled; or

16.2.3 where no reserve candidate is available or willing to fill the vacancy, to call an election; or

16.2.4 to leave the seat vacant until the next scheduled elections are to be held where the unexpired term of office is one year or less.

16.3 When deciding on a course of action, the Council of Governors must always ensure that the aggregate number of Governors who are Public Governors on the Council of Governors always remains in the majority.

16.4 Where the vacancy arises amongst the Appointed Governors, the Secretary will request the relevant Partnership Organisation to appoint a Replacement Governor, in line with the eligibility criteria set out for Governors at paragraph 18 and Annex 5, to hold office for the remainder of the unexpired term of office. The Partnership Organisation shall agree the appointment of a Replacement Governor with the Secretary within three months of being notified.

16.5 The validity of any act of the Council of Governors is not affected by any vacancy among the Governors or by any defect in the appointment of any Governor.

16.6 Where a vacancy arises on the Council of Governors amongst the Public Governors for reason of the expiry of a term of office, the provisions relating to such a vacancy set out in Annex 3 will apply.

17 Council of Governors – tenure

17.1 All governors may hold office for a term of up to three years

17.2 All governors may hold office for a maximum of three~~wo~~ terms

17.3 A governor shall be eligible for re-election or re-appointment at the end of his/her term subject to 17.2 (above)

17.4 An Elected Governor shall cease to hold office if he/she ceases to be a member of the constituency by which he/she was elected.

17.5 An Appointed Governor shall cease to hold office if the appointing organisation withdraws its sponsorship of him/her.

17.6 Any Governor shall cease to hold office if he/she is disqualified for any of the reasons set out in the constitution.

18 Council of Governors – disqualification and removal

18.1 In line with section 11.1, an individual who is a member of a constituency shall not, while membership of that constituency continues, be a member of any other constituency. In addition, the following may not become or continue as a member of the Council of Governors:

18.1.1 He/she is a person in relation to whom a moratorium period under a debt relief order applies (under Part 7A of the Insolvency Act 1986);

18.1.2 in the case of an Elected Governor, he/she ceases to be a Member of the relevant constituency by which he/she was elected;

18.1.3 in the case of an Appointed Governor, the appointing organisation withdraws their sponsorship of him/her;

18.1.4 he/she is under 18 years of age at the date at which he/she is nominated for election or appointment;

18.1.5 he/she is a Director of the Foundation Trust, or an executive director, non-executive director or Chair of another NHS foundation trust, or other Health Service Body (unless they are appointed by an appointing organisation which is an NHS body);

18.1.6 he/she is a governor of another NHS foundation trust and there presents a conflict of interest with the affairs of the Foundation Trust which cannot be resolved;

18.1.7 he/she has been a Director of the Foundation Trust in the preceding five years prior to the date of his/her nomination to stand as an Elected Governor, or in the case of an Appointed Governor, the date of his/her appointment;

18.1.8 subject to paragraphs 18.7 and 18.8 below, he/she is incapable by reason of his/her mental disorder, illness or injury of managing and/or administering his/her property and/or affairs;

18.1.9 prior to putting himself/herself forward for consideration as an Elected Governor or Appointed Governor, he/she has

- failed to register as a member of the Foundation Trust
- has registered but failed to allow sufficient time for his/her application to be processed (ie. five working days) prior to the date of a governor awareness training session (pre-election event);
- failed to attend a pre-election or pre-appointment governor awareness training event, the purpose of which is to ensure that prospective Governors are made fully aware of the responsibilities and duties of a Governor and the commitments that the role entails, prior to the individual standing for office as a Governor;

18.1.10 he/she has refused, without reasonable cause, to undertake any training which the Foundation Trust and/or Council of Governors requires all Governors to undertake;

18.1.11 he/she is a person who, by reference to information revealed by a Disclosure and Barring Service check, is considered by a committee comprising the Chair, Lead Governor and Secretary to be inappropriate on the grounds that his/her appointment might adversely affect public confidence in the Foundation Trust or otherwise might bring the Foundation Trust into disrepute;

18.1.12 he/she has failed any other relevant identity or other check carried out by the Foundation Trust;

18.1.13 he/she has failed to sign and deliver to the Secretary a statement in the form required by the Foundation Trust confirming acceptance of the Governors' Code of Conduct;

18.1.14 he/she has failed to make, or falsely makes, any declaration required by paragraph 15.6 of this Constitution;

18.1.15 he/she has been declared by the Council of Governors to be an habitual and/or vexatious complainant;

18.1.16 the relevant Partnership Organisation which he/she represents ceases to exist;

18.1.17 he/she has been expelled or removed from the post of governor from the Foundation Trust or another NHS foundation trust; or

18.1.18 he/she is an active member of a body or organisation with policies or objectives such that his/her membership thereof would likely cause the Foundation Trust to be in breach of its statutory obligations or to bring the Foundation Trust into disrepute.

18.2 Further circumstances in which an individual may not become or continue as a member of the Council of Governors are set out in Annex 5.

18.3 Where a person has been elected or appointed to be a Governor and he/she becomes disqualified under provisions set out paragraph 18 or Annex 5, he/she shall notify the Secretary in writing of such disqualification as soon as is practicable and, in any event, within ten Clear Days of first becoming aware of those matters which rendered him/her disqualified.

18.4 If it comes to the notice of the Secretary at the time of his/her taking office or later that the Governor is so disqualified, the Secretary shall immediately declare that the Governor in question is disqualified and notify him/her in writing to that effect as soon as is practicable.

18.5 Upon dispatch of any such notification, a Governor's tenure of office, if any, shall be terminated immediately and the Secretary shall cause his/her name to be removed from the register of members of the Council of Governors. From that point, the individual shall immediately cease to be or act as a Governor.

18.6 If a Governor is found to be incapable, by reason of mental disorder, illness or injury, of managing and/or administering his/her property and/or affairs for the purposes of paragraphs 18.1.8 above, a committee comprising the Chair, Secretary, and Lead Governor shall be convened.

18.7 The committee (as set out above) shall consider the Governor's circumstances, taking such steps as it considers appropriate to ensure that the Governor's views are understood.

18.8 Where the committee deems that the Governor is incapable, by reason of mental disorder, illness or injury, of managing and/or administering his/her property and/or affairs, he/she shall be immediately suspended from office. The Governor shall be duly

informed.

18.9 The committee shall make a recommendation to the next general meeting of the Council of Governors that the Council of Governors should either:

18.9.1 temporarily suspend the Governor from office until such time the Council of Governors, in its absolute discretion, considers the Governor to be capable of managing and/or administering his/her property and/or affairs; or

18.9.2 disqualify the Governor from office where the Council of Governors in its absolute discretion, considers him/her to be incapable of managing and/or administering his/her property and affairs.

18.10 At the general meeting of the Council of Governors at which the committee's recommendations are considered, a resolution shall be approved by not less than three quarters of the members of the Council of Governors present and voting, to either:

18.10.1 temporarily suspend the Governor from office for an agreed, specified period; or

18.10.2 disqualify the Governor from office; or

18.10.3 remove the suspension of the Governor, should the Council of Governors not agree with the committee's recommendation.

18.11 In considering whether an individual is incapable by reason of mental disorder, illness or injury of managing and/or administering his/her property and/or affairs, the committee (described above) shall take into account the provisions of the Mental Capacity Act 2005, or any statutory modification thereof, and shall be entitled to take appropriate professional advice from internal Foundation Trust advisors and/or external advisors as necessary.

18.12 If a Governor fails to attend three consecutive meetings of the Council of Governors in any Financial Year, his/her tenure of office is to be terminated immediately unless the Council of Governors is satisfied by a three quarters majority of those members of the Council of Governors present and voting at a meeting of the Council of Governors that:

18.12.1 the absence was due to a reasonable cause; and

18.12.2 the Governor will be able to start attending meetings of the Council of Governors again within such a period as the other Governors consider reasonable.

18.13 Notwithstanding the provisions of paragraph 18.12 above, if a Governor fails to attend three out of four consecutive meetings of the Council of Governors and he/she has previously been the subject of a decision in his/her favour under paragraph 18.10 above, the Governor's tenure of office is to be terminated immediately.

18.14 A Governor shall vacate his/her office immediately if:

18.14.1 he/she is considered to have acted in a manner inconsistent with the values of the Foundation Trust or in a manner detrimental to or contrary to:

18.14.1.1 the interests of the Foundation Trust; or

18.14.1.2 the Licence; or

18.14.1.3 the Governors' Code of Conduct; or

18.14.2 he/she has failed to declare an interest as required by the Constitution or he/she has spoken or voted at a meeting on a matter in which he/she has an interest contrary to the Constitution. For the purpose of this paragraph, "interest" includes a relevant and material interest, or a pecuniary, personal or family interest, whether that interest is actual or potential and whether than interest is direct or indirect; or

18.14.3 he/she is adjudged to have acted in a manner inconsistent with the values of the Foundation Trust or in a manner detrimental to it by a majority of not less than three quarters of the members of the Council of Governors present and voting at a meeting of the Council of Governors.

18.15 A Governor whose office is terminated subject to paragraph 18.14 above shall not be eligible to stand for re-election or re-appointment to the Council of Governors for a period of three years from the date of his/her removal from office or the date on which any appeal against his/her removal from office is disposed of, whichever is the later.

18.16 A Governor may resign from office at any time during the term of that office by giving notice in writing to the Secretary. Where possible and appropriate, a resigning Governor should agree a notice period with the Secretary prior to resigning from office.

18.17 If the Chair considers that the grounds for removal set out in paragraphs 18.1, 18.2 or 18.14 may apply to a Governor, the Chair may immediately suspend the Governor for a period to be determined by the Chair,

18.18 A Governor may not stand for re-election or be reappointed while they are suspended in accordance with this paragraph 18.

19 Council of Governors – duties of Governors

19.1 The general duties of the Council of Governors are:

19.1.1 to hold the Non-Executive Directors individually and collectively to account for the performance of the Board of Directors, and

19.1.2 to represent the interests of the Members of the Foundation Trust as a whole and the interests of the public.

20 Council of Governors – skills and knowledge

20.1 The Foundation Trust must take steps to secure that the Governors are equipped with the skills and knowledge they require in their capacity as Governors.

21 Council of Governors – meetings of Governors

Admission of the Public

21.1 Meetings of the Council of Governors shall be open to members of the public. Members

of the public and representatives of the press may be excluded from a meeting for special reasons as set out in Annex 6.

Calling Meetings

21.2 Subject to paragraph 29 below, the Council of Governors is to meet at least four times per year. Meetings are to be held at such times and places as the Council of Governors may determine.

21.3 One of the Council of Governors' meetings shall be an annual meeting held no later than 30 September in each year when the Council of Governors is to receive and consider the Annual Accounts and any report of the Auditor on them and the Board of Directors is to present to the Council of Governors the Annual Report (the "Annual Governors' Meeting").

21.4 For the purposes of obtaining information about the Foundation Trust's performance of its functions or the Directors' performance of their duties (and deciding whether to propose a vote on the Foundation Trust's or Directors' performance), the Council of Governors may require one or more of the Directors to attend a meeting of the Council of Governors.

21.5 The Council of Governors may invite the Chief Executive, members of the Board of Directors or a representative of the Auditor or other advisors to attend and speak at a meeting of the Council of Governors.

21.6 The Chair of the Foundation Trust may, in exceptional circumstances, call a meeting of the Council of Governors at any time. If the Chair refuses to call a meeting after a requisition for that purpose, signed by at least one third of the whole number of members of the Council of Governors, or if without so refusing the Chair does not call a meeting within fourteen days after a requisition to do so, then the members of the Council of Governors may forthwith call a meeting provided they have been requisitioned to do so by more than 50% of the members of the Council of Governors.

Notice of meetings and agenda

21.7 Meetings of the Council of Governors shall be held at such times and places as the Council of Governors may determine.

21.8 Before each meeting of the Council of Governors, a notice of the meeting, specifying the business proposed to be transacted at it shall be delivered to every Governor, by post or electronically.

21.9 Agendas shall be sent to Governors five Clear Days before the meeting and supporting papers, whenever possible, shall be despatched no later than three Clear Days before the meeting, save in an emergency and with the agreement of the Chair.

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

21.11 Want of service of the notice on any Governor shall not affect the validity of the meeting. A notice of the meeting shall be presumed to have been served one day after posting or, in the case of a notice being sent electronically, on the date of transmission.

21.12 The Council of Governors shall agree the dates of general meetings of the Council of Governors in advance which shall be publicised through reasonable and appropriate means.

Conduct of meetings

21.13 The Chair of the Foundation Trust (i.e. the Chair of the Board of Directors, appointed in accordance with the provisions of paragraph 34 below) or, in his/her absence the Deputy Chair (appointed in accordance with the provisions of paragraph 36 below), or in his/her absence one of the Non-Executive Directors shall preside at meetings of the Council of Governors and be the Meeting Chair.

21.14 If the Meeting Chair has a conflict of interest in relation to the business being discussed, then the Deputy Chair shall chair that part of the meeting. Should the Deputy Chair not be present then one of the other non-executive directors shall chair that part of the meeting.

21.15 Governors' behaviour at meetings (and generally as a representative of the Foundation Trust) is expected to be exemplary. Statements of Governors made at meetings of the Council of Governors shall be relevant to the matter under discussion and the decision of the Meeting Chair on questions of order, relevancy, regularity and any other matters shall be final.

21.16 The names of the Meeting Chair and Governors present at the meeting shall be recorded in the minutes.

Voting

21.17 Every question at a meeting of the Council of Governors shall be determined by a majority of votes of the Governors present and qualified to vote. In the case of the number of votes for and against a motion being equal, the Meeting Chair shall have a casting vote.

21.18 Every Governor must make an annual declaration that he is qualified to vote at meetings of the Council of Governors. He/she will do so in the form specified below:

Declaration to the Secretary of the Queen Victoria Hospital NHS Foundation Trust

Elected Governors

"I hereby declare that I am, at the date of this declaration, a member of the [Public / Staff] Constituency, and I am not prevented from being a member of the Council of Governors by reason of any provision of paragraph 8 of Schedule 7 to the 2006 Act or the Constitution."

Appointed Governors

"I hereby declare that I am at the date of this declaration a properly Appointed Governor and I am not prevented from being a member of the Council of Governors by reason of any provision of paragraph 8 of Schedule 7 to the 2006 Act or the Constitution."

21.19 A Governor may not vote at a meeting of the Council of Governors unless, prior to the meeting, he/she has made the declaration referred to in paragraph 21.19 above.

21.20 Each Governor must also notify the Secretary as soon as possible and provide a further declaration at any subsequent meeting if his/her circumstances have changed.

21.21 All Governors shall be deemed to have confirmed the declaration upon attending any subsequent meeting of the Council of Governors, and every agenda for meetings of the Council of Governors will draw this to the attention of Governors.

21.22 All questions put to the vote shall, at the discretion of the Meeting Chair, be determined by oral expression or by a show or hands. A paper ballot may be used if the majority of Governors present so request.

21.23 If half of the Governors present so request, the voting (other than by paper ballot) on any question may be recorded to show how each Governor present voted or abstained.

21.24 If a Governor so requests, his/her vote shall be recorded by name upon any vote (other than by paper ballot).

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

Electronic Communication

21.26 The Council of Governors may agree that Governors can participate in its meetings by telephone, video or computer link or other such agreed means. Participation in a meeting in this manner shall be deemed exceptional but shall constitute presence in person at the meeting. Express approval from the Meeting Chair must be sought in advance.

21.27 Further provisions which apply in these circumstances are set out in Annex 7.

Content and length of speeches

21.28 Approval to speak at meetings shall be given by the Meeting Chair. This includes Governors, Members, members of the public or press, Officers or any other person in attendance at a meeting.

21.29 Speeches must be directed to the matter, motion or question under discussion or to a point of order.

21.30 Unless, in the opinion of the Meeting Chair, it would not be desirable or appropriate to limit speeches on any topic to be discussed, having regard to its nature complexity or importance, no proposal, speech nor any reply, may exceed three minutes.

21.31 In the interests of time, the Meeting Chair may, in his/her absolute discretion, limit the number of replies, questions or speeches which are heard at any one meeting.

Quorum

21.32 Any meeting of the Council of Governors requires a quorum of at least half of the total number of Governors to be present, with a majority of those present being Public Governors.

21.33 No business shall be carried out at a meeting which is not quorate.

21.34 If the Meeting Chair or a Governor has been disqualified from participating in the discussion on any matter and/or from voting on any resolution by reason of the declaration of a conflict of interest (paragraphs 22, 40 and Annex 8), he/she shall no longer count towards the quorum. If a quorum is then not available for the discussion and/or the passing of a resolution on any matter, that matter may not be discussed further or voted upon at that meeting. Such a position shall be recorded in the minutes of the meeting. The meeting must then proceed to the next agenda item.

21.35 If at any meeting of the Council of Governors, there is no quorum present within 30 minutes of the time fixed for the start of the meeting, the meeting shall stand adjourned for a period of at least five Clear Days. The Secretary shall give notice of the date, time and place of the adjourned meeting and, notwithstanding paragraph 21.34 above, upon re-convening, those present shall constitute a quorum.

Committees and groups

21.36 The Council of Governors may appoint committees or groups consisting of its members to assist it in carrying out its functions but may not delegate any of its powers or functions to them. A committee or group so appointed may appoint its own working groups.

21.37 These committees or groups may include Directors or Officers of the Foundation Trust and/or outside advisors to help them in their tasks.

22 Council of Governors – Conflicts of interest of Governors

22.1 If a Governor has a relevant and material interest, or a pecuniary, personal or family interest, whether that interest is actual or potential and whether that interest is direct or indirect, in any proposed contract or other matter which is under consideration or is to be considered by the Council of Governors, the Governor shall disclose the nature and extent of that interest to the members of the Council of Governors as soon as he/she becomes aware of it.

22.2 If a declaration under this paragraph proves to be, or becomes, inaccurate or incomplete, the Governor must make a further declaration before the Foundation Trust enters into the transaction or arrangement.

22.3 This paragraph does not require a declaration of an interest of which the Governor is not aware or where the Governor is not aware of the transaction or arrangement in question.

22.4 A Governor need not declare an interest if:

22.5 it cannot reasonably be regarded as likely to give rise to a conflict of interest; or

22.6 to the extent that the Governors are already aware of it.

22.7 Any interests raised by the Governors in this way shall be recorded in the register of interests of the Governors.

22.8 Further provisions as to the circumstances in which a Governor must declare a conflict of interest are set out in Annex 8.

23 Council of Governors – remuneration, travel and other expenses

23.1 Governors are not to receive remuneration from the Foundation Trust provided that this shall not prevent remuneration of Governors by their employer.

23.2 Subject to any Foundation Trust policy on the payment of expenses, the Foundation Trust may pay travelling and other expenses to members of the Council of Governors at rates determined by the Foundation Trust. These shall be published in the Annual Report.

24 Referral to Monitor's panel for advising Governors

24.1 In this paragraph, the "Panel" means a panel of persons appointed by Monitor to which a Governor of the Foundation Trust may refer a question as to whether the Foundation Trust has failed or is failing:

24.1.1 to act in accordance with the Constitution; or

24.1.2 to act in accordance with provision made by or under Chapter 5 of the 2006 Act.

24.2 A Governor may refer a question to the panel only if more than half of the members of the Council of Governors present and voting approve the referral at a general meeting of the Council of Governors.

25 Governors' Steering Committee (GSC)

25.1 The purpose of the Governors' Steering Committee is to:

25.1.1 support and facilitate the work of the Council of Governors and make recommendations to it on any aspects of its work;

25.1.2 facilitate communication between the Council of Governors and the Board of Directors;

25.1.3 provide advice and support to the Chair, Chief Executive and the Secretary;

25.1.4 initiate appropriate reviews and reports on matters within the remit of the Council of Governors; and

25.1.5 actively engage the Governors in adding value to the Foundation Trust.

25.2 The GSC shall have authority to form working groups to facilitate the work of the GSC and to support any recommendations it may make to the Council of Governors.

25.3 The GSC shall meet as regularly as it considers necessary to fulfil its obligations. It shall report to the Council of Governors as required.

25.4 Members of the GSC shall be chosen by the Council of Governors and the GSC shall be chaired by the Lead Governor.

25.5 The GSC shall invite others to attend its meetings as it considers appropriate and as the need arises.

26 Lead Governor

26.1 In accordance with a process approved by the Chair after consulting the Council of Governors, the Secretary will administer the nomination procedure for a Lead Governor.

26.2 The Council of Governors may appoint a Deputy Lead Governor. The secretary will administer the nomination procedure for a Deputy Lead Governor.

26.3 (not used)

27 Meeting of the Council of Governors to consider the Annual Accounts and Reports

27.1 The following documents are to be presented to the Council of Governors at a general meeting of the Council of Governors (the "Annual Governors' Meeting"):

27.1.1 the Annual Accounts;

27.1.2 any report of the Auditor on them; and

27.1.3 the Annual Report.

28 Annual Members' Meeting

28.1 The Foundation Trust shall hold an annual meeting of its Members (the "Annual Members' Meeting"). The Annual Members' Meeting shall be open to all members of the public.

28.2 In addition to the obligations set out in paragraph 28.3 below, the Council of Governors shall present to each Annual Members' Meeting:

28.2.1 a report on steps taken to secure that, taken as a whole, the actual Membership of the Public Constituency is representative of those eligible for such Membership;

28.2.2 the progress of the Membership Strategy; and

28.2.3 any changes to the Membership Strategy.

28.3 At least one member of the Board of Directors must attend each Annual Members' Meeting and present the following documents:

28.3.1 the Annual Accounts;

28.3.2 any report of the Auditor on them;

28.3.3 the Annual Report.

29 Combined Meetings of Members and Governors

29.1 The Foundation Trust may combine a meeting of the Council of Governors convened for the purposes of paragraph 27.1 above with the Annual Members' Meeting (paragraph 28).

30 Special Members' Meetings

30.1 Notwithstanding any provisions contained in this Constitution regarding meetings of the Council of Governors, the Annual Members' Meetings or meetings of the Board of Directors, the Board of Directors or the Council of Governors may resolve to call special meetings of the Foundation Trust for the benefit of its Members (a "Special Members' Meeting") for the purpose of providing Members with information and to offer Members an opportunity to provide feedback to the Foundation Trust.

30.2 Special Members' Meetings are open to all Members of the Foundation Trust, Governors, Directors and representatives of the Auditor and any external consultant as well as members of the general public and representatives of the press unless determined otherwise.

30.3 Notwithstanding the provisions of paragraph 30.2 above, the Board of Directors or Council of Governors may invite to attend a Special Members' Meeting any experts or advisors whose attendance they consider to be in the best interests of the Foundation Trust.

30.4 Arrangements for the Special Members' Meeting shall be carried out in accordance with arrangements for meetings of the Council of Governors except that the quoracy shall be as follows:

30.4.1 Chair (or Deputy Chair);

30.4.2 at least one Member from the Staff Constituency; and

30.4.3 at least one Member from the Public Constituency.

31 Board of Directors – composition

31.1 The Trust is to have a Board of Directors. It shall comprise both Executive Directors and Non-Executive Directors, at least half of which, excluding the Chair, should comprise Non-Executive Directors determined by the Board to be independent.

31.2 The Board of Directors is to comprise:

31.2.1 the following Non-Executive Directors:

31.2.1.1 a Chair; and

31.2.1.2 at least four other Non-Executive Directors.

31.2.2 the following Executive Directors:

31.2.2.1 a Chief Executive (who shall be the Accounting Officer);

31.2.2.2 a Finance Director; and

31.2.2.3 at least two other Executive Directors.

31.3 One of the Executive Directors is to be a Registered Medical Practitioner or a Registered Dentist.

31.4 One of the Executive Directors is to be a Registered Nurse or a Registered Midwife.

31.5 Subject to the provisions of paragraphs 31.3 and 31.4 above, the Board of Directors shall determine any change in the number of Directors, provided that any change in the number shall be in the range set out at paragraph 31.2 above, and that the number of Non-Executive Directors (including the Chair) shall always be greater than the number of Executive Directors. The Council of Governors shall be consulted if the changes relate to the Non-Executive Directors.

31.6 The validity of any act of the Foundation Trust is not affected by any vacancy among the Directors or by any defect in the appointment of any Directors.

32 Board of Directors – general duty

32.1 The general duty of the Board of Directors and of each Director individually, is to act with a view to promoting the success of the Foundation Trust so as to maximise the benefits for the Members of the Foundation Trust as a whole and for the public.

33 Board of Directors – qualification for appointment as a Non-Executive Director

33.1 A person may be appointed as a Non-Executive Director only if he/she:

33.1.1 is a Member of the Public Constituency, and

33.1.2 he/she is not disqualified by virtue of paragraph 38 or Annex 5 below.

34 Board of Directors – appointment of the Chair and other Non-Executive Directors

34.1 The Council of Governors at a general meeting of the Council of Governors shall appoint the Chair of the Foundation Trust and the other Non-Executive Directors, taking into account the views of the Board of Directors on the qualities, skills and experience required for each position.

34.2 The Chair and the Non-Executive Directors shall be appointed for a period of office of up to three years. Any term beyond six years will be subject to annual re-appointment.

34.3 Non-Executive Directors shall be appointed in accordance with a process agreed by the Appointments Committee on behalf of the Council of Governors.

34.4 An existing Non-Executive Director, nearing the end of his/her term, shall be considered for a further term of office, subject to the following:

34.4.1 a satisfactory appraisal that he/she continues to be effective;

34.4.2 he/she continues to demonstrate commitment to the role;

34.4.3 he/she is willing to complete a further term of office;

34.4.4 he/she is not precluded by paragraph 34.2 by virtue of time already served as a Non-Executive Director.

34.5 Should the Appointments Committee decide to advertise externally for a Non-Executive Director, a specification shall be drawn up and approved by the Appointments Committee that shall set out the personal and professional qualities needed.

34.6 Where paragraph 34.5 applies, the Appointments Committee shall follow a process which involves advertising for the vacancy, shortlisting against the specification and interviewing candidates. In the case of appointing a Non-Executive Director, the interview panel will include at least one Public Governor and the Chair. In the case of appointing the Chair, the interview panel will include at least one Public Governor and the Senior Independent Director.

34.7 Recommendations for appointment shall be taken to the next general meeting of the Council of Governors for formal appointment.

35 Board Directors – suspension and removal of the Chair and other Non-Executive Directors

35.1 Removal of the Chair or another Non-Executive Director shall require the approval of three quarters of the members of the Council of Governors.

35.2 During any meeting of the Council of Governors at which the Chair may be suspended or removed, the Senior Independent Director shall preside, or if the Senior Independent Director is absent from the meeting or is absent temporarily on the grounds of a conflict of interest, another Non-Executive Director shall preside.

35.3 Suspension or removal of the Chair or another Non-Executive Director shall require a resolution to be submitted by three quarters of the members of the Council of Governors and sponsored by at least one Governor.

35.4 The Governor sponsoring the resolution shall set out in writing the reasons in support of the resolution. At the meeting of the Council of Governors where the resolution is to be considered and voted upon, the Chair or other Non-Executive Director, who is the subject of the resolution, shall be given the opportunity to respond to the reasons given. If the individual fails to attend the meeting without due cause, the meeting may proceed in their absence. The decision to proceed in these circumstances shall be at the sole discretion of the Meeting Chair.

35.5 In making the decision to remove the Chair or another Non-Executive Director, the Council of Governors shall take into account the results of the annual appraisal concerning the individual in question. The Council of Governors shall also remove or suspend a Non-Executive Director in consultation with the Chair (if the matter concerns another Non-Executive Director) or the Senior Independent Director (if the matter concerns the Chair).

35.6 If any resolution to suspend or remove either the Chair or another Non-Executive Director is not approved at the meeting of the Council of Governors where the matter was considered, no further resolution can be put forward to suspend or remove such Non-Executive Director, or the Chair, which is based on the same reasons, within twelve calendar months of the date of the meeting at which the resolution was considered.

35.7 Suspension is a temporary measure which shall be used to prevent the Chair or a Non-Executive Director from exercising his or her functions pending the completion of an investigation or removal from office.

35.8 The Council of Governors may use the power of suspension in the following circumstances:

35.8.1 where the Foundation Trust is in receipt of information which gives cause for concern about the Chair or a Non-Executive Director continuing to hold office

because of its effect on the reputation of the Trust or on the integrity of the individual in question;

35.8.2 where there is sufficient evidence to warrant removal from office but before removal takes effect; or

35.8.3 where there is an allegation of fraud or other impropriety or other alleged misconduct that would require the Chair or a Non-Executive Director to be suspended to protect patients, staff or public funds.

36 Board of Directors – appointment of the Senior Independent Director and Deputy Chair

36.1 A Senior Independent Director shall be appointed by the Board of Directors in consultation with the Council of Governors.

36.2 A Non-Executive Director appointed as the Senior Independent Director shall be the Senior Independent Director for a period consistent with his/her existing term of office as a Non-Executive Director.

36.3 Any Non-Executive Director so appointed may at any time resign from the office of Senior Independent Director by giving notice in writing to the Secretary.

36.4 The Senior Independent Director may also fulfil the role of the Deputy Chair.

36.5 The Council of Governors at a general meeting of the Council of Governors shall appoint one of the non-executive Directors as Deputy Chair, who may be the Senior Independent Director.

36.6 If the Chair is unable to discharge his/her functions as a Chair of the Foundation Trust, the Deputy Chair will be the "acting Chair" until such time as the Chair is able to discharge his/her functions as Chair or a new Chair is appointed by the Council of Governors in accordance with paragraph 34 above.

37 Board of Directors – appointment and removal of the Chief Executive and other Executive Directors

37.1 The Non-Executive Directors shall appoint or remove the Chief Executive.

37.2 The appointment of the Chief Executive shall require the approval of the Council of Governors.

37.3 A committee consisting of the Chair, the Chief Executive and the other Non-Executive Directors shall appoint or remove the other Executive Directors.

37.4 The Foundation Trust shall establish a committee of Non-Executive Directors and the Chief Executive to decide the remuneration and allowances, and the other terms and conditions of office, of the Executive Directors (the "Nomination and Remuneration Committee"). When deciding the remuneration and allowances, and the other terms and conditions of office of the Chief Executive, the membership of the Nomination and Remuneration Committee shall not include the Chief Executive.

38 Board of Directors - disqualification

38.1 The following may not become or continue as a member of the Board of Directors:

38.1.1 either:

a. an executive or non-executive director or governor of another NHS foundation trust, or

b. an executive or non-executive director of another Health Service Body, or

c. an executive or non-executive director of a body corporate

which presents a conflict of interest with the affairs of the Foundation Trust which cannot be resolved;

38.1.2 someone who is incapable by reason of his/her mental disorder, illness or injury of managing and/or administering his/her property and/or affairs. In considering whether an individual is incapable by reason of mental disorder, illness or injury of managing and/or administering his/her property and/or affairs, the provisions of the Mental Capacity Act 2005, or any statutory modification thereof, shall be taken into account. Further internal or external advice shall be sought where necessary;

38.1.3 an individual who has refused, without reasonable cause, to fulfil any training requirement established by the Board of Directors;

38.1.4 a person who is the subject of a disqualification order made under the Company Directors' Disqualification Act 1986;

38.1.5 on the basis of disclosures obtained through an application to the Disclosure and Barring Service, he/she is not considered suitable by the Chair; or

38.1.6 someone who has failed to sign and deliver to the Secretary a statement in the form required by the Foundation Trust confirming acceptance of the Directors' Code of Conduct.

38.2 Further circumstances in which an individual may not become or continue as a member of the Board of Directors are set out in Annex 5.

39 Board of Directors – meetings

39.1 Meetings of the Board of Directors shall be open to members of the public. Members of the public and representatives of the press may be excluded from a meeting for special reasons as set out in Annex 6.

39.2 The Board of Directors may agree that Directors can participate in its meetings by telephone, video or computer link or other such agreed means. Participation in a meeting in this manner shall be deemed exceptional but shall constitute presence in person at the meeting.

39.3 Further provisions which apply in these circumstances are set out in Annex 7.

39.4 Before holding a meeting, the Board of Directors must send a copy of the agenda of the meeting to the Council of Governors. As soon as practicable after holding a meeting, the Board of Directors must send a copy of the minutes of the meeting to the Council of Governors.

39.5 In the case of an equality of votes at a meeting of the Board of Directors, the Chair (or Meeting Chair as may be) shall have a casting vote.

39.6 (not used)

40 Board of Directors – Conflicts of interests of Directors

40.1 The duties that a Director of the Foundation Trust has by virtue of being a Director include in particular:

40.1.1 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;

40.1.2 a duty not to accept a benefit from a third party by reason of being a Director or doing (or not doing) anything in that capacity.

40.2 The duty referred to in sub-paragraph 40.1.1 is not infringed if:

40.2.1 the situation cannot reasonably be regarded as likely to give rise to a conflict of interest; or

40.2.2 the matter has been authorised in accordance with the Constitution.

40.3 The duty referred to in sub-paragraph 40.1.2 is not infringed if acceptance of the benefit cannot reasonably be regarded as likely to give rise to a conflict of interest.

40.4 In sub-paragraph 40.1.2, "third party" means a person other than:

40.4.1 the Foundation Trust; or

40.4.2 a person acting on its behalf.

40.5 If a Director of the Foundation Trust has in any way a relevant and material interest or a direct or indirect interest in a proposed transaction or arrangement with the Foundation Trust, the Director must declare the nature and extent of that interest to the other Directors. This shall be recorded in the register of interests of the Directors.

40.6 If a declaration under this paragraph proves to be, or becomes, inaccurate or incomplete, a further declaration must be made.

40.7 Any declaration required by this paragraph must be made before the Foundation Trust enters into the transaction or arrangement.

40.8 This paragraph does not require a declaration of an interest of which the Director is not aware or where the Director is not aware of the transaction or arrangement in question.

40.9 A Director need not declare an interest:

40.9.1 if it cannot reasonably be regarded as likely to give rise to a conflict of interest;

40.9.2 if, or to the extent that, the Directors are already aware of it;

40.9.3 if, or to the extent that, it concerns terms of the Director's appointment that

have been or are to be considered by:

40.9.3.1 a meeting of the Board of Directors; or

40.9.3.2 a committee of the Directors appointed for the purpose under the Constitution.

40.10 Any interests raised by the Directors in this way shall be recorded in the register of interests of the Directors.

40.11 A matter shall have been authorised for the purposes of paragraph 40.2.2 if:

40.11.1 The Directors, in accordance with the requirements set out in this paragraph [40.11], authorise any matter or situation proposed to them by any Director which would, if not authorised, involve a Director (an "Interested Director**"**) breaching his/her duty under paragraph 40.1.1 above to avoid conflicts of interest (a "Conflict**"**).

40.11.2 Any authorisation under this paragraph will be effective only if:

40.11.2.1 the matter in question shall have been proposed by any Director for consideration in the same way that any other matter may be proposed to the Directors under the provisions of this Constitution or in such other manner as the Directors may determine;

40.11.2.2 any requirement as to the quorum for consideration of the relevant matter is met without counting the Interested Director or any other Interested Director; and

40.11.2.3 the matter was agreed to without the Interested Director voting or would have been agreed to if the Interested Director's and any other Interested Director's vote had not been counted.

40.11.3 Any authorisation of a Conflict under this paragraph may (whether at the time of giving the authorisation or subsequently):

40.11.3.1 extend to any actual or potential conflict of interest which may reasonably be expected to arise out of the Conflict so authorised;

40.11.3.2 provide that the Interested Director be excluded from the receipt of documents and information and the participation in discussions (whether at meetings of the Directors or otherwise) related to the Conflict;

40.11.3.3 provide that the Interested Director shall or shall not be an eligible Director in respect of any future decision of the Directors in relation to any resolution related to the Conflict;

40.11.3.4 impose upon the Interested Director such other terms for the purposes of dealing with the Conflict as the Directors think fit

40.11.3.5 provide that, where the Interested Director obtains, or has obtained (through his/her involvement in the Conflict and otherwise than through his/her position as a Director of the Foundation Trust) information that is confidential to a third party, he/she will not be obliged to disclose that information to the Board of Directors, or to use it in relation to the Foundation Trust's affairs where to do so would amount to a breach of that confidence; and

40.11.3.6 permit the Interested Director to absent himself/herself from the discussion of matters relating to the Conflict at any meeting of the Directors and be excused from reviewing papers prepared by, or for, the Directors to the extent they relate to such matters. Where the Directors authorise a Conflict, the Interested Director will be obliged to conduct himself/herself in accordance with any terms imposed by the Directors in relation to the Conflict.

40.11.4 Where the Directors authorise a Conflict, the Interested Director shall be obliged to conduct himself/herself in accordance with any terms imposed by the Directors in relation to the Conflict.

40.11.5 The Directors may revoke or vary such authorisation at any time, but this will not affect anything done by the Interested Director, prior to such revocation or variation in accordance with the terms of such authorisation.

40.11.6 A Director is not required, by reason of being a Director to account to the Foundation Trust for any remuneration, profit or other benefit which he/she derives from or in connection with a relationship involving a Conflict which has been authorised by the Directors (subject in each case to any terms, limits or conditions attaching to that authorisation) and no contract shall be liable to be avoided on such grounds.

40.12 Subject to paragraph 40.13 below if a question arises at a meeting of Directors or of a committee of Directors as to the right of a Director to participate in the meeting (or part of the meeting) for voting or quorum purposes, the question may, before the conclusion of the meeting, be referred to the Chair whose ruling in relation to any Director other than the Chair is to be final and conclusive.

40.13 If any question as to the right to participate in the meeting (or part of the meeting) should arise in respect of the Chair, the question is to be decided by a decision of the

Directors (other than the Chair) at that meeting, for which purpose the Chair is not to be counted as participating in the meeting (or that part of the meeting) for voting or quorum purposes.

40.14 Further provisions as to the circumstances in which a Director must declare a conflict of interest are set out in Annex 8.

41 Board of Directors – remuneration and terms of office

41.1 The Council of Governors at a general meeting of the Council of Governors shall decide the remuneration and allowances, and the other terms and conditions of office, of the Chair and the other Non-Executive Directors. These shall be published in the Annual Report.

41.2 Subject to any Foundation Trust policy on the payment of expenses, the Foundation Trust may pay travelling and other expenses to members of the Board of Directors at rates determined by the Foundation Trust.

42 Registers

42.1 The Foundation Trust shall have:

42.1.1 a register of Members showing, in respect of each Member, the constituency to which he/she belongs;

42.1.2 a register of members of the Council of Governors;

42.1.3 a register of interests of the Governors;

42.1.4 a register of Directors; and

42.1.5 a register of interests of the Directors.

42.2 The Secretary shall be responsible for compiling and maintaining the registers which may be kept in either paper or electronic form. Admission to or removal from any register shall be in accordance with the provisions of this Constitution. The Secretary shall update registers with new or amended information as soon as is practical.

43 Admission to and removal from the registers

Register of Members

43.1 The Secretary shall maintain a register of Members in two parts.

43.2 Part one, which shall be the register referred to in the 2006 Act, shall include the name of each Member and the Constituency to which they belong and this shall be open to inspection by the public in accordance with paragraph 45 below.

43.3 Part two shall contain all the information from the application referred to in paragraph 7 and shall not be open to inspection by the public nor may copies or extracts from it be available to any third party (save to the extent that copies or extracts from it be made available to any third party appointed to the Foundation Trust to maintain the register of the Members and to conduct elections in accordance with the provisions of paragraph 15).

43.4 Notwithstanding the provisions of paragraphs 44.1 to 44.3 (inclusive), the Foundation Trust shall extract such information as it needs in aggregate to satisfy itself that the actual Membership of the Foundation Trust's Public Constituency is representative of those eligible for Membership and for the administration of the provisions of this Constitution.

Register of members of the Council of Governors

43.5 The register of members of the Council of Governors shall list:

43.5.1 the name of each Governor;

43.5.2 their category of membership of the Council of Governors (Public, Staff, Local Authority or Partnership Governor);

43.5.3 an address through which they can be contacted, which may be the Secretary;

43.5.4 the dates of his/her terms of office including start and end date, or date of his/her resignation/removal.

Register of interests of the Governors

43.6 The register of interests of the Governors shall contain:

43.6.1 the names of each Governor;

43.6.2 whether he/she has declared any interests and, if so, the interests declared in accordance with this Constitution;

43.6.3 the dates of his/her terms of office including start and end date, or date of his/her resignation/removal.

Register of Directors

43.7 The register of Directors shall list:

43.7.1 the name of each Director;

43.7.2 their capacity on the Board of Directors;

43.7.3 address through which they can be contacted, which may be the Secretary;

43.7.4 the dates of his/her terms of office including start and end date, or date of his/her resignation/removal.

Register of interests of the Directors

43.8 The register of interest of the Directors shall contain:

43.8.1 the name of each Director;

43.8.2 whether he/she has any declared any interests and, if so, if the interests declared in accordance with this Constitution;

43.8.3 the dates of his/her terms of office including start and end date, or date of his/her resignation/removal.

44 Registers – inspection and copies

44.1 The Foundation Trust shall make the registers specified in paragraph 43 above available for inspection by members of the public, except in the circumstances set out below or as otherwise prescribed by regulations, including, for the avoidance of doubt, the Public Benefit Corporation (Register of Members) Regulations 2004 (SI2004/539).

44.2 The Foundation Trust shall not make any part of its registers available for inspection by members of the public which shows details of any Member of the Foundation Trust, if the Member so requests.

44.3 So far as the registers are required to be made available:

44.3.1 they are to be available for inspection free of charge at all reasonable times; and

44.3.2 a person who requests a copy of or extract from the registers is to be provided with a copy or extract.

44.4 If the person requesting a copy or extract is not a Member of the Foundation Trust, the Foundation Trust may impose a reasonable charge for doing so.

45 Documents available for public inspection

45.1 The Foundation Trust shall make the following documents available for inspection by members of the public free of charge at all reasonable times and on its website:

45.1.1 a copy of the current Constitution;

45.1.2 a copy of the latest Annual Accounts and of any report of the Auditor on them; and

45.1.3 a copy of the latest Annual Report.

45.2 The Foundation Trust shall also make the following documents relating to a special administration of the Foundation Trust available for inspection by members of the public free of charge at all reasonable times and on its website:

45.2.1 a copy of any order made under section 65D (appointment of trust special administrator), 65J (power to extend time), 65KC (action following Secretary of State's rejection of final report), 65L (trusts coming out of administration) or 65LA (trusts to be dissolved) of the 2006 Act;

45.2.2 a copy of any report laid under section 65D (appointment of trust special administrator) of the 2006 Act;

45.2.3 a copy of any information published under section 65D (appointment of trust special administrator) of the 2006 Act;

45.2.4 a copy of any draft report published under section 65F (administrator's draft report) of the 2006 Act;

45.2.5 a copy of any statement provided under section 65F (administrator's draft report) of the 2006 Act;

45.2.6 a copy of any notice published under section 65F (administrator's draft report), 65G (consultation plan), 65H (consultation requirements), 65J (power to extend time), 65KA (Monitor's decision), 65KB (Secretary of State's response to Monitor's decision), 65KC (action following Secretary of State's rejection of final report) or 65KD (Secretary of State's response to re-submitted final report) of the 2006 Act;

45.2.7 a copy of any statement published or provided under section 65G (consultation plan) of the 2006 Act;

45.2.8 a copy of any final report published under section 65I (administrator's final report);

45.2.9 a copy of any statement published under section 65J (power to extend time) or 65KC (action following Secretary of State's rejection of final report) of the 2006 Act;

45.2.10 a copy of any information published under section 65M (replacement of trust special administrator) of the 2006 Act.

45.3 Any person who requests a copy of or extract from any of the above documents is to be provided with a copy or extract.

45.4 If the person requesting a copy or extract is not a Member of the Foundation Trust, the Foundation Trust may impose a reasonable charge for doing so.

46 Auditor

46.1 The Foundation Trust shall have an Auditor.

46.2 The Audit Committee shall make recommendations to the Council of Governors on the appointment of the Auditor.

46.3 In appointing the Auditor, the Council of Governors shall have regard to the recommendations of the Audit Committee.

46.4 The Council of Governors shall appoint or remove the Auditor at a general meeting of the Council of Governors.

46.5 The Accounting Officer shall ensure that the Auditor carries out his/her duties in accordance with Schedule 10 to the 2006 Act.

47 Audit Committee

47.1 The Foundation Trust shall establish a committee of Non-Executive Directors as an Audit Committee to review the establishment of an effective system of internal control and risk management, and to perform such monitoring and reviewing and to carry out other such functions as are appropriate.

48 Accounts

48.1 The Foundation Trust must keep proper accounts and proper records in relation to the accounts.

48.2 Monitor may with the approval of the Secretary of State give directions to the Foundation Trust as to the content and form of its accounts.

48.3 The accounts are to be audited by the Foundation Trust's Auditor.

48.4 The Foundation Trust shall prepare in respect of each Financial Year Annual Accounts in such form as Monitor may with the approval of the Secretary of State direct.

48.5 The functions of the Foundation Trust with respect to the preparation of the Annual Accounts shall be delegated to the Accounting Officer.

49 Annual Report, Forward Plans and other non-NHS work

49.1 The Foundation Trust shall prepare an Annual Report and send it to Monitor.

49.2 Each Annual Report shall give:

49.2.1 information on any steps taken by the Foundation Trust to ensure that (taken as a whole) the actual Membership of the Public Constituency is representative of those eligible for such Membership;

49.2.2 information on the remuneration of the Directors and on the expenses of the Governors and the Directors;

49.2.3 the information on the impact that income received by the Trust, otherwise than from the fulfilment of the Principal Purpose, has had on the provision of goods and services for those purposes; and

49.2.4 such other information as may be prescribed by Monitor.

49.3 The Foundation Trust shall give information as to its forward planning in respect of each Financial Year to Monitor.

49.4 The Forward Plan shall be prepared by the Board of Directors.

49.5 In preparing the Forward Plan, the Directors shall have regard to the views of the Council of Governors.

49.6 Each Forward Plan shall include information about:

49.6.1 the activities other than the provision of goods and services for the purposes of the health service in England that the Foundation Trust proposes to carry on, and

49.6.2 the income it expects to receive from doing so.

49.7 Where a Forward Plan contains a proposal that the Foundation Trust carry on an activity of a kind mentioned in sub-paragraph 49.6.1, the Council of Governors must:

49.7.1 determine whether it is satisfied that the carrying on of the activity will not to any significant extent interfere with the fulfilment by the Foundation Trust of its Principal Purpose or the performance of its other functions; and

49.7.2 notify the Directors of the Foundation Trust of its determination.

49.8 The Trust's total income in any financial year is made up of: (a) income attributable to its principal purpose as provided in paragraph 3.1 above; plus (b) income attributable to the provision of goods and services for any other purposes ("non NHS income"). If the Trust in any Financial Year proposes to increase its non NHS income and this would result in the non NHS income as a proportion of its total income increasing by 5% or more, then the Trust may implement the proposal only if more than half of the members of the Council of Governors present and voting at a meeting of the Council of Governors approve its implementation.

50 Instruments

50.1 The Foundation Trust shall have a seal.

50.2 The seal shall not be affixed except under the authority of the Board of Directors.

51 Indemnity

51.1 Members of the Council of Governors, the Board of Directors, the Secretary and other Officers of the Foundation Trust who act honestly and in good faith shall not have to meet out of their own personal resources any personal civil liability which is incurred in the execution or purported execution of their functions save where they have acted recklessly. Any costs arising in this way shall be met by the Foundation Trust.

51.2 The Foundation Trust may purchase and maintain insurance against this liability for its own benefit and for the benefit of members of the Council of Governors, Board of Directors, Secretary and other Officers.

51.3 The Foundation Trust may take out insurance either through the NHS Litigation Authority or otherwise in respect of Directors' and Officers' liability, including liability arising by reason of the Foundation Trust acting as a corporate trustee of an NHS charity.

52 Disputes between the Council of Governors and the Board of Directors

52.1 Subject to paragraph 24 above, in the event of a dispute between the Council of Governors and the Board of Directors:

52.1.1 in the first instance, the Chair, on the advice of the Secretary and other such advice as the Chair may see fit to obtain, shall seek to resolve the dispute;

52.1.2 if the Chair is unable to resolve the dispute, he/she shall appoint and chair a special committee comprising equal numbers of Directors and Governors to consider the circumstances and to make recommendations to the Council of Governors and the Board of Directors with a view to resolving the dispute;

52.1.3 if the recommendations (if any) of the special committee are unsuccessful in resolving the dispute, the Chair may refer the dispute back to the Board of Directors who shall make the final decision.

52.2 The dispute resolution procedures set out in this paragraph do not preclude the Governors from referring the matter to a panel of persons appointed by Monitor as set out in paragraph 24 (above). In these circumstances, the dispute must relate to a question about the Trust failing or failure to act in accordance with the Constitution or in accordance with provision made by or under Chapter 5 of the 2006 Act and must otherwise satisfy the conditions set out in paragraph 24.

53 Amendment of the Constitution

53.1 The Trust may make amendments of its Constitution only if:

53.1.1 more than half of the members of the Council of Governors present and voting at a meeting of the Council of Governors approve the amendments;

53.1.2 more than half of the members of the Board of Directors present and voting at a meeting of the Board of Directors approve the amendments.

53.2 Amendments made under paragraph 53.1 take effect as soon as the conditions in that paragraph are satisfied, but the amendment has no effect in so far as the Constitution would, as a result of the amendment, not accord with Schedule 7 of the 2006 Act.

53.3 Where an amendment is made to the Constitution in relation to the powers or duties of the Council of Governors (or otherwise with respect to the role that the Council of Governors has as part of the Foundation Trust):

53.3.1 at least one member of the Council of Governors must attend the next Annual Members' Meeting and present the amendment to the Members; and

53.3.2 the Foundation Trust must give the Members an opportunity to vote on whether they approve the amendment.

53.4 If more than half of the Members present and voting approve the amendment, the amendment continues to have effect; otherwise, it ceases to have effect and the Foundation Trust must take such steps as are necessary as a result.

53.5 Amendments by the Foundation Trust of its Constitution are to be notified to Monitor. For the avoidance of doubt, Monitor's functions do not include a power or duty to determine whether or not the Constitution, as a result of the amendments, accords with Schedule 7 of the 2006 Act.

54 Mergers etc. and Significant Transactions

54.1 The Foundation Trust may only apply for a merger, acquisition, separation or dissolution with the approval of more than half of the members of the Council of Governors.

54.2 The Foundation Trust may enter into a Significant Transaction only if more than half of the members of the Council of Governors of the Foundation Trust present and voting approve entering into the transaction.

54.3 A "Significant Transaction" is a transaction which meets any of the following criteria:

Ratio	Description	Percentage
Assets	The Gross Assets subject to the transaction divided by the gross assets of the Trust.	>25
Income	The income attributable to: • the assets; or • the contract associated with the transaction divided by the income of the Trust.	>25
Consideration to total Trust Capital	The Gross Capital of the company or business being acquired/divested divided by the Total Capital of the Trust following completion, or the effects on the Total Capital of the Trust resulting from a transaction.	>25

For the purposes of this paragraph:

"Gross Assets" is the total of fixed assets and current assets;

"Gross Capital" equals the market value of the target's shares and debt securities, plus the excess of current liabilities over current assets; and

"Total Capital" of the Trust equals taxpayers' equity.

54.4 Notwithstanding the above provisions and for the avoidance of doubt, a Significant Transaction does not include:

54.4.1 a transaction pursuant to: Sections 56, 56A 56B and 57A of the 2006 Act; or

54.4.2 any contracts in place from time to time with Horsham and Mid Sussex Clinical Commissioning Group (or its successor organisation) on behalf of Kent Surrey and Sussex Clinical Commissioning Groups (or their successor organisations), any other Clinical Commissioning Groups and/or the NHS Commissioning Board.

54.5 Any transaction which meets any of the criteria set out in paragraph 54.3 shall be notified to the Council of Governors if the percentage is in excess of 10% but less than 25%.

ANNEX 1 – THE PUBLIC CONSTITUENCY

(Paragraph 8)

PUBLIC CONSTITUENCY OF THE FOUNDATION TRUST

NAME OF CONSTITUENCY	AREA	MIMIMUM NO. OF MEMBERS	NO. OF GOVERNORS
Kent, Surrey, East and West Sussex and South London	The electoral wards of: Kent County Council West Sussex County Council East Sussex County Council Surrey County Council Medway Unitary Authority Brighton and Hove City Council London Borough of Croydon London Borough of Kingston London Borough of Merton London Borough of Richmond London Borough of Sutton London Borough of Bexley London Borough of Bromley London Borough of Greenwich London Borough of Lambeth London Borough of Lewisham London Borough of Southwark London Borough of Wandsworth	200	20

ANNEX 2 – THE STAFF CONSTITUENCY

(Paragraph 9)

STAFF CONSTITUENCY OF THE FOUNDATION TRUST

DESCRIPTION OF MEMBERS	MINIMUM NO. OF MEMBERS	NO. OF GOVERNORS
Staff employed by Queen Victoria Hospital NHS Foundation Trust as set out in paragraph 9.1 of the Constitution	50	3

ANNEX 3 – COMPOSITION OF COUNCIL OF GOVERNORS

(Paragraph 14)

COMPOSITION OF THE COUNCIL OF GOVERNORS OF THE FOUNDATION TRUST

Governor Type	Governor Description	No. of Governors
Elected	Public	**20**
Elected	Staff	3
Total of Elected Governors		**23**
Appointed (Local Authority)	Local Authority – West Sussex County Council	1
Appointed (Partnership Organisation)	East Grinstead Town Council	1
Appointed (Partnership Organisation)	The League of Friends	1
Total of Appointed Governors		**3**
Total Number of Governors		**26**

VACANCIES ARISING ON THE EXPIRY OF A GOVERNOR TERM OF OFFICE

Where a term of office for a Public Governor expires, the Trust will ordinarily hold an election for the relevant public constituency with the duly elected Public Governor for that constituency taking office on the expiry of the existing Public Governor's term of office.

Where requested by the Board for good reason, the Council of Governors shall consider a request to delay such an election for a period of 12 months. Any further period of delay shall only be with the further approval of the Council of Governors and for such period as they may determine. Any votes on such proposals to be by a majority of the Council of Governors voting. Good reasons for a delay include, but are not limited to, the following:

- The effects of a pandemic or other health or civil emergency (or government guidance on the holding of elections for foundation trusts); or
- Anticipated transactions involving the Trust under any of sections 56 (mergers), 56A (Acquisitions) or 57A (dissolution) of the 2006 Act within the forthcoming 12 months.

The request for a delay by the Board and the approval by the Council of Governors may occur at any time prior to the expiry of any relevant existing Public Governor's term of office.

When considering such a request, the Council of Governors must take into account that the Trust must always ensure that the aggregate number of Governors who are Public Governors on the Council of Governors always remains the majority of Governors on the Council of Governors. The request shall be granted where a majority of the Council of Governors voting approve.

Where an election for a Public Governor constituency occurs following any period of delay approved by the Council of Governors, the election thereafter will be for a term ending on the date that the term would have ended but for the delay to the election.

In the case of elections delayed in 2020 by virtue of the pandemic (and prior to these provisions appearing in the Constitution), the election for each Public Governor constituency will be for a term ending on the date that the term would have ended but for the delay to the election.

The validity of any act of the Council of Governors is not affected by any vacancy among the Governors or by any defect in the appointment of any Governor.

ANNEX 4 – THE MODEL ELECTION RULES

(Paragraph 15)

MODEL ELECTION RULES FOR ELECTIONS TO THE COUNCIL OF GOVERNORS

1. Interpretation

1.1 In these rules, unless the context otherwise requires: “2006 Act” means the National Health Service Act 2006;

“corporation” means the public benefit corporation subject to this constitution; “council of governors” means the council of governors of the corporation; “declaration of identity” has the meaning set out in rule 21.1;

“election” means an election by a constituency, or by a class within a constituency, to fill a vacancy among one or more posts on the council of governors;

“e-voting” means voting using either the internet, telephone or text message; “e-voting information” has the meaning set out in rule 24.2;

“ID declaration form” has the meaning set out in Rule 21.1; “internet voting record” has the meaning set out in rule 26.4(d);

“internet voting system” means such computer hardware and software, data other equipment and services as may be provided by the returning officer for the purpose of enabling voters to cast their votes using the internet;

“lead governor” means the governor nominated by the corporation to fulfil the role described in Appendix B to The NHS Foundation Trust Code of Governance (Monitor, December 2013) or any later version of such code.

“list of eligible voters” means the list referred to in rule 22.1, containing the information in rule 22.2;

“method of polling” means a method of casting a vote in a poll, which may be by post, internet, text message or telephone;

“Monitor” means the corporate body known as Monitor as provided by section 61 of the 2012 Act;

“numerical voting code” has the meaning set out in rule 64.2(b) “polling website” has the meaning set out in rule 26.1;

“postal voting information” has the meaning set out in rule 24.1;

“telephone short code” means a short telephone number used for the purposes of submitting a vote by text message;

“telephone voting facility” has the meaning set out in rule 26.2; “telephone voting record” has the meaning set out in rule 26.5 (d); “text message voting facility” has the meaning set out in rule 26.3; “text voting record” has the meaning set out in rule 26.6 (d);

“the telephone voting system” means such telephone voting facility as may be provided by the returning officer for the purpose of enabling voters to cast their votes by telephone;
“the text message voting system” means such text messaging voting facility as may be provided by the returning officer for the purpose of enabling voters to cast their votes by text message;

“voter ID number” means a unique, randomly generated numeric identifier allocated to each voter by the Returning Officer for the purpose of e-voting,

“voting information” means postal voting information and/or e-voting information

1.2 Other expressions used in these rules and in Schedule 7 to the NHS Act 2006 have the same meaning in these rules as in that Schedule.

2. Timetable

2.1 The proceedings at an election shall be conducted in accordance with the following timetable:

Proceeding	Time
Publication of notice of election	Not later than the fortieth day before the day of the close of the poll
Final day for delivery of nomination forms to returning officer	Not later than the twenty eighth day before the day of the close of the poll
Publication of statement of nominated candidates	Not later than the twenty seventh day before the day of the close of the poll
Final day for delivery of notices of withdrawals by candidates from election	Not later than twenty fifth day before the day of the close of the poll
Notice of the poll	Not later than the fifteenth day before the day of the close of the poll
Close of the poll	By 5.00pm on the final day of the election

3. Computation of time

3.1 In computing any period of time for the purposes of the timetable:

(a) a Saturday or Sunday;

(b) Christmas day, Good Friday, or a bank holiday, or

(c) a day appointed for public thanksgiving or mourning,

shall be disregarded, and any such day shall not be treated as a day for the

purpose of any proceedings up to the completion of the poll, nor shall the returning officer be obliged to proceed with the counting of votes on such a day.

3.2 In this rule, “bank holiday” means a day which is a bank holiday under the Banking and Financial Dealings Act 1971 in England and Wales

4. Returning Officer

4.1 Subject to rule 69, the returning officer for an election is to be appointed by the corporation.

4.2 Where two or more elections are to be held concurrently, the same returning officer may be appointed for all those elections.

5. Staff

5.1 Subject to rule 69, the returning officer may appoint and pay such staff, including such technical advisers, as he or she considers necessary for the purposes of the election.

6. Expenditure

6.1 The corporation is to pay the returning officer:

(a) any expenses incurred by that officer in the exercise of his or her functions under these rules,

(b) such remuneration and other expenses as the corporation may determine.

7. Duty of co-operation

7.1 The corporation is to co-operate with the returning officer in the exercise of his or her functions under these rules.

PART 4 STAGES COMMON TO CONTESTED AND UNCONTESTED ELECTIONS

8. Notice of election

8.1 The returning officer is to publish a notice of the election stating:

(a) the constituency, or class within a constituency, for which the election is being held,

(b) the number of members of the council of governors to be elected from that constituency, or class within that constituency,

(c) the details of any nomination committee that has been established by the corporation,

(d) the address and times at which nomination forms may be obtained;

(e) the address for return of nomination forms (including, where the return of nomination forms in an electronic format will be permitted, the e-mail address for such return) and the date and time by which they must be received by the returning officer,

(f) The date and time by which any notice of withdrawal must be received by the returning officer

(g) the contact details of the returning officer

(h) the date and time of the close of the poll in the event of a contest.

9. Nomination of candidates

9.1 Subject to rule 9.2, each candidate must nominate themselves on a single nomination form.

9.2 The returning officer:

(a) is to supply any member of the corporation with a nomination form, and is to prepare a nomination form for signature at the request of any member of the corporation, but it is not necessary for a nomination to be on a form supplied by the returning officer and a nomination can, subject to rule 13, be in an electronic format.

10. Candidate's particulars

10.1 The nomination form must state the candidate's:

(a) full name,

(b) contact address in full (which should be a postal address although an e-mail address may also be provided for the purposes of electronic communication), and

(c) constituency, or class within a constituency, of which the candidate is a member.

11. Declaration of interests

11.1 The nomination form must state:

(a) any financial interest that the candidate has in the corporation, and

(b) whether the candidate is a member of a political party, and if so, which party, and if the candidate has no such interests, the paper must include a statement to that effect.

12. Declaration of eligibility

12.1 The nomination form must include a declaration made by the candidate:

(a) that he or she is not prevented from being a member of the council of governors by paragraph 8 of Schedule 7 of the 2006 Act or by any provision of the constitution; and,

(b) for a member of the public or patient constituency, of the particulars of his or her qualification to vote as a member of that constituency, or class within that constituency, for which the election is being held.

13. Signature of candidate

13.1 The nomination form must be signed and dated by the candidate, in a manner prescribed by the returning officer, indicating that:

(a) they wish to stand as a candidate,

(b) their declaration of interests as required under rule 11, is true and correct, and

(c) their declaration of eligibility, as required under rule 12, is true and correct.

13.2 Where the return of nomination forms in an electronic format is permitted, the returning officer shall specify the particular signature formalities (if any) that will need to be complied with by the candidate.

14. Decisions as to the validity of nomination

14.1 Where a nomination form is received by the returning officer in accordance with these rules, the candidate is deemed to stand for election unless and until the returning officer:

(a) decides that the candidate is not eligible to stand,

(b) decides that the nomination form is invalid,

(c) receives satisfactory proof that the candidate has died, or

(d) receives a written request by the candidate of their withdrawal from candidacy.

14.2 The returning officer is entitled to decide that a nomination form is invalid only on one of the following grounds:

(a) that the paper is not received on or before the final time and date for return of nomination forms, as specified in the notice of the election,

(b) that the paper does not contain the candidate's particulars, as required by rule 10;

(c) that the paper does not contain a declaration of the interests of the candidate, as required by rule 11,

(d) that the paper does not include a declaration of eligibility as required by rule 12, or

(e) that the paper is not signed and dated by the candidate, if required by rule 13.

14.3 The returning officer is to examine each nomination form as soon as is practicable after he or she has received it, and decide whether the candidate has been validly nominated.

14.4 Where the returning officer decides that a nomination is invalid, the returning officer must endorse this on the nomination form, stating the reasons for their decision.

14.5 The returning officer is to send notice of the decision as to whether a nomination is valid or invalid to the candidate at the contact address given in the candidate's nomination form. If an e-mail address has been given in the candidate's nomination form (in addition to the candidate's postal address), the returning officer may send notice of the decision to that address.

15. Publication of statement of candidates

15.1 The returning officer is to prepare and publish a statement showing the candidates who are standing for election.

15.2 The statement must show:

(a) the name, contact address (which shall be the candidate's postal address), and constituency or class within a constituency of each candidate standing, and

(b) the declared interests of each candidate standing, as given in their nomination form.

15.3 The statement must list the candidates standing for election in alphabetical order by surname.

15.4 The returning officer must send a copy of the statement of candidates and copies of the nomination forms to the corporation as soon as is practicable after publishing the statement.

16. Inspection of statement of nominated candidates and nomination forms

16.1 The corporation is to make the statement of the candidates and the nomination forms supplied by the returning officer under rule 15.4 available for inspection by members of the corporation free of charge at all reasonable times.

16.2 If a member of the corporation requests a copy or extract of the statement of candidates or their nomination forms, the corporation is to provide that member with the copy or extract free of charge.

17. Withdrawal of candidates

17.1 A candidate may withdraw from election on or before the date and time for withdrawal by candidates, by providing to the returning officer a written notice of withdrawal which is signed by the candidate and attested by a witness.

18. Method of election

18.1 If the number of candidates remaining validly nominated for an election after any withdrawals under these rules is greater than the number of members to be elected to the council of governors, a poll is to be taken in accordance with Parts 5 and 6 of

these rules.

18.2 If the number of candidates remaining validly nominated for an election after any withdrawals under these rules is equal to the number of members to be elected to the council of governors, those candidates are to be declared elected in accordance with Part 7 of these rules.

18.3 If the number of candidates remaining validly nominated for an election after any withdrawals under these rules is less than the number of members to be elected to be council of governors, then:

(a) the candidates who remain validly nominated are to be declared elected in accordance with Part 7 of these rules, and

(b) the returning officer is to order a new election to fill any vacancy which remains unfilled, on a day appointed by him or her in consultation with the corporation.

19. Poll to be taken by ballot

19.1 The votes at the poll must be given by secret ballot.

19.2 The votes are to be counted and the result of the poll determined in accordance with Part 6 of these rules.

19.3 The corporation may decide that voters within a constituency or class within a constituency, may, subject to rule 19.4, cast their votes at the poll using such different methods of polling in any combination as the corporation may determine.

19.4 The corporation may decide that voters within a constituency or class within a constituency for whom an e-mail address is included in the list of eligible voters may only cast their votes at the poll using an e-voting method of polling.

19.5 Before the corporation decides, in accordance with rule 19.3 that one or more e-voting methods of polling will be made available for the purposes of the poll, the corporation must satisfy itself that:

(a) if internet voting is to be a method of polling, the internet voting system to be used for the purpose of the election is:

(i) configured in accordance with these rules; and

(ii) will create an accurate internet voting record in respect of any voter who casts his or her vote using the internet voting system;

(b) if telephone voting to be a method of polling, the telephone voting system to be used for the purpose of the election is:

(i) configured in accordance with these rules; and

(ii) will create an accurate telephone voting record in respect of any voter who casts his or her vote using the telephone voting system;

(c) if text message voting is to be a method of polling, the text message voting system to be used for the purpose of the election is:

(i) configured in accordance with these rules; and

(ii) will create an accurate text voting record in respect of any voter who

casts his or her vote using the text message voting system.

20. The ballot paper

20.1 The ballot of each voter (other than a voter who casts his or her ballot by an e- voting method of polling) is to consist of a ballot paper with the persons remaining validly nominated for an election after any withdrawals under these rules, and no others, inserted in the paper.

20.2 Every ballot paper must specify:

(a) name of the corporation,

(b) the constituency, or class within a constituency, for which the election is being held,

(c) the number of members of the council of governors to be elected from that constituency, or class within that constituency,

(d) the names and other particulars of the candidates standing for election, with the details and order being the same as in the statement of nominated candidates, the

(e) instructions on how to vote by all available methods of polling, including the relevant voter's voter ID number if one or more e-voting methods of polling are available,

(f) if the ballot paper is to be returned by post, the address for its return and the date and time of the close of the poll, and

(g) the contact details of the returning officer.

20.3 Each ballot paper must have a unique identifier.

20.4 Each ballot paper must have features incorporated into it to prevent it from being reproduced.

21. The declaration of identity (public and patient constituencies)

21.1 The corporation shall require each voter who participates in an election for a public or patient constituency to make a declaration confirming:

(a) that the voter is the person:

(i) to whom the ballot paper was addressed, and/or

(ii) to whom the voter ID number contained within the e-voting information was allocated,

(b) that he or she has not marked or returned any other voting information in the election, and

(c) the particulars of his or her qualification to vote as a member of the constituency or class within the constituency for which the election is being held.

(*"declaration of identity")

and the corporation shall make such arrangements as it considers appropriate to facilitate the making and the return of a declaration of identity by each voter, whether by the completion of a paper form ("ID declaration form") or the use of an electronic method.

21.2 The voter must be required to return his or her declaration of identity with his or her ballot.

21.3 The voting information shall caution the voter that if the declaration of identity is not duly returned or is returned without having been made correctly, any vote cast by the voter may be declared invalid.

Action to be taken before the poll

22. List of eligible voters

22.1 The corporation is to provide the returning officer with a list of the members of the constituency or class within a constituency for which the election is being held who are eligible to vote by virtue of rule 27 as soon as is reasonably practicable after the final date for the delivery of notices of withdrawals by candidates from an election.

22.2 The list is to include, for each member:

(a) a postal address; and,

(b) the member's e-mail address, if this has been provided to which his or her voting information may, subject to rule 22.3, be sent.

22.3 The corporation may decide that the e-voting information is to be sent only by e-mail to those members in the list of eligible voters for whom an e-mail address is included in that list.

23. Notice of poll

23.1 The returning officer is to publish a notice of the poll stating:

(a) the name of the corporation,

(b) the constituency, or class within a constituency, for which the election is being held,

(c) the number of members of the council of governors to be elected from that constituency, or class with that constituency,

(d) the names, contact addresses, and other particulars of the candidates standing for election, with the details and order being the same as in the statement of nominated candidates,

(e) that the ballot papers for the election are to be issued and returned, if appropriate, by post,

(f) the methods of polling by which votes may be cast at the election by voters in a constituency or class within a constituency, as determined by the corporation in accordance with rule 19.3,

(g) the address for return of the ballot papers,

(h) the uniform resource locator (url) where, if internet voting is a method of polling, the polling website is located;

(i) the telephone number where, if telephone voting is a method of polling, the telephone voting facility is located,

(j) the telephone number or telephone short code where, if text message voting is a method of polling, the text message voting facility is located,

(k) the date and time of the close of the poll,

(l) the address and final dates for applications for replacement voting information, and

(m) the contact details of the returning officer.

24. Issue of voting information by returning officer

24.1 Subject to rule 24.3, as soon as is reasonably practicable on or after the publication of the notice of the poll, the returning officer is to send the following information by post to each member of the corporation named in the list of eligible voters:

(a) a ballot paper and ballot paper envelope,

(b) the ID declaration form (if required),

(c) information about each candidate standing for election, pursuant to rule 61 of these rules, and

(d) a covering envelope; ("postal voting information").

24.2 Subject to rules 24.3 and 24.4, as soon as is reasonably practicable on or after the publication of the notice of the poll, the returning officer is to send the following information by e-mail and/ or by post to each member of the corporation named in the list of eligible voters whom the corporation determines in accordance with rule 19.3 and/ or rule 19.4 may cast his or her vote by an e-voting method of polling:

(a) instructions on how to vote and how to make a declaration of identity (if required),

(b) the voter's voter ID number,

(c) information about each candidate standing for election, pursuant to rule 64 of these rules, or details of where this information is readily available on the internet or available in such other formats as the Returning Officer thinks appropriate,

(d) contact details of the returning officer, ("e-voting information").

24.3 The corporation may determine that any member of the corporation shall:

(a) only be sent postal voting information; or

(b) only be sent e-voting information; or

(c) be sent both postal voting information and e-voting information;

for the purposes of the poll.

24.4 If the corporation determines, in accordance with rule 22.3, that the e-voting information is to be sent only by e-mail to those members in the list of eligible voters for whom an e- mail address is included in that list, then the returning officer shall only send that information by e-mail.

24.5 The voting information is to be sent to the postal address and/ or e-mail address for each member, as specified in the list of eligible voters.

25. Ballot paper envelope and covering envelope

25.1 The ballot paper envelope must have clear instructions to the voter printed on it, instructing the voter to seal the ballot paper inside the envelope once the ballot paper has been marked.

25.2 The covering envelope is to have:

(a) the address for return of the ballot paper printed on it, and

(b) pre-paid postage for return to that address.

25.3 There should be clear instructions, either printed on the covering envelope or elsewhere, instructing the voter to seal the following documents inside the covering envelope and return it to the returning officer –

(a) the completed ID declaration form if required, and

(b) the ballot paper envelope, with the ballot paper sealed inside it.

26. E-voting systems

26.1 If internet voting is a method of polling for the relevant election then the returning officer must provide a website for the purpose of voting over the internet (in these rules referred to as "the polling website").

26.2 If telephone voting is a method of polling for the relevant election then the returning officer must provide an automated telephone system for the purpose of voting by the use of a touch-tone telephone (in these rules referred to as "the telephone voting facility").

26.3 If text message voting is a method of polling for the relevant election then the returning officer must provide an automated text messaging system for the purpose of voting by text message (in these rules referred to as "the text message voting facility").

26.4 The returning officer shall ensure that the polling website and internet voting system provided will:

(a) require a voter to:

(i) enter his or her voter ID number; and
(ii) where the election is for a public or patient constituency, make a declaration of identity; in order to be able to cast his or her vote;

(c) specify:

(i) the name of the corporation
(ii) the constituency, or class within a constituency, for which the election is being held.
(iii) the number of members of the council of governors to be elected from that constituency, or class within that constituency,
(iv) the names and other particulars of the candidates standing for election, with the details and order being the same as in the statement of nominated candidates,

(v) instructions on how to vote and how to make a declaration of identity,
(vi) the date and time of the close of the poll, and
(vii) the contact details of the returning officer;
(viii)

(c) prevent a voter from voting for more candidates than he or she is entitled to at the election;

(d) create a record ("internet voting record") that is stored in the internet voting system in respect of each vote cast by a voter using the internet that comprises of-

(i) the voter's voter ID number;
(ii) the voter's declaration of identity (where required);
(iii) the candidate or candidates for whom the voter has voted; and
(iv) the date and time of the voter's vote,

(e) if the voter's vote has been duly cast and recorded, provide the voter with confirmation of this; and

(f) prevent any voter from voting after the close of poll.

26.5 The returning officer shall ensure that the telephone voting facility and telephone voting system provided will:

(a) require a voter to

(i) enter his or her voter ID number in order to be able to cast his or her vote; and
(ii) where the election is for a public or patient constituency, make a declaration of identity;

(b) specify:

(i) the name of the corporation,
(ii) the constituency, or class within a constituency, for which the election is being held,
(iii) the number of members of the council of governors to be elected from that constituency, or class within that constituency,
(iv) instructions on how to vote and how to make a declaration of identity,
(v) the date and time of the close of the poll, and
(vi) the contact details of the returning officer;

(c) prevent a voter from voting for more candidates than he or she is entitled to at the election;

(d) create a record ("telephone voting record") that is stored in the telephone voting system in respect of each vote cast by a voter using the telephone that

comprises of:

(i) the voter's voter ID number;
(ii) the voter's declaration of identity (where required);
(iii) the candidate or candidates for whom the voter has voted; and
(iv) the date and time of the voter's vote

if the voter's vote has been duly cast and recorded, provide the voter with confirmation of this;

(f) prevent any voter from voting after the close of poll.

26.6 The returning officer shall ensure that the text message voting facility and text messaging voting system provided will:

(a) require a voter to:

(i) provide his or her voter ID number; and
(ii) where the election is for a public or patient constituency, make a declaration of identity;

in order to be able to cast his or her vote;

(b) prevent a voter from voting for more candidates than he or she is entitled to at the election;

(c) create a record ("text voting record") that is stored in the text messaging voting system in respect of each vote cast by a voter by text message that comprises of:

(i) the voter's voter ID number;
(ii) the voter's declaration of identity (where required);
(iii) the candidate or candidates for whom the voter has voted; and
(iv) the date and time of the voter's vote

(d) if the voter's vote has been duly cast and recorded, provide the voter with confirmation of this;

(e) prevent any voter from voting after the close of poll.

The poll

27. Eligibility to vote

27.1 An individual who becomes a member of the corporation on or before the closing date for the receipt of nominations by candidates for the election, is eligible to vote in that election.

28. Voting by persons who require assistance

28.1 The returning officer is to put in place arrangements to enable requests for assistance to vote to be made.

28.2 Where the returning officer receives a request from a voter who requires assistance to vote, the returning officer is to make such arrangements as he or she considers necessary to enable that voter to vote.

29. Spoilt ballot papers and spoilt text message votes

29.1 If a voter has dealt with his or her ballot paper in such a manner that it cannot be accepted as a ballot paper (referred to as a "spoilt ballot paper"), that voter may apply to the returning officer for a replacement ballot paper.

29.2 On receiving an application, the returning officer is to obtain the details of the unique identifier on the spoilt ballot paper, if he or she can obtain it.

29.3 The returning officer may not issue a replacement ballot paper for a spoilt ballot paper unless he or she:

(a) is satisfied as to the voter's identity; and

(b) has ensured that the completed ID declaration form, if required, has not been returned.

29.4 After issuing a replacement ballot paper for a spoilt ballot paper, the returning officer shall enter in a list ("the list of spoilt ballot papers"):

(a) the name of the voter, and

(b) the details of the unique identifier of the spoilt ballot paper (if that officer was able to obtain it), and

(c) the details of the unique identifier of the replacement ballot paper.

29.5 If a voter has dealt with his or her text message vote in such a manner that it cannot be accepted as a vote (referred to as a "spoilt text message vote"), that voter may apply to the returning officer for a replacement voter ID number.

29.6 On receiving an application, the returning officer is to obtain the details of the voter ID number on the spoilt text message vote, if he or she can obtain it.

29.7 The returning officer may not issue a replacement voter ID number in respect of a spoilt text message vote unless he or she is satisfied as to the voter's identity.

29.8 After issuing a replacement voter ID number in respect of a spoilt text message vote, the returning officer shall enter in a list ("the list of spoilt text message votes"):

(a) the name of the voter, and

(b) the details of the voter ID number on the spoilt text message vote (if that officer was able to obtain it), and

(c) the details of the replacement voter ID number issued to the voter

30. Lost voting information

30.1 Where a voter has not received his or her voting information by the tenth day before the close of the poll, that voter may apply to the returning officer for replacement voting information.

30.2 The returning officer may not issue replacement voting information in respect of lost voting information unless he or she:

(a) is satisfied as to the voter's identity,

(b) has no reason to doubt that the voter did not receive the original voting information,

(c) has ensured that no declaration of identity, if required, has been returned.

30.3 After issuing replacement voting information in respect of lost voting information, the returning officer shall enter in a list ("the list of lost ballot documents"):

(a) the name of the voter

(b) the details of the unique identifier of the replacement ballot paper, if applicable, and

(c) the voter ID number of the voter.

31. Issue of replacement voting information

31.1 If a person applies for replacement voting information under rule 29 or 30 and a declaration of identity has already been received by the returning officer in the name of that voter, the returning officer may not issue replacement voting information unless, in addition to the requirements imposed by rule 29.3 or 30.2, he or she is also satisfied that that person has not already voted in the election, notwithstanding the fact that a declaration of identity if required has already been received by the returning officer in the name of that voter.

31.2 After issuing replacement voting information under this rule, the returning officer shall enter in a list ("the list of tendered voting information"):

(a) the name of the voter,

(b) the unique identifier of any replacement ballot paper issued under this rule;

(c) the voter ID number of the voter.

32. ID declaration form for replacement ballot papers (public and patient constituencies)

32.1 In respect of an election for a public or patient constituency an ID declaration form must be issued with each replacement ballot paper requiring the voter to make a declaration of identity.

Polling by internet, telephone or text

33. Procedure for remote voting by internet

33.1 To cast his or her vote using the internet, a voter will need to gain access to the polling website by keying in the url of the polling website provided in the voting information.

33.2 When prompted to do so, the voter will need to enter his or her voter ID number.

33.3 If the internet voting system authenticates the voter ID number, the system will give the voter access to the polling website for the election in which the voter is eligible to vote.

33.4 To cast his or her vote, the voter will need to key in a mark on the screen opposite the particulars of the candidate or candidates for whom he or she wishes to cast his or her vote.

33.5 The voter will not be able to access the internet voting system for an election once his or her vote at that election has been cast.

34. Voting procedure for remote voting by telephone

34.1 To cast his or her vote by telephone, the voter will need to gain access to the telephone voting facility by calling the designated telephone number provided in the voter information using a telephone with a touch-tone keypad.

34.2 When prompted to do so, the voter will need to enter his or her voter ID number using the keypad.

34.3 If the telephone voting facility authenticates the voter ID number, the voter will be prompted to vote in the election.

34.4 When prompted to do so the voter may then cast his or her vote by keying in the numerical voting code of the candidate or candidates, for whom he or she wishes to vote.

34.5 The voter will not be able to access the telephone voting facility for an election once his or her vote at that election has been cast.

35. Voting procedure for remote voting by text message

35.1 To cast his or her vote by text message the voter will need to gain access to the text message voting facility by sending a text message to the designated telephone number or telephone short code provided in the voter information.

35.2 The text message sent by the voter must contain his or her voter ID number and the numerical voting code for the candidate or candidates, for whom he or she wishes to vote.

35.3 The text message sent by the voter will need to be structured in accordance with the instructions on how to vote contained in the voter information, otherwise the vote will not be cast.

Procedure for receipt of envelopes, internet votes, telephone votes and text message votes

36. Receipt of voting documents

36.1 Where the returning officer receives:

(a) a covering envelope, or

(b) any other envelope containing an ID declaration form if required, a ballot paper envelope, or a ballot paper,

before the close of the poll, that officer is to open it as soon as is practicable; and rules 37 and 38 are to apply.

36.2 The returning officer may open any covering envelope or any ballot paper envelope for the purposes of rules 37 and 38, but must make arrangements to ensure that no person obtains or communicates information as to:

(a) the candidate for whom a voter has voted, or

(b) the unique identifier on a ballot paper.

36.3 The returning officer must make arrangements to ensure the safety and security of the ballot papers and other documents.

37. Validity of votes

37.1 A ballot paper shall not be taken to be duly returned unless the returning officer is satisfied that it has been received by the returning officer before the close of the poll, with an ID declaration form if required that has been correctly completed, signed and dated.

37.2 Where the returning officer is satisfied that rule 37.1 has been fulfilled, he or she is to:

(a) put the ID declaration form if required in a separate packet, and

(b) put the ballot paper aside for counting after the close of the poll.

37.3 Where the returning officer is not satisfied that rule 37.1 has been fulfilled, he or she is to:

(a) mark the ballot paper “disqualified”,

(b) if there is an ID declaration form accompanying the ballot paper, mark it “disqualified” and attach it to the ballot paper,

(c) record the unique identifier on the ballot paper in a list of disqualified documents (the “list of disqualified documents”); and

(d) place the document or documents in a separate packet.

37.4 An internet, telephone or text message vote shall not be taken to be duly returned unless the returning officer is satisfied that the internet voting record, telephone voting record or text voting record (as applicable) has been received by the returning officer before the close of the poll, with a declaration of identity if required that has been correctly made.

37.5 Where the returning officer is satisfied that rule 37.4 has been fulfilled, he or she is to put the internet voting record, telephone voting record or text voting record (as applicable) aside for counting after the close of the poll.

37.6 Where the returning officer is not satisfied that rule 37.4 has been fulfilled, he or she is to:

(a) mark the internet voting record, telephone voting record or text voting record (as applicable) “disqualified”,

(b) record the voter ID number on the internet voting record, telephone voting record or text voting record (as applicable) in the list of disqualified documents; and

(c) place the document or documents in a separate packet.

38. Declaration of identity but no ballot paper (public and patient constituency)1

38.1 Where the returning officer receives an ID declaration form if required but no ballot paper, the returning officer is to:

(a) mark the ID declaration form “disqualified”,

(b) record the name of the voter in the list of disqualified documents, indicating that a declaration of identity was received from the voter without a ballot

paper, and

(c) place the ID declaration form in a separate packet

39. De-duplication of votes

39.1 Where different methods of polling are being used in an election, the returning officer shall examine all votes cast to ascertain if a voter ID number has been used more than once to cast a vote in the election.

39.2 If the returning officer ascertains that a voter ID number has been used more than once to cast a vote in the election he or she shall:

(a) only accept as duly returned the first vote received that was cast using the relevant voter ID number; and

(b) mark as “disqualified” all other votes that were cast using the relevant voter ID number

39.3 Where a ballot paper is disqualified under this rule the returning officer shall:

(a) mark the ballot paper “disqualified”,

(b) if there is an ID declaration form accompanying the ballot paper, mark it“ disqualified” and attach it to the ballot paper,

(c) record the unique identifier and the voter ID number on the ballot paper in the list of disqualified documents;

(d) place the document or documents in a separate packet; and

(e) disregard the ballot paper when counting the votes in accordance with these rules.

39.4 Where an internet voting record, telephone voting record or text voting record is disqualified under this rule the returning officer shall:

(a) mark the internet voting record, telephone voting record or text voting record (as applicable) “disqualified”,

(b) record the voter ID number on the internet voting record, telephone voting record or text voting record (as applicable) in the list of disqualified documents;

(c) place the internet voting record, telephone voting record or text voting record (as applicable) in a separate packet, and

(d) disregard the internet voting record, telephone voting record or text voting record (as applicable) when counting the votes in accordance with these rules.

40. Sealing of packets

40.1 As soon as is possible after the close of the poll and after the completion of the procedure under rules 37 and 38, the returning officer is to seal the packets containing:

(a) the disqualified documents, together with the list of disqualified documents inside it,

(b) the ID declaration forms, if required,

(c) the list of spoilt ballot papers and the list of spoilt text message votes,

(d) the list of lost ballot documents,

(e) the list of eligible voters, and

(f) the list of tendered voting information

and ensure that complete electronic copies of the internet voting records, telephone voting records and text voting records created in accordance with rule 26 are held in a device suitable for the purpose of storage.

STV41. Interpretation of Part 6

STV41.1 In Part 6 of these rules:

"ballot document" means a ballot paper, internet voting record, telephone voting record or text voting record.

"continuing candidate" means any candidate not deemed to be elected, and not excluded,

"count" means all the operations involved in counting of the first preferences recorded for candidates, the transfer of the surpluses of elected candidates, and the transfer of the votes of the excluded candidates,

"deemed to be elected" means deemed to be elected for the purposes of counting of votes but without prejudice to the declaration of the result of the poll,

"mark" means a figure, an identifiable written word, or a mark such as "X",

"non-transferable vote" means a ballot document:

(a) on which no second or subsequent preference is recorded for a continuing candidate,

or

(b) which is excluded by the returning officer under rule STV49,

"preference" as used in the following contexts has the meaning assigned below:

(a) "first preference" means the figure "1" or any mark or word which clearly indicates a first (or only) preference,

(b) "next available preference" means a preference which is the second, or as the case may be, subsequent preference recorded in consecutive order for a continuing candidate (any candidate who is deemed to be elected or is excluded thereby being ignored); and

(c) in this context, a "second preference" is shown by the figure "2" or any

mark or word which clearly indicates a second preference, and a third preference by the figure "3" or any mark or word which clearly indicates a third preference, and so on,

"*quota*" means the number calculated in accordance with rule STV46,

"surplus" means the number of votes by which the total number of votes for any candidate (whether first preference or transferred votes, or a combination of both) exceeds the quota; but references in these rules to the transfer of the surplus means the transfer (at a transfer value) of all transferable ballot documents from the candidate who has the surplus,

"stage of the count" means:

(a) the determination of the first preference vote of each candidate,
(b) the transfer of a surplus of a candidate deemed to be elected, or
(c) the exclusion of one or more candidates at any given time,

"transferable vote" means a ballot document on which, following a first preference, a second or subsequent preference is recorded in consecutive numerical order for a continuing candidate,

"transferred vote" means a vote derived from a ballot document on which a second or subsequent preference is recorded for the candidate to whom that ballot document has been transferred, and

"transfer value" means the value of a transferred vote calculated in accordance with rules STV47.4 or STV47.7.

42. Arrangements for counting of the votes

42.1 The returning officer is to make arrangements for counting the votes as soon as is practicable after the close of the poll.

42.2 The returning officer may make arrangements for any votes to be counted using vote counting software where:

(a) the board of directors and the council of governors of the corporation have approved:

(i) The use of such software for the purpose of counting votes in the relevant election, and

(ii) a policy governing the use of such software, and

(b) the corporation and the returning officer are satisfied that the use of

such software will produce an accurate result.

43. The count

43.1 The returning officer is to:

(a) count and record the number of:

(i) ballot papers that have been returned; and
(ii) the number of internet voting records, telephone voting records and/or text voting records that have been created, and

(b) count the votes according to the provisions in this Part of the rules

and/or the provisions of any policy approved pursuant to rule 42.2(ii) where vote counting software is being used.

43.2 The returning officer, while counting and recording the number of ballot papers, internet voting records, telephone voting records and/or text voting records and counting the votes, must make arrangements to ensure that no person obtains or communicates information as to the unique identifier on a ballot paper or the voter ID number on an internet voting record, telephone voting record or text voting record.

43.3 The returning officer is to proceed continuously with counting the votes as far as is practicable.

STV44 Rejected ballot papers and rejected text voting records

STV44.1 Any ballot paper:

(a) which does not bear the features that have been incorporated into the other ballot papers to prevent them from being reproduced,

(b) on which the figure "1" standing alone is not placed so as to indicate a first preference for any candidate,

(c) on which anything is written or marked by which the voter can be identified except the unique identifier, or

(d) which is unmarked or rejected because of uncertainty,

shall be rejected and not counted, but the ballot paper shall not be rejected by

reason only of carrying the words “one”, “two”, “three” and so on, or any other mark instead of a figure if, in the opinion of the returning officer, the word or mark clearly indicates a preference or preferences.

STV44.2 The returning officer is to endorse the word “rejected” on any ballot paper which under this rule is not to be counted.

STV44.3 Any text voting record:

(a) on which the figure “1” standing alone is not placed so as to indicate a first preference for any candidate,
(b) on which anything is written or marked by which the voter can be identified except the unique identifier, or
(c) which is unmarked or rejected because of uncertainty,

shall be rejected and not counted, but the text voting record shall not be rejected by reason only of carrying the words “one”, “two”, “three” and so on, or any other mark instead of a figure if, in the opinion of the returning officer, the word or mark clearly indicates a preference or preferences.

STV44.4 The returning officer is to endorse the word “rejected” on any text voting record which under this rule is not to be counted.

STV44.5 The returning officer is to draw up a statement showing the number of ballot papers rejected by him or her under each of the subparagraphs (a) to (d) of rule STV44.1 and the number of text voting records rejected by him or her under each of the sub-paragraphs (a) to (c) of rule STV44.3.

FPP44. Rejected ballot papers and rejected text voting records

FPP44.1 Any ballot paper:

(a) which does not bear the features that have been incorporated into the other ballot papers to prevent them from being reproduced,
(b) on which votes are given for more candidates than the voter is entitled to vote,
(c) on which anything is written or marked by which the voter can be identified except the unique identifier, or
(d) which is unmarked or rejected because of uncertainty,

shall, subject to rules FPP44.2 and FPP44.3, be rejected and not counted.

FPP44.2 Where the voter is entitled to vote for more than one candidate, a ballot

paper is not to be rejected because of uncertainty in respect of any vote where no uncertainty arises, and that vote is to be counted.

FPP44.3 A ballot paper on which a vote is marked:

(a) elsewhere than in the proper place,
(b) otherwise than by means of a clear mark,
(c) by more than one mark,

is not to be rejected for such reason (either wholly or in respect of that vote) if an intention that the vote shall be for one or other of the candidates clearly appears, and the way the paper is marked does not itself identify the voter and it is not shown that he or she can be identified by it.

FPP44.4 The returning officer is to:

(a) endorse the word "rejected" on any ballot paper which under this rule is not to be counted, and
(b) in the case of a ballot paper on which any vote is counted under rules FPP44.2 and FPP 44.3, endorse the words "rejected in part" on the ballot paper and indicate which vote or votes have been counted.

FPP44.5 The returning officer is to draw up a statement showing the number of rejected ballot papers under the following headings:

(a) does not bear proper features that have been incorporated into the ballot paper,
(b) voting for more candidates than the voter is entitled to,
(c) writing or mark by which voter could be identified, and
(d) unmarked or rejected because of uncertainty,

and, where applicable, each heading must record the number of ballot papers rejected in part.

FPP44.6 Any text voting record:

(a) on which votes are given for more candidates than the voter is entitled to vote,
(b) on which anything is written or marked by which the voter can be identified except the voter ID number, or
(c) which is unmarked or rejected because of uncertainty, shall, subject to rules FPP44.7 and FPP44.8, be rejected and not counted.

FPP44.7 Where the voter is entitled to vote for more than one candidate, a text voting record is not to be rejected because of uncertainty in respect of any vote where no uncertainty arises, and that vote is to be counted.

FPP448 A text voting record on which a vote is marked:

(a) otherwise than by means of a clear mark,
(b) by more than one mark, is not to be rejected for such reason (either wholly or in respect of that vote) if an intention that the vote shall be for one or other of the candidates clearly appears, and the way the text voting record is marked does not itself identify the voter and it is not shown that he or she can be identified by it.

FPP44.9 The returning officer is to:

(a) endorse the word "rejected" on any text voting record which under this rule is not to be counted, and
(b) in the case of a text voting record on which any vote is counted under rules FPP44.7 and FPP 44.8, endorse the words "rejected in part" on the text voting record and indicate which vote or votes have been counted.

FPP44.10 The returning officer is to draw up a statement showing the number of rejected text voting records under the following headings:

(a) voting for more candidates than the voter is entitled to,
(b) writing or mark by which voter could be identified, and
(c) unmarked or rejected because of uncertainty,

and, where applicable, each heading must record the number of text voting records rejected in part.

STV45 First stage

STV45.1 The returning officer is to sort the ballot documents into parcels according to the candidates for whom the first preference votes are given.

STV45.2 The returning officer is to then count the number of first preference votes given on ballot documents for each candidate, and is to record those numbers.

STV45.3 The returning officer is to also ascertain and record the number of valid ballot documents.

STV46. The quota

STV46.1 The returning officer is to divide the number of valid ballot documents by a number exceeding by one the number of members to be elected.

STV46.2 The result, increased by one, of the division under rule STV46.1 (any fraction being disregarded) shall be the number of votes sufficient to secure the election of a candidate (in these rules referred to as "the quota").

At any stage of the count a candidate whose total votes equals or exceeds the quota shall be deemed to be elected, except that any election where there is only one vacancy a candidate shall not be deemed to be elected until the procedure set out in rules STV47.1 to STV47.3 has been complied with.

STV47 Transfer of votes

STV47.1 Where the number of first preference votes for any candidate exceeds the quota, the returning officer is to sort all the ballot documents on which first preference votes are given for that candidate into sub-parcels so that they are grouped:

(a) according to next available preference given on those ballot documents for any continuing candidate, or
(b) where no such preference is given, as the sub-parcel of non-transferable votes.

STV47.2 The returning officer is to count the number of ballot documents in each parcel referred to in rule STV47.1.

STV47.3 The returning officer is, in accordance with this rule and rule STV48, to transfer each sub-parcel of ballot documents referred to in rule STV47.1 (a) to the candidate for whom the next available preference is given on those ballot documents.

STV47.4 The vote on each ballot document transferred under rule STV47.3 shall be at a value ("the transfer value") which:

(a) reduces the value of each vote transferred so that the total value of all such votes does not exceed the surplus, and
(b) is calculated by dividing the surplus of the candidate from whom the votes are being transferred by the total number of the ballot documents on which those votes are given, the calculation being made to two decimal places (ignoring the remainder if any).

STV47.5 Where at the end of any stage of the count involving the transfer of ballot documents, the number of votes for any candidate exceeds the

quota, the returning officer is to sort the ballot documents in the sub-parcel of transferred votes which was last received by that candidate into separate sub-parcels so that they are grouped:

(a) according to the next available preference given on those ballot documents for any continuing candidate, or
(b) where no such preference is given, as the sub-parcel of non-transferable votes.

STV47.6 The returning officer is, in accordance with this rule and rule STV48, to transfer each sub- parcel of ballot documents referred to in rule STV47.5 (a) to the candidate for whom the next available preference is given on those ballot documents.

STV47.7 The vote on each ballot document transferred under rule STV47.6 shall be at: a transfer value calculated as set out in rule STV47.4(b), or
(b) at the value at which that vote was received by the candidate from whom it is now being transferred,
(c) whichever is the less.

STV47.8 Each transfer of a surplus constitutes a stage in the count.

STV47.9 Subject to rule STV47.10, the returning officer shall proceed to transfer transferable ballot documents until no candidate who is deemed to be elected has a surplus or all the vacancies have been filled.

STV47.10 Transferable ballot documents shall not be liable to be transferred where any surplus or surpluses which, at a particular stage of the count, have not already been transferred, are:

(a) less than the difference between the total vote when credited to the continuing candidate with the lowest recorded vote and the vote of the candidate with the next lowest recorded vote, or
(b) less than the difference between the total votes of the two or more continuing candidates, credited at that stage of the count with the lowest recorded total numbers of votes and the candidate next above such candidates.

STV47.11 This rule does not apply at an election where there is only one vacancy.

STV48. Supplementary provisions on transfer

STV48.1 If, at any stage of the count, two or more candidates have surpluses, the transferable ballot documents of the candidate with the highest

surplus shall be transferred first, and if:

(a) The surpluses determined in respect of two or more candidates are equal, the transferable ballot documents of the candidate who had the highest recorded vote at the earliest preceding stage at which they had unequal votes shall be transferred first, and

(b) the votes credited to two or more candidates were equal at all stages of the count, the returning officer shall decide between those candidates by lot, and the transferable ballot documents of the candidate on whom the lot falls shall be transferred first.

STV48.2 The returning officer shall, on each transfer of transferable ballot documents under rule STV47:

(a) record the total value of the votes transferred to each candidate,

(b) add that value to the previous total of votes recorded for each candidate and record the new total,

(c) record as non-transferable votes the difference between the surplus and the total transfer value of the transferred votes and add that difference to the previously recorded total of non-transferable votes, and

(d) compare:

(i) the total number of votes then recorded for all of the candidates, together with the total number of non-transferable votes, with

(ii) the recorded total of valid first preference votes.

STV48.3 All ballot documents transferred under rule STV47 or STV49 shall be clearly marked, either individually or as a sub-parcel, so as to indicate the transfer value recorded at that time to each vote on that ballot document or, as the case may be, all the ballot documents in that sub-parcel.

STV48.4 Where a ballot document is so marked that it is unclear to the returning officer at any stage of the count under rule STV47 or STV49 for which candidate the next preference is recorded, the returning officer shall treat any vote on that ballot document as a non- transferable vote; and votes on a ballot document shall be so treated where, for example, the names of two or more candidates (whether continuing candidates or not) are so marked that, in the opinion of the returning officer, the same order of preference is indicated or the numerical sequence is broken.

STV49 Exclusion of candidates

STV49.1 If:

(a) all transferable ballot documents which under the provisions of rule STV47 (including that rule as applied by rule STV49.11) and this rule are required to be transferred, have been transferred, and

(b) subject to rule STV50, one or more vacancies remain to be filled, the returning officer shall exclude from the election at that stage the candidate with the then lowest vote (or, where rule STV49.12 applies, the candidates with the then lowest votes).

STV9.2 The returning officer shall sort all the ballot documents on which first preference votes are given for the candidate or candidates excluded under rule STV49.1 into two sub- parcels so that they are grouped as:

(a) ballot documents on which a next available preference is given, and

(b) ballot documents on which no such preference is given (thereby including ballot documents on which preferences are given only for candidates who are deemed to be elected or are excluded).

STV49.3 The returning officer shall, in accordance with this rule and rule STV48, transfer each sub- parcel of ballot documents referred to in rule STV49.2 to the candidate for whom the next available preference is given on those ballot documents.

STV49.4 The exclusion of a candidate or of two or more candidates together, constitutes a further stage of the count.

STV49.5 If, subject to rule STV50, one or more vacancies still remain to be filled, the returning officer shall then sort the transferable ballot documents, if any, which had been transferred to any candidate excluded under rule STV49.1 into sub- parcels according to their transfer value.

STV49.6 The returning officer shall transfer those ballot documents in the sub-parcel of transferable ballot documents with the highest transfer value to the continuing candidates in accordance with the next available preferences given on those ballot documents, (thereby passing over candidates who are deemed to be elected or are excluded).

STV49.7 The vote on each transferable ballot document transferred under rule STV49.6 shall be at the value at which that vote was received by the candidate excluded under rule STV49.1.

STV9.8 Any ballot documents on which no next available preferences have been expressed shall be set aside as non-transferable votes.

STV49.9 After the returning officer has completed the transfer of the ballot documents in the sub- parcel of ballot documents with the highest transfer value he or she shall proceed to transfer in the same way the sub-parcel of ballot documents with the next highest value and so on until he/she has dealt with each sub-parcel of a candidate excluded under rule STV49.1.

STV49.10 The returning officer shall after each stage of the count completed under this rule:

(a) record:
  (i) the total value of votes, or
  (ii) the total transfer value of votes transferred to each candidate,
(b) add that total to the previous total of votes recorded for each candidate and record the new total,
(c) record the value of non-transferable votes and add that value to the previous non- transferable votes total, and
(d) compare:
  (i) the total number of votes then recorded for each candidate together with the total number of non-transferable votes, with
  (ii) the recorded total of valid first preference votes.

STV49.11 If after a transfer of votes under any provision of this rule, a candidate has a surplus, that surplus shall be dealt with in accordance with rules STV47.5 to STV47.10 and rule STV48.

STV49.12 Where the total of the votes of the two or more lowest candidates, together with any surpluses not transferred, is less than the number of votes credited to the next lowest candidate, the returning officer shall in one operation exclude such two or more candidates.

STV49.13 If when a candidate has to be excluded under this rule, two or more candidates each have the same number of votes and are lowest:

(a) regard shall be had to the total number of votes credited to those candidates at the earliest stage of the count at which they had an unequal number of votes and the candidate with the

lowest number of votes at that stage shall be excluded, and

(b) where the number of votes credited to those candidates was equal at all stages, the returning officer shall decide between the candidates by lot and the candidate on whom the lot falls shall be excluded.

STV50. Filling of last vacancies

STV50.1 Where the number of continuing candidates is equal to the number of vacancies remaining unfilled the continuing candidates shall thereupon be deemed to be elected.

STV50.2 Where only one vacancy remains unfilled and the votes of any one continuing candidate are equal to or greater than the total of votes credited to other continuing candidates together with any surplus not transferred, the candidate shall thereupon be deemed to be elected.

STV50.3 Where the last vacancies can be filled under this rule, no further transfer of votes shall be made.

STV51 Order of election of candidates

STV51.1 The order in which candidates whose votes equal or exceed the quota are deemed to be elected shall be the order in which their respective surpluses were transferred, or would have been transferred but for rule STV47.10.

STV51.2 A candidate credited with a number of votes equal to, and not greater than, the quota shall, for the purposes of this rule, be regarded as having had the smallest surplus at the stage of the count at which he/she obtained the quota.

STV51.3 Where the surpluses of two or more candidates are equal and are not required to be transferred, regard shall be had to the total number of votes credited to such candidates at the earliest stage of the count at which they had an unequal number of votes and the surplus of the candidate who had the greatest number of votes at that stage shall be deemed to be the largest.

STV51.4 Where the number of votes credited to two or more candidates were equal at all stages of the count, the returning officer shall decide between them by lot and the candidate on whom the lot falls shall be deemed to have been elected first.

FPP51 Equality of votes

FPP51.1 Where, after the counting of votes is completed, an equality of votes is

found to exist between any candidates and the addition of a vote would entitle any of those candidates to be declared elected, the returning officer is to decide between those candidates by a lot, and proceed as if the candidate on whom the lot falls had received an additional vote.

PART 7 FINAL PROCEEDINGS IN CONTESTED AND UNCONTESTED ELECTIONS

FPP52. Declaration of result for contested elections

FPP52.1 In a contested election, when the result of the poll has been ascertained, the returning officer is to:

(a) declare the candidate or candidates whom more votes have been given than for the other candidates, up to the number of vacancies to be filled on the council of governors from the constituency, or class within a constituency, for which the election is being held to be elected,

(b) give notice of the name of each candidate who he or she has declared elected:

(i) where the election is held under a proposed constitution pursuant to powers conferred on the [insert name] NHS Trust by section 33(4) of the 2006 Act, to the Chair of the NHS Trust, or

(ii) in any other case, to the Chair of the corporation; and

(c) give public notice of the name of each candidate whom he or she has declared elected.

FPP52.2 The returning officer is to make:

(a) the total number of votes given for each candidate (whether elected or not), and

(b) the number of rejected ballot papers under each of the headings in rule FPP44.5,

(c) the number of rejected text voting records under each of the headings in rule FPP44.10, available on request.

STV52. Declaration of result for contested elections

STV52.1 In a contested election, when the result of the poll has been ascertained, the returning officer is to:

(a) declare the candidates who are deemed to be elected under Part 6 of these rules as elected,

(b) give notice of the name of each candidate who he or she has declared elected –

(i) where the election is held under a proposed constitution pursuant to powers conferred on the [insert name] NHS

Trust by section 33(4) of the 2006 Act, to the Chair of the NHS Trust, or

(ii) in any other case, to the Chair of the corporation, and give public notice of the name of each candidate who he or she has declared elected.

STV52.2 The returning officer is to make:

(a) the number of first preference votes for each candidate whether elected or not,
(b) any transfer of votes,
(c) the total number of votes for each candidate at each stage of the count at which such transfer took place,
(d) the order in which the successful candidates were elected, and
(e) the number of rejected ballot papers under each of the headings in rule STV44.1,
(f) the number of rejected text voting records under each of the headings in rule STV44.3, available on request.

53. Declaration of result for uncontested elections

53.1 In an uncontested election, the returning officer is to as soon as is practicable after final day for the delivery of notices of withdrawals by candidates from the election:

(a) declare the candidate or candidates remaining validly nominated to be elected,
(b) give notice of the name of each candidate who he or she has declared elected to the Chair of the corporation, and
(c) give public notice of the name of each candidate who he or she has declared elected.

54. Sealing up of documents relating to the poll

54.1 On completion of the counting at a contested election, the returning officer is to seal up the following documents in separate packets:

(a) the counted ballot papers, internet voting records, telephone voting records and text voting records,
(b) the ballot papers and text voting records endorsed with “rejected in part”,
(c) the rejected ballot papers and text voting records, and
(d) the statement of rejected ballot papers and the statement of rejected text voting records, and ensure that complete electronic copies of the internet voting records, telephone voting records and text voting records created in accordance with rule 26 are held in a device suitable for the purpose of storage.

54.2 The returning officer must not open the sealed packets of:

(a) the disqualified documents, with the list of disqualified documents inside it,
(b) the list of spoilt ballot papers and the list of spoilt text message votes,
(c) the list of lost ballot documents, and
(d) the list of eligible voters,
or access the complete electronic copies of the internet voting records, telephone voting records and text voting records created in accordance with rule 26 and held in a device suitable for the purpose of storage.

54.3 The returning officer must endorse on each packet a description of:

(a) its contents,

(b) the date of the publication of notice of the election,

(c) the name of the corporation to which the election relates, and

(d) the constituency, or class within a constituency, to which the election relates.

55. Delivery of documents

55.1 Once the documents relating to the poll have been sealed up and endorsed

pursuant to rule 56, the returning officer is to forward them to the chair of the corporation.

56. Forwarding of documents received after close of the poll

56.1 Where:

(a) any voting documents are received by the returning officer after the close of the poll, or
(b) any envelopes addressed to eligible voters are returned as undelivered too late to be resent, or
(c) any applications for replacement voting information are made too late to enable new voting information to be issued,
the returning officer is to put them in a separate packet, seal it up, and endorse and forward it to the Chair of the corporation.

57. Retention and public inspection of documents

57.1 The corporation is to retain the documents relating to an election that are forwarded to the chair by the returning officer under these rules for one year, and then, unless otherwise directed by the board of directors of the corporation, cause them to be destroyed.

57.2 With the exception of the documents listed in rule 58.1, the documents relating to an election that are held by the corporation shall be available for inspection by members of the public at all reasonable times.

57.3 A person may request a copy or extract from the documents relating to an election that are held by the corporation, and the corporation is to provide it, and may impose a reasonable charge for doing so.

58. Application for inspection of certain documents relating to an election

58.1 The corporation may not allow:

(a) the inspection of, or the opening of any sealed packet containing –
  (i) any rejected ballot papers, including ballot papers rejected in part,
  (ii) any rejected text voting records, including text voting records rejected in part,
  (iii) any disqualified documents, or the list of disqualified documents,
  (iv) any counted ballot papers, internet voting records, telephone voting records or text voting records, or

(v) the list of eligible voters, or

(b) access to or the inspection of the complete electronic copies of the internet voting records, telephone voting records and text voting records created in accordance with rule 26 and held in a device suitable for the purpose of storage, by any person without the consent of the board of directors of the corporation.

58.2 A person may apply to the board of directors of the corporation to inspect

any of the documents listed in rule 58.1, and the board of directors of the corporation may only consent to such inspection if it is satisfied that it is necessary for the purpose of questioning an election pursuant to Part 11.

58.3 The board of directors of the corporation's consent may be on any terms or conditions that it thinks necessary, including conditions as to –

(a) persons,
(b) time,
(c) place and mode of inspection,
(d) production or opening,

and the corporation must only make the documents available for inspection in accordance with those terms and conditions.

58.4 On an application to inspect any of the documents listed in rule 58.1 the board of directors of the corporation must:

(a) in giving its consent, and
(b) in making the documents available for inspection

ensure that the way in which the vote of any particular member has been given shall not be disclosed, until it has been established –

(i) that his or her vote was given, and

(ii) that Monitor has declared that the vote was invalid.

PART 9 DEATH OF A CANDIDATE DURING A CONTESTED ELECTION

FPP59. Countermand or abandonment of poll on death of candidate

FPP59.1 If at a contested election, proof is given to the returning officer's satisfaction before the result of the election is declared that one of the persons named or to be named as a candidate has died, then the returning officer is to:

(a) countermand notice of the poll, or, if voting information has been issued, direct that the poll be abandoned within that constituency or class, and

(b) order a new election, on a date to be appointed by him or her in consultation with the corporation, within the period of 40 days, computed in accordance with rule 3 of these rules, beginning with the day that the poll was countermanded or abandoned.

FPP59.2 Where a new election is ordered under rule FPP59.1, no fresh nomination is necessary for any candidate who was validly nominated for the election where the poll was countermanded or abandoned but further candidates shall be invited for that constituency or class.

FPP59.3 Where a poll is abandoned under rule FPP59.1(a), rules FPP59.4 to FPP59.7 are to apply.

FPP59.4 The returning officer shall not take any step or further step to open envelopes or deal with their contents in accordance with rules 38 and 39, and is to make up separate sealed packets in accordance with rule 40.

FPP59.5 The returning officer is to:

(a) count and record the number of ballot papers, internet voting records, telephone voting records and text voting records that have been received,

(b) seal up the ballot papers, internet voting records, telephone voting records and text voting records into packets, along with the records of the number of ballot papers, internet voting records, telephone voting records and text voting records and ensure that complete electronic copies of the internet voting records telephone voting records and text voting records created in accordance with rule 26 are held in a device suitable for the purpose of storage.

FPP59.6 The returning officer is to endorse on each packet a description of:

(a) its contents,
(b) the date of the publication of notice of the election,
(c) the name of the corporation to which the election relates, and
(d) the constituency, or class within a constituency, to which the election relates.

FPP59.7 Once the documents relating to the poll have been sealed up and endorsed pursuant to rules FPP59.4 to FPP59.6, the returning officer is to deliver them to the Chair of the corporation, and rules 57 and 58 are to apply.

STV59. Countermand or abandonment of poll on death of candidate

STV59.1 If, at a contested election, proof is given to the returning officer's satisfaction before the result of the election is declared that one of the persons named or to be named as a candidate has died, then the returning officer is to:

(a) publish a notice stating that the candidate has died, and

(b) proceed with the counting of the votes as if that candidate had been excluded from the count so that –

(i) ballot documents which only have a first preference

recorded for the candidate that has died, and no preferences for any other candidates, are not to be counted, and

(ii) ballot documents which have preferences recorded for other candidates are to be counted according to the consecutive order of those preferences, passing over preferences marked for the candidate who has died.

STV59.2 The ballot documents which have preferences recorded for the candidate who has died are to be sealed with the other counted ballot documents pursuant to rule 54.1(a).

Election expenses

60. Election expenses

60.1 Any expenses incurred, or payments made, for the purposes of an election which contravene this Part are an electoral irregularity, which may only be questioned in an application made to Monitor under Part 11 of these rules.

61. Expenses and payments by candidates

61.1 A candidate may not incur any expenses or make a payment (of whatever nature) for the purposes of an election, other than expenses or payments that relate to:

(a) personal expenses,

(b) travelling expenses, and expenses incurred while living away from home, and,

(c) expenses for stationery, postage, telephone, internet(or any similar means of communication) and other petty expenses, to a limit of £100.

62. Election expenses incurred by other persons

62.1 No person may:

(a) incur any expenses or make a payment (of whatever nature) for the purposes of a candidate's election, whether on that candidate's behalf or otherwise, or

(b) give a candidate or his or her family any money or property (whether as a gift, donation, loan, or otherwise) to meet or contribute to expenses incurred by or on behalf of the candidate for the purposes of an election.

62.2 Nothing in this rule is to prevent the corporation from incurring such expenses, and making such payments, as it considers necessary pursuant to rules 63 and 64.

Publicity

63. Publicity about election by the corporation

63.1 The corporation may:

(a) compile and distribute such information about the candidates, and

(b) organise and hold such meetings to enable the candidates to speak and

respond to questions, as it considers necessary.

63.2 Any information provided by the corporation about the candidates, including information compiled by the corporation under rule 64, must be:

(a) objective, balanced and fair,

(b) equivalent in size and content for all candidates,

(c) compiled and distributed in consultation with all of the candidates standing for election, and

(d) must not seek to promote or procure the election of a specific candidate or candidates, at the expense of the electoral prospects of one or more other candidates.

63.3 Where the corporation proposes to hold a meeting to enable the candidates to speak, the corporation must ensure that all of the candidates are invited to attend, and in organising and holding such a meeting, the corporation must not seek to promote or procure the election of a specific candidate or candidates at the expense of the electoral prospects of one or more other candidates.

64. Information about candidates for inclusion with voting information

64.1 The corporation must compile information about the candidates standing for election, to be distributed by the returning officer pursuant to rule 24 of these rules.

64.2 The information must consist of:

(a) a statement submitted by the candidate of no more than 250 words,
(b) if voting by telephone or text message is a method of polling for the election, the numerical voting code allocated by the returning officer to each candidate, for the purpose of recording votes using the telephone voting facility or the text message voting facility ("numerical voting code"), and
(c) a photograph of the candidate.

65. Meaning of "for the purposes of an election"

65.1 In this Part, the phrase "for the purposes of an election" means with a view to, or otherwise in connection with, promoting or procuring a candidate's election, including the prejudicing of another candidate's electoral prospects; and the phrase "for the purposes of a candidate's election" is to be construed accordingly.

65.2 The provision by any individual of his or her own services voluntarily, on his or her own time, and free of charge is not to be considered an expense for the

purposes of this Part.

PART 11 QUESTIONING ELECTIONS AND THE CONSEQUENCE OF IRREGULARITIES

66. Application to question an election

66.1 An application alleging a breach of these rules, including an electoral irregularity under Part 10, may be made to Monitor.

66.2 An application may only be made once the outcome of the election has been declared by the returning officer.

66.3 An application may only be made to Monitor by:

(a) a person who voted at the election or who claimed to have had the right to vote, or

(b) a candidate, or a person claiming to have had a right to be elected at the election.

66.4 The application must:

(a) describe the alleged breach of the rules or electoral irregularity, and

(b) be in such a form as Monitor may require.

66.5 The application must be presented in writing within 21 days of the declaration of the result of the election.

66.6 If Monitor requests further information from the applicant, then that person must provide it as soon as is reasonably practicable.

66.7 Monitor shall delegate the determination of an application to a person or panel of persons to be nominated for the purpose.

66.8 The determination by the person or panel of persons nominated in accordance with rule 66.7shall be binding on and shall be given effect by the corporation, the applicant and the members of the constituency (or class within a constituency) including all the candidates for the election to which the application relates.

66.9 Monitor may prescribe rules of procedure for the determination of an application including costs.

67. Secrecy

67.1 The following persons:

(a) the returning officer,

(b) the returning officer's staff,

must maintain and aid in maintaining the secrecy of the voting and the counting of the votes, and must not, except for some purpose authorised by law, communicate to any person any information as to:

(i) the name of any member of the corporation who has or has not been given voting information or who has or has not voted,

(ii) the unique identifier on any ballot paper,

(iii) the voter ID number allocated to any voter,

(iii) the candidate(s) for whom any member has voted.

67.2 No person may obtain or attempt to obtain information as to the candidate(s) for whom a voter is about to vote or has voted, or communicate such information to any person at any time, including the unique identifier on a ballot paper given to a voter or the voter ID number allocated to a voter.

67.3 The returning officer is to make such arrangements as he or she thinks fit to ensure that the individuals who are affected by this provision are aware of the duties it imposes.

68. Prohibition of disclosure of vote

68.1 No person who has voted at an election shall, in any legal or other proceedings to question the election, be required to state for whom he or she has voted.

69. Disqualification

69.1 A person may not be appointed as a returning officer, or as staff of the returning officer pursuant to these rules, if that person is:

(a) a member of the corporation,

(b) an employee of the corporation,

(c) a director of the corporation, or

(c) a director of the corporation, or

(d) employed by or on behalf of a person who has been nominated for election.

70. Delay in postal service through industrial action or unforeseen event

70.1 If industrial action, or some other unforeseen event, results in a delay in:

(a) the delivery of the documents in rule 24, or

(b) the return of the ballot papers,

the returning officer may extend the time between the publication of the notice of the poll and the close of the poll by such period as he or she considers appropriate.

ANNEX 5 – ELIGIBILITY AND DISQUALIFICATION CRITERIA FOR GOVERNORS AND DIRECTORS

(Paragraphs 18 and 38)

1.1 A person may not become or continue as a member of the Council of Governors or the Board of Directors if:

a) he/she has been adjudged bankrupt or whose estate has been sequestrated and (in either case) has not been discharged;

b) he/she has made a composition or arrangement with, or granted a trust deed for, his/her creditors and has not been discharged in respect of it;

c) he/she has within the preceding five years has been convicted anywhere in the world of any offence if a sentence of imprisonment (whether suspended or not) for a period of not less than three months (without the option of a fine) was imposed on him/her;

d) he/she has, within the preceding two years, been dismissed (otherwise than by reason of redundancy or ill health) from any paid employment within a Health Service Body;

e) his/her tenure of office as the Chair or director of a Health Service Body has been terminated on grounds that his/her appointment is not in the interest of the health service, for non-attendance at meetings or for non-disclosure of a material interest;

f) he/she is a member of a Local Authority Health Overview and Scrutiny Committee;

g) he/she is a member of a Health and Wellbeing Board;

h) he/she is a member of Health Watch (nationally or locally);

i) he/she is the subject of a Sex Offenders' Order and/or his/her name is included in the Sex Offenders' Register;

j) he/she is a person who is included in any barred list established under the Safeguarding Vulnerable Groups Act 2006;

k) he/she is a Close Family Member of a Governor or Director of the Foundation Trust;

l) he/she has failed to repay (without good cause) monies properly owed to the Foundation Trust;

m) he/she has demonstrated aggressive or violent behaviour (such as verbal assault, physical assault, violence or harassment) at any NHS hospital, NHS premises or NHS establishment, or against the Foundation Trust's employees or other persons who exercise functions for purposes of the Foundation Trust whether or not in circumstances leading to his/her removal or exclusion from any NHS hospital, premises or establishment.

ANNEX 6 – CONDUCT OF MEETINGS OF THE COUNCIL OF GOVERNORS AND THE BOARD OF DIRECTORS

(Paragraphs 21 and 39)

1.1 Members of the public and representatives of the press shall be afforded facilities to attend all formal meetings of the Council of Governors and the Board of Directors except in circumstances where a special resolution is passed that members of the public and representatives of the press shall be excluded from a meeting.

1.2 The reasons for passing such a resolution shall be due to the sensitive or confidential nature of the discussion which might include information relating to:

a) employees, former employees or applicants;

b) occupiers or former occupiers of accommodation provided by or at the expense of the Foundation Trust;

c) patients or service users;

d) information relating to the financial or business affairs of a particular person.

1.3 Further, the Council of Governors or the Board of Directors, as the case may be, may resolve that:

a) in the interests of public order, the meeting should be adjourned, for a reasonable, specified period, to enable the meeting to complete business without the presence of the public or the press; or

b) publicity would be prejudicial to the public interest by reason of the confidential nature of the business to be transacted; or

c) there is another special reason, which shall be stated in the resolution, which requires that members of the public and representatives of the press be excluded.

1.4 Matters to be dealt with, following the exclusion of the public and representatives of the press, shall be confidential to the Governors or the Directors as the case may be. Members of the Council of Governors, Board of Directors, Officers and/or others in attendance at the request of the Chair shall not reveal or disclose the content of papers or reports presented, or any discussion on these generally, which take place while the public and press are excluded, without the express permission of the Chair.

1.5 The Chair may exclude any member of the public or representative of the press from a meeting of the Council of Governors or the Board of Directors, as the case may be, if he/she considers that they are interfering with or preventing the proper conduct of the meeting.

1.6 Nothing in this Constitution requires the Council of Governors or the Board of Directors, as the case may be, to allow members of the public and representatives of the press to record proceedings in any manner whatsoever other than in writing, or to make any oral report of proceedings as they take place, without the prior agreement of the Chair or the Meeting

Chair.

ANNEX 7 – MEETINGS OF THE COUNCIL OF GOVERNORS AND THE BOARD OF DIRECTORS ANNEX 7 – ELECTRONIC COMMUNICATION

(Paragraphs 21 and 39)

1.1 In exceptional cases, arrangements can be made for Governors or Directors to participate in meetings of the Council of Governors or the Board of Directors, as the case may be, by telephone, video or computer link or other such agreed means.

1.2 In these circumstances the following provisions apply:

a) "Communication" and "electronic communication" shall have the meanings set out in the Electronic Communications Act 2000 or any statutory modification or re-enactment thereof.

b) A Governor or Director, as the case may be, in electronic communication with the Chair and all other parties to a meeting of the Council of Governors or the Board of Directors or of a committee thereof shall be regarded for all purposes as personally attending such a meeting provided that, but only for so long as, at such a meeting he/she has the ability to communicate interactively and simultaneously with all other parties attending the meeting including all persons attending by way of electronic communication.

c) A meeting at which one or more of the Governors or Directors, as the case may be, attends by way of electronic communication is deemed to be held at such a place as the Governors or Directors, as the case may be, shall at the said meeting resolve. In the absence of such a resolution, the meeting shall be deemed to be held at the place (if any) where a majority of the Governors or Directors, as the case may be, attending the meeting are physically present, or in default of such a majority, the place at which the Chair of the meeting is physically present.

d) Meetings held in accordance with this paragraph are subject to paragraph 21.32. For such a meeting to be valid, a quorum must be present and maintained throughout the meeting.

e) The minutes of a meeting held in this way must state that it was held by electronic communication and that the Governors or Directors, as the case may be, were all able to hear each other and were present throughout the meeting.

ANNEX 8 – CONFLICTS OF INTEREST OF GOVERNORS AND DIRECTORS

(Paragraphs 22 and 40)

1.1 Interests which should be regarded as “relevant and material” for Governors and Directors are set out below:

a) directorships, including non-executive directorships, held in private companies or public limited companies (with the exception of dormant companies); or

b) ownership, part ownership or directorship of private companies, businesses or consultancies likely or possibly seeking to do business with the NHS or the Foundation Trust; or

c) significant or controlling share in organisations likely or possibly seeking to do business with the NHS or the Foundation Trust; or

d) a position of authority in a charity or voluntary organisation in the field of health or social care; or

e) any connection with a voluntary or other organisation contracting for NHS or Foundation Trust services or commissioning NHS or Foundation Trust services; or

f) any connection with an organisation, entity or company considering entering into or having entered into a financial arrangement with the Foundation Trust, including but not limited to lenders of banks.

1.2 For the avoidance of doubt, they shall be included in the relevant register of interests of the Governors or the Directors, as the case may be.

1.3 A "family interest" is an interest of a Close Family Member of a Governor or Director which, if it were the interest of that Governor or Director, would be a personal or pecuniary interest of his/hers.

1.4 If Governors or Directors have any doubt about the relevance or materiality of an interest, this should be discussed with the Secretary. Influence rather than immediacy of the relationship is more important in assessing the relevance of an interest.

1.5 There shall be arrangements for excluding Governors and Directors from discussion or consideration of matters in which they have a “relevant or material” interest.

Report cover-page					
References					
Meeting title:	Board of Directors				
Meeting date:	12/03/2026		**Agenda reference:**	**153-26**	
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. There have been no changes to risk scores since the Board review on 12 February 2026.				
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:	Jan, Feb, March 2026	Decision:	
Next steps:				

Report to: Board of Directors
Agenda item: 153-26
Date of meeting: 12 March 2026
Report from: Leonora May, Company secretary
Exec risk leads
Report author: Leonora May, Company secretary
Date of report: February 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 January February and March 2026. The Audit and risk committee completed a deep dive on the estates BAF risk at its meeting in March 2026.

The Finance and performance and Audit and risk committees have suggested that cyber should be considered to be separated out as its own strategic risk to ensure the appropriate level of focus. The strategic risks that make up the BAF will need to be considered at the beginning of 2026/27 in the context of the key strategic objectives for 2026/27 and cyber will be included in that review by the Board.

Executive summary

Heat map

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

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.

There have been no changes to risk scores since the Board review on 12 February 2026.

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 has met its target score • Board cyber training completed • All actions in DSPT and CAF remediation plan are completed • The funding request for the EPR programme team from December 2025 was successful (action) • EPR ‘Go Live’ was a success with no negative patient impact caused
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 • The Director of Estates and facilities post is due to be filled in February 2026 • Progress is being made with Fire officer role recruitment • 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** There is a risk that the Trust will not deliver the full value of its £7.5m cost improvement plan for 2025/26 and cost improvement plans for future years; deliver a breakeven position for 2025/26 and for future years and/ or that the working cash balance will reduce to lower than £1m Caused by the Trust's significant cost improvement target of £7.5m for 2025/26 including the requirement for corporate service cost reductions; changes to the funding regime including capping of income levels; significant activity levels, and financial pressures across other NHS organisations delaying payments Resulting in the Trust not being financially sustainable for the future	20	16	12	⟷	Amber (indicates that there are some issues that need to be monitored and addressed)	This risk is currently outside of risk appetite, with a higher score. The risk appetite for this area is minimal (1-3)	• The score remains the same as at last review • Good progress has been made in delivering the 2025/26 cost improvement programme, however, more is being delivered non-recurrently than planned • The medium term financial plan has been submitted but more work is required • The business plan for 2026/27 has been submitted • Assurance is required that further recurrent savings can be made • Internal audit on compliance with governing documents and policies concluded reasonable assurance with considerable progress and strengthening of controls
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 interim Chair is in post • Plans are progressing to recruit to NED roles • Proposal received from RSASP demonstrates a delay in shared Chair and CEO from the initial plan of March 2026
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 reduction; leadership capacity and managers capability	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 • Organisational culture assessment presented to the Board in November 2025

	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							• 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 was reduced from 12 to 9 given positive assurance as discussed at the last Quality and safety committee meeting • Nursing staffing levels have been reduced in line with efficiencies • New gap in assurance related to the bi-annual raising concerns paper presented to the Board in February 2026 which demonstrated a decline in 'tell the CNO' reports • The monitoring of timely response to complaints action has been completed • The PSIRF policy and resource action is off track
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 out of date policies has increased to 54 despite 7 policies being ratified since the last review. This reflects the routine cycle of rolling reviews and policy expiry dates. 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 • Assurance presented to the Audit and risk committee at its meeting in January 2026 demonstrates no known breaches of governing documents since Q4 2024/25

								• 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 • A new organisational risk has been added related to the risk that implementation may be delayed beyond September 2026 due to finance and governance reviews being undertaken • Financial and governance reviews have commenced • Focus work is underway to develop the communication and engagement plan for the next phase in collaboration with partners • Two new actions have been added for this risk. The timeline for transition planning being agreed between partners and the communication and engagement plan being agreed between partners

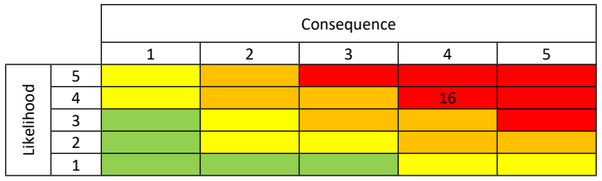
KSO1	KSO2	KSO3	KSO4	KSO5	Overall Assurance Rating (RAG)	Q3- 2025/26	Q4- 2025/26				
✓			✓	✓							

BAF

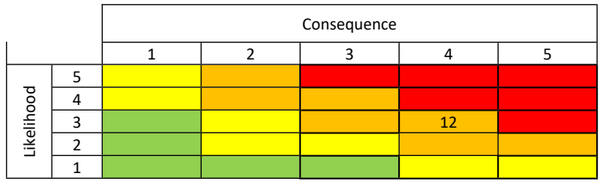
Risk description
Risk:
There is a risk that the Trust will not deliver against its operational plan and national access standards
Caused by:
Rise in waiting lists; increased demand; national changes; support to the wider Sussex system
Resulting in:
Patients waiting longer than we would like for treatment; 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:**	4 February 2026		
Risk Handler(s)	Deputy Chief operating officer	**Date Risk last formally discussed:**	2 March 2026	**Group**	Finance and performance committee

Inherent Score

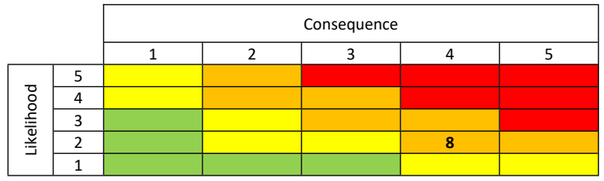


Current Score



Direction of travel since last review	⟷

Target Score



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:**	17 February 2026		
Risk Handler(s)	Bill Gordon, Chief digital information officer	**Date Risk last formally discussed:**	2 March 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 February 2026, Amber (see action 7) 2nd line:	Actions to be completed in CAF DSPT improvement plan. 1/2/2026 196/197 areas now complete. Board cyber training booked for 12/2/2026

	DSPT and CAF annual submission for standards met demonstrates the Trust is approaching standards (not met), June 2025. All actions in the improvement plan completed, February 2026 Green (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. All actions in the improvement plan completed, February 2026 Green (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. All actions in the improvement plan completed, February 2026 Green (see action 1) 2nd line: DSPT and CAF annual submission for standards met demonstrates the Trust is approaching standards (not met), June 2025. All actions in the improvement plan completed, February 2026 Green (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. All alerts have been dealt with in required timeframe, February 2026 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. All areas have been addressed, February 2026 Green 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,. All actions in the improvement plan completed, February 2026 Green (see action 1)	Board training required to be completed Q1 2026/27. Completed February 2026 Actions to be completed in CAF DSPT improvement plan. Completed February 2026 Cyber table top exercise to be completed ahead of EPR ‘go live’. Completed November 2025
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. Funding received to March 2026. Amber (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	Trust reliant on external funding to progress. Funding received to 31 March 2026. Significant inflationary increase in resource cost anticipated in relation to digital resources which is not budgeted for.

	opportunities to share costs and functions across the system for implementation from 1 April 2026, October 2025, Funding received to March 2026. Amber (see actions 3 and 8)	
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. Funding received to March 2026. Green 2nd line: Outsourced functions to 3rd party providers through managed service contracts. Contract monitoring processes in place, Green	Time limited resource with no confirmation of long term funding. Funding received to 31 March 2026.

Actions	**Timescale**	**Lead**	**Status** (complete, on track, off track, not yet started)
1. Completion of DSPT and CAF remediation plan	28 February 2026	CDIO	Complete
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	Complete
5. Board cyber training	31 March 2026	CS	Complete
6. Regular reporting to the Finance and performance committee Re EPR Go Live	31 March 2026	CDIO	In progress / ongoing
7. Digital policies to be updated and approved through governance routes	28 February 2026	CDIO	In progress
8. Ongoing discussions with NHSE about availability of funding to support digital	31 March 2026	CDIO	In progress / ongoing
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:**	13 February 2025		
Risk Handler(s)	Deputy Director of Estates and Facilities	**Date Risk last formally discussed:**	2 March 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. Following the E&FSC meeting on 26th February, only 4 estate policies will be out of date. 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 Authorised engineer (AE) for electrical appoionted and review on electrical compliance to be completed Authorised engineer (AE) for medical gases appointed and review on medical gas compliance to be completed

	Policy log demonstrates that key estates policies are in place to support compliance with statutory requirements, February2025, Amber (see action 7) 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, February 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 was completed in December 2025 and the report is being actioned.	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, February 2025, Amber (see action 2). Receipt of the additional £2.8m of estates safety funding in 2025/26 and 3.6m in 2026/27 will go a long way to address this. 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, January 2026, Amber (see action 2) Regular reporting on financial performance through the IQPR demonstrates that the estates capital budget mostly spent at January 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 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:	Assurance from annual review of Asbestos Management Plan D Additional roofing actions have now been prioritised and funded.

	Regular review of Management Plan by estates leadership incl. visual inspection of asbestos areas demonstrates a requirement to remove certain asbestos contained roofing materials (ACM's) within six months. Amber (see action 2) 3rd line: 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 key roles are in place including Associate Director of Estates and Facilities, Project managers and Compliance Manager, however there are gaps in expertise relation to electrical and mechanical and the Director of Estates, February 2025, Red (see actions 4 and 5)	Lack of qualified persons in roles incl authorised persons such as electrical and mechanical. 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	Appointment offered
2. Seeking additional funding from NHSE for funding for critical infrastructure risks	31 March 2026	DEF	Completed
3. Arrange for a six facet survey to be completed	31 March 2026	DEF	On going
4. Appointment of authorised engineer (AE) to be completed	31 March 2026	DEF	Not yet started
5. Review of estates specific business continuity plans	31 March 2026	ADEF	Not yet started
6. All estates policies to be updated in line with requirements	31 March 2025	ADEF	Off track, but will be corrected by end of February
7. Continued oversight of estates capital spend to support year end position	31 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 2026/27 and cost improvement plans for future years; deliver a breakeven position for 2026/27 and for future years and/ or that the working cash balance will reduce to lower than £1m.

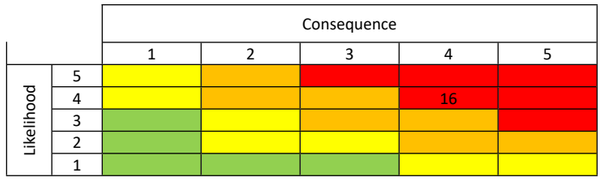
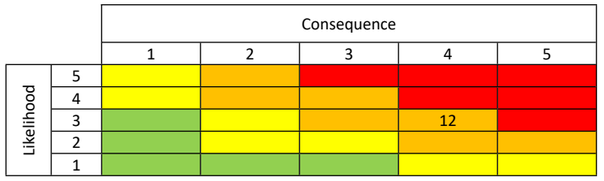
Caused by:

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

Resulting in:

The Trust not being financially sustainable for the future.

Responsible committee	Finance and performance committee	**Date Risk Added:**	13 November 2025		
Principal Exec – Risk Owner	Chief Finance Officer	**Date Risk last reviewed:**	13 February 2026		
Risk Handler(s)	Deputy Chief Finance Officer	**Date Risk last formally discussed:**	2 March 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, February 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, some non-recurrent in 25/26 and unidentified savings for 26/27. Opinion from internal audit on financial management review.

	being delivered non-recurrently than planned, February 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, February 2025, Amber	Opinion from internal audit on financial management review.
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, February 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	The Trust has submitted its 5 year MTFP but significant amounts of internal and system work are still to be undertaken, Amber (see action 3)	Medium term financial plan Board sign off and ongoing monitoring of progress.
Annual business planning process incl. budget setting	1st line: Business plan for 2026/27 to the Finance Performance committee and Board demonstrates planned breakeven position, however this is high risk, February 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 well underway but more to do to make fully robust, February 2025, Amber	National planning guidance for 2026/27 received and is fed into internal and system plans. Opinion from internal audit on financial management review.

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

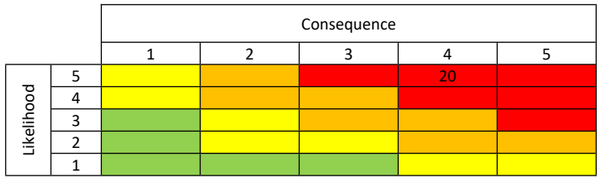
Actions			
1. Continued identification of cost improvement programmes and conversion of non-recurrent to recurrent schemes	Ongoing	CFO	Ongoing
2. Develop Governance handbook to support staff across organisation	31 March 2026	CS	Ongoing
3. Medium term financial plan to be developed as part of the 2026/27 business planning process	Q4 25/26	CFO	Plan submitted, but further work required.
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				
✓	✓	✓	✓	✓							

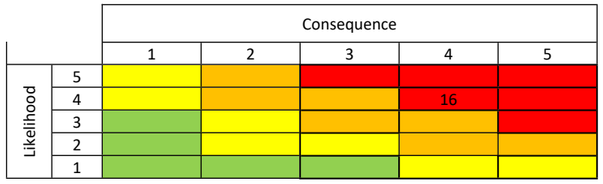
BAF	**Risk description** Risk: There is a risk that there will not be leadership capacity to deliver the strategic partnership, key strategic objectives and key projects Caused by: Three interim executive roles including Chief executive officer; turnover in Board level roles and organisational memory 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:**	18 February 2026		
Risk Handler(s)	Chief executive officer	**Date Risk last formally discussed:**	25 February 2026	**Group**	Strategy and culture committee

Inherent Score

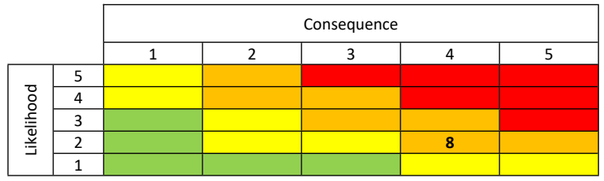


Current Score



Direction of travel since last review	⟷

Target Score



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) 3rd line:	Interim Chair in post from 19 January 2026 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

	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 January 2026, Amber (see action 4)	Project benefits realisation tracking across the Trust to be developed Confirmation about SRO leadership for the CDC programmes following executive team changes during 2026
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

Actions	**Timescale**	**Lead**	**Status** (complete, on track, off track, not yet started)
1. Shared Chair and CEO to be in post by March 2026	September 2026	CEO	Date changed to September 2026 in line with RSASP timeline in proposal
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	March 2026	DCSO	On track
5. Non-executive director arrangements from June 2026 to be agreed	January 2026	Interim Chair, CS	Off track- plans for recruitment being worked through

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:**	17 February 2026		
Risk Handler(s)	Deputy Chief people officer	**Date Risk last formally discussed:**	25 February 2026	**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 January 2026 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. CTSG focus will be on speaking up, February 2026 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 will determine focus of group. January 2026, 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. 2025 staff survey results will be published in March 2026 Amber (see actions 1 and 4) People Pulse Survey for 2025/26 (up to January 2026) was responded to by 474 staff. In Q4 139 (10.7%) staff completed the People Pulse Survey. The Q4 results demonstrated an improvement in mood and motivation, Amber (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, December 2025. Next assurance report due at ELT in February 2026 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. Work on the action plan continues, February 2026 Green 2nd line: Mandatory and statutory training compliance reported monthly through IQPR, demonstrates 92% compliance overall with improvement required in some specific areas such as Resus, October 2025. MAST compliance stable in November 2025 with a focus on Data Security (IG) training and fire training. MAST compliance in January 2026 is stable, Green	Managers training programme commenced October 2025. Assurance will be in manager and staff feedback, ER cases, FTSU increases. February 2026 – feedback from cohorts demonstrating growth in confidence. Cohorts continue through Q4 of 2025/26. Evaluation feedback will continue to be reviewed.
Managers training programme, prioritising bands 6-8a- two day programme including policies and softer skills such as supporting staff to speak up and holding difficult conversations	1st line: 2 cohorts underway with feedback / evaluation undertaken after each training day. Positive feedback received from participants, December 2026. Cohorts booked throughout 2026/27, February 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 from November 2025 to February 2026 Amber Employee relations team weekly review of employee relations cases, demonstrates focus points for specific support and interventions required, October 2025. February 2026 – weekly review meetings continue, with thematics from cases triangulated with other data Green (see action 1) 2nd line: Organisational cultural assessment undertaken to be presented to the Board in November 2025, demonstrates that there are micro cultures and ongoing focus required to embed behavioural framework. Presented to Board in November, with ongoing work to support culture development (December 2025). Update on areas of consideration and next steps to be presented to Strategy and Culture Committee in March 2026 Green	

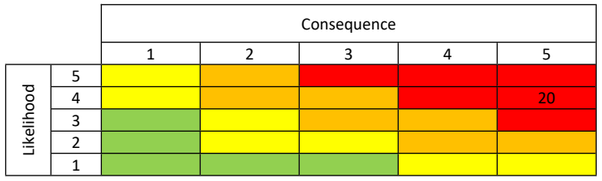
Mechanisms in place for staff to provide feedback incl. Staff Survey, Quarterly People Pulse Surveys, Freedom to Speak Up Service, 'Tell Liz', 'Ask Abigail'	2nd line: 2024 Staff survey results published in March 2025 with a 57% response rate, demonstrate disabled staff have a less positive experience than non-disabled staff and staff do not always feel confident action will be taken if they speak up. 2025 staff survey results will be published in March 2026 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. People Pulse Survey for 2025/26 (up to January 2026) was responded to by 474 staff. In Q4 139 (10.7%) staff completed the People Pulse Survey. The Q4 results demonstrated an improvement in mood and motivation, Amber (see actions 1 and 4) 3rd line: FTSU Guardian report presented to the Board in July 2025 demonstrated that more staff are speaking up but some staff still wishing to stay anonymous due to concerns about the consequence. FTSU report and Raising concerns report presented to the Board in February 2026, with some staff still wishing to stay anonymous Green	Ongoing action plans from staff survey. Once 2025 staff survey results are available in March 2026 (once embargo is lifted), specific action plans will be worked on with departments

Actions	**Timescale**	**Lead**	**Status** (complete, on track, off track, not yet started)
1. Ongoing promotion and embedding of behaviour framework and values through workshops, staff survey action plans and team charters.	March 2026	Head of Leadership and OD	Ongoing- workshops completed in September, October and November 2025 and January 2026. Will continue into 2026/27.
2. Communication and engagement plan to encourage non-clinical staff to apply for Charity funded training to support their development	March 2026	Head of Leadership and OD	Ongoing
3. Communication and engagement plan to encourage a wider diversity of apprenticeship applicants	March 2026	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	April 2027	Chief People Officer	Not yet started – to be discussed with Chief People Officers of partner organisations
5. Organisational culture review incl. associated programmes of work	March 2026	Chief People Officer	Presented to Board in November 2025 with ongoing programmes of work. Update paper being presented to Strategy and Culture Committee on 25 February 2026

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:**	26 February 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, February 2026, Green 2nd line: Quality and safety sub-committee of Board and executive sub-committee for quality in place with oversight of quality and safety matters. Green Incident reporting through Datix demonstrates no significant quality and safety issues because of cost improvement programme initiatives to date, February 2026, Green	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 94.45% (target 90%) for December 2025 Green	
Incidents - consistent reporting of incidents with learning including thematic review supported by clinical governance framework. Patient safety incident response framework (PSIRF) approach in place and central incident reporting through the Learning from Patient Safety Events (LfPSE) platform	1st line: Summary incident reports collated and actively managed through directorates and groups reporting into Quality Committee Green Exec/ Board level time 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 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, quarterly IPC meetings, no clinical concerns in December 2025 Green Demonstration of learning through morbidity & mortality meetings, governance meetings, IQPR and the Clinical Learning Forum, Green 3rd line: Biannual quality review by the ICB raised no quality concerns, Q3 in 2025/26, Green Internal audit review of incident management during August 2025. Outcome received and submitted to Audit & Risk Committee, action plan underway	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 Green Responsiveness to patient complaints is embedded within assurance on 2025/26 quality priorities, Green Patient stories to Board, November 2025, Green Annual Complaints Report, July 2025, Green 3rd line:	Assurance on achievement of timely response to complaints (reduced from 40 to 30 days). Dependency of process on a single individual.

	Reporting demonstrates that there have not been any complaints escalated to the PHSO during 2024/25 and 2025/26 to date, February 2026, Green	
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. Biannual Raising concerns paper identified a reduction in 'Tell CNO' enquiries which may be linked to lack of anonymity, to review and monitor for next paper. July 2026
Clinical audit - plan to identify risks to quality, safety and effectiveness of care	1st line: Quality and Compliance Team regularly monitoring against audit and effectiveness standards. Green 2nd line: Quality and safety sub-committee of Board and executive sub-committee for quality in place with oversight of quality and safety matters Green Reporting on compliance with audit programme and NICE guidelines through ECQR demonstrates that where the Trust is not compliant, there are mitigations in place to manage the risks, February 2026, Green 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, and have been reviewed in line with cost improvement plans, January 2026, Green (see action 6) 3rd line:	Reconfiguration of nursing staff and review of the impact on quality once in place, March 2026.

	NHSE Oversight of safer staffing processes and compliance, Green	
Archie EPR implementation included extensive clinical engagement	1st line: CNIO in post with clinical safety capability supporting maintenance of hazard log and clinical safety case, recruiting to CCIO role and identifying staff to support CSO function Amber (see action 7) 2nd line: Third party vendor provided independent clinical safety assessment to ensure areas of non-compliance with DCB1060 highlighted prior to go live, remaining actions completed by Archie EPR Programme Team, Green (see action 7)	Funding constraint in ongoing support for EPR programme including clinical safety for 26/27
Clinical Governance reporting framework established	1st line: Dedicated clinical governance staff time to ensure consistent recognition and evaluation of quality and safety metrics, Green (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).

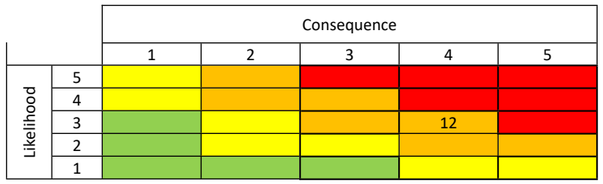
Actions	**Timescale**	**Lead**	**Status** (complete, on track, off track, not yet started)
1. Evidence of actions following staff survey address deficiencies in staff confidence to speak up needs to be addressed through behavioural framework initiatives	31 March 2026	CPO, CNO, CMO	In progress
2. QIAs to be performed for all productivity initiatives as well as CIPs: Policy being revised to incorporate QIA, EIAs and ongoing monitoring / assurance	31 March 2026	CNO, COO, CMO, CIP Leads	In progress

3. Review PSIRF policy and ensure resources in place to enable delivery	31 January 2026	CNO, Head of Patient Safety	In progress - off track
4. Monitoring of timely responsiveness to complaints target, consideration of dependency on individual for service	31 January 2026	CNO, Head of Patient Safety	Complete
5. Engagement with directorates to ensure completion of audit deliverables. No overdue projects in directorates (eg. Completed, closed etc.)	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, through optimisation, identify opportunities for reviewing and monitoring safety and effectiveness	31 March 2026	CIO, CMO	In progress
8. Clinical governance structure undergone numerous changes so embedding of new processes needs to be established. Clinical Lead for Quality to be appointed	31 March 2026	CNO, CMO	Complete
9. 90% clinical 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, Company Secretary	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:**	2 March 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, 54 are out of date which is an increase since the last review. No key corporate policies are out of date, February 2026, Red/Amber (see action 2) 3rd line: Reporting on progress of internal audit plan to Audit and risk committee demonstrates actions are being completed in a timely manner, January 2026, Green	
Governing documents in place including Trust Constitution, Scheme of delegation and reservation of powers, Standing financial instructions aligned to statutory and regulatory requirements	1st line: Reporting to the Audit and risk committee regarding compliance demonstrates no known breaches since Q4 2024/25, January 2026, 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 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
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 2025/26, related to NED pay. This is compared to multiple areas of compliance being reported in previous years. March 2026, Green	

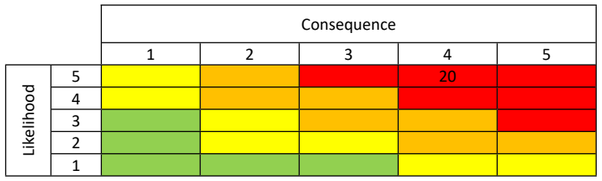
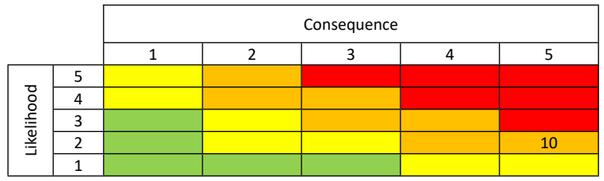
Actions	**Timescale**	**Lead**	**Status** (complete, on track, off track, not yet started)
1. Review of effectiveness of 'policy for policies'	July 2026	CS, executive team	On track
2. Continued oversight of management of out of date policies incl. priority areas	March 2026	Policy owners	Ontrack
3. Develop Governance handbook to support staff across organisation	March 2026	CS	Ongoing
4. Assurance to Audit and risk committee about compliance with governing documents	March 2026	CS, CFO	Completed

5. Review of progress against actions to address gaps within Provider capability assessment	April 2026	Board	On track
Links to Organisational Risk Register			

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:**	3 March 2026		
Risk Handler(s)	Deputy Chief Strategy Officer	**Date Risk last formally discussed:**	25 February 2026	**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:	The partnership transition timeline remains under discussion, therefore the position of delivery remains challenged at this time. Proposed shared Chair and CEO by September 2026. Financial and governance planning has commenced. Implementation and transition plan in progress. Paper was tabled at SCC in February regarding transition planning progress to date, including next steps for 2026/27. This includes risk register management. Finance and governance reviews have commenced.

	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	Further engagement planned with partners following recent SCC meeting. Focus work is underway to develop the communication and engagement plan for the next phase.
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	Focus work is underway to develop the communication and engagement plan for the next phase in collaboration with partners. QVH will continue the stakeholder assurance group to support direct staff involvement in the process.
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) Transition and implementation plan was shared with Strategy and culture committee in February 2026, demonstrates commencement of workstreams and finance and governance reviews, Amber 3rd line: Review of NHSE timeline demonstrates alignment with QVH timeline, October 2025, Green	Timeline for transition planning to be agreed between partners in March 2026.
Governance and oversight - Oversight by the Strategy and culture committee (SCC) and Board including input from Council of Governors and Strategic assurance group. Strategic direction by NHSE and ICB	2nd line: 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)	

	3rd line: Partnership working group between QVH and RSFT/ASPH in place and meeting weekly. March 2026, Green	

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 2026	DCSO	Complete
4. Development of transition and implementation (incl. Governance) plan for partnership	February 2026	CEO, DCSO, CS	On track
5. Timeline for transition planning needs to be agreed between partners	March 2026	Chair, CEO	In progress
6. Communication and engagement plan needs to be agreed between partners	March 2026	DCSO	In progress
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:	12/03/2026	**Agenda reference:**	**154-26**		
Report title:	Annual report Emergency Preparedness Resilience and Response (EPRR)				
Sponsor:	Kirsten Timmins, Chief Operating Officer				
Author:	Kirsten Timmins, Chief Operating Officer				
Appendices:	Outcome of Emergency Planning Core Standards Assessment in 2025				
Executive summary					
Purpose of report:	To provide an update on the Trust's preparedness to respond to an emergency incident, and the outcome of the EPRR annual self-assessment process.				
Summary of key issues	The Annual Emergency Preparedness, Resilience and Response (EPRR) report to the Board provides statutory assurance (under the Civil Contingencies Act 2004) that an organisation is prepared for, and can respond to, emergencies. It outlines compliance with NHS England core standards, details incidents managed, training undertaken, and sets key improvement priorities. Key components of the Annual EPRR Report • Assurance Level: A self-assessment rating (Full, Substantial, Partial, or Non-compliant) regarding adherence to national standards. • Incident Management: A summary of any major or critical incidents and business continuity issues managed in the past year. • Training & Exercises: Evidence of training, workshops, and live exercises conducted to test preparedness. • Action Planning: Progress on previous improvements and specific goals for the coming 12 months. • Governance: Confirmation of accountabilities, including local health resilience partnership participation. The Board is required to review this report annually in a public session to ensure they are fulfilling their statutory duties and that the organisation has robust plans to maintain patient safety during incidents. Progress on actions will be overseen by the Quality and Safety Committee throughout 2026/27.				
Recommendation:	The Board is asked to **note** the annual report on EPRR and that progress on actions will be overseen by the Quality and Safety Committee throughout 2026/27.				
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:	Impact on BAF 1 (patient services) and BAF 5 (compliance breach)				
Organisational risk register:	Ability to meet duties on the Trust in relation to emergency planning and response under the Civil Contingencies Act 2004.				
Regulation:	NHSE, ICB, CQC all oversee the performance of trusts regarding emergency planning.				
Legal:	None				

Resources:	None			
Assurance route				
Previously considered by:	Quality and Safety Committee			
	Date:	26/02/2026	Decision:	For onward assurance to Board
Next steps:				

Report to: Board of Directors
Agenda item: 154-26
Date of meeting: 12 March 2026
Report from: Kirsten Timmins, Chief Operating Officer
Report author: Kirsten Timmins, Chief Operating Officer
Date of report: 27 February 2026
Appendices: Outcome of Emergency Planning Core Standards Assessment in 2025

Emergency Preparedness Resilience and Response (EPRR) Annual Report

Introduction

The paper is to provide an update on the outcome of the annual EPRR assurance self-assessment process, and a summary of the Trust's preparedness to respond to an emergency situation.

Situation

The Annual Emergency Preparedness, Resilience and Response (EPRR) report to the Board provides statutory assurance (under the Civil Contingencies Act 2004) that an organisation is prepared for, and can respond to, emergencies. It outlines compliance with NHS England core standards, details incidents managed, training undertaken, and sets key improvement priorities.

Key components of the Annual EPRR Report

- Assurance Level: A self-assessment rating (Full, Substantial, Partial, or Non-compliant) regarding adherence to national standards.
- Incident Management: A summary of any major or critical incidents and business continuity issues managed in the past year.
- Training & Exercises: Evidence of training, workshops, and live exercises conducted to test preparedness.
- Action Planning: Progress on previous improvements and specific goals for the coming 12 months.
- Governance: Confirmation of accountabilities, including local health resilience partnership participation.

The Board is required to review this report annually in a public session to ensure they are fulfilling their statutory duties and that the organisation has robust plans to maintain patient safety during incidents.

Background

Under the Civil Contingencies Act 2004, Queen Victoria NHS Foundation Trust is categorised as a Category 1 Responder. This places specific duties on the Trust in relation to emergency planning and response. Additionally, the Trust has other obligations as required by contracts and assurance standards set by NHS England.

1. Annual Assurance Self-Assessment Rating

All NHS Trusts who are category 1 and 2 responders (Civil Contingencies Act 2004) are required to complete a self-assessment and submit a statement of readiness to NHS England stating compliance against the national requirements of EPRR. The annual assurance process was formally completed with assessments by the ICS EPRR team.

There are 4 levels of compliance, and nationally the majority of trusts and ICBs are rated as having 'substantial' compliance.

Organisational rating	Criteria
Fully	The organisation is fully compliant against 100% of the relevant NHS core standards for EPRR.
Substantial	The organisation is fully compliant against 89-99% of the relevant NHS core standards for EPRR.
Partial	The organisation is fully compliant against 77-88% of the relevant NHS core standards for EPRR.
Non-compliant	The organisation is fully compliant up to 76% of the relevant NHS core standards for EPRR.

The Trust submitted its EPRR Core Standards Assurance Process in September 2025 and received confirmation of the independent ICB review on 11 December 2025. In 2023, the trust was rated as having substantial compliance. In 2024, the trust received a rating of fully complaint. For 2025, the trust submitted an overall rating of substantial compliance. Of the 59 core standards, the four areas self-assessed as not being fully compliant were in relation to Data Security and Protection Toolkit (DSPT), supplier business continuity, EPRR resource, and training and exercising. The ICB agreed with our assessment and this is outlined in the letter attached.

Update on non-fully compliant standards at February 2026

Actions are in progress against the four areas not assessed as fully complaint.

- EPRR resource – While the substantive resource level has not formally changed, the administrative support previously provided on an ad hoc basis ceased in September 2024. This has resulted in a gap that impacts our ability to maintain assurance, attend system EPRR meetings, and ensure training records for on-call managers. ELT approved in December 2025 the recruitment of a part time band 7 EPRR lead. The trust has gone out to advert for a part time role at the end of January 2026.
- Training and exercising- With a dedicated EPRR resource in place, the trust will focus on ensuring managers have a record of all their training and experience of managing incidents, and the trust is running its own EPRR exercises.
- DSPT compliance -The trust has an improvement plan re DSPT which is on track and being monitored through Finance and Performance Committee and Audit and Risk Committee.
- Assurance of commissioned providers / suppliers Business Continuity Plans (BCPs) - The procurement team is in the process of gaining assurance that commissioned providers/suppliers have BCPs in place. We currently categorise contracts into Gold/silver /Bronze based on financial value or operational importance. Procurement will seek BCPs from all our Gold contracts by 30th June 2026. Business Continuity Plans for Silver contracts will be sought by March 2027.

Progress on actions will be overseen by the Quality and Safety Committee throughout 2026/27.

2. Incident Management

The Trust has activated procedures to respond to a number of incidents during 2025, including;

- Three rounds of industrial action (July, November and December 2025)
- Estates issues requiring the need to move a number of wards to alternative locations
- Adverse weather including flash flooding
- General estate issues
- Water outage impacting the whole of East Grinstead

Debriefing sessions were undertaken following incidents to identify the lessons learnt and opportunities for improvement.

A paper was discussed at Audit and Risk Committee in August 2024 regarding the trust's approach to managing incidents both in hours and out of hours.

3. Training and Exercising

The ICB has a programme of work, which informs our programme of work for the year, and includes attendance at ICB meetings, Sussex wide exercises, and ensuring policies are kept up to date. The trust attends a number of ICB forums including Training and exercising group, and policies and procedures group where learning and best practice is shared among trusts. Given the small size of the trust, QVH has not typically run our own exercises, and instead attend training run by the ICB or larger trusts with EPRR teams. Learning from these exercises is discussed in the on call managers meeting and updated where necessary in our trust policies.

The Trust continues to train internal staff on a variety of incident scenarios and participate in the Sussex Local Health Resilience Partnership training opportunities. Training has been undertaken on how to manage hazardous material incidents such as chemical or radiation emergencies as part of the annual training programme, specifically directed towards our MIU service.

During 2025 the Trust took part in ICB led incident escalations to check the communication protocols, and an IT table top exercise to test our business continuity based on a cyber-attack. The trust undertook a fire evacuation on Ross Tilley Ward, with a programme of fire evacuations planned over the course of the year.

4. Priorities for the year ahead

Through the recruitment of the EPRR Lead the ambition of the service is to embed a KPI framework that meets the needs of the Trust and delivers assurance regarding the continued compliance of the EPRR Framework.

The future aspiration of the EPRR function is to utilise the NHSE Business Continuity Management Toolkit to support the validation of local level Business Continuity Plans and to develop a KPI framework for the Trust focussing on;

- Increasing the number of EPRR exercises,
- All on-call managers to complete a training needs analysis and training logs to ensure they had the relevant competencies and experience, supported by the completion of Principles of Health Command training.
- Attendance by key personnel at debriefing sessions
- Ensuring Business Continuity Plans are up to date, compliant, and reflect learning from incidents.

These KPIs would be developed through exploration and learning from system partners and internal benchmarking.

5. Governance

The Chief Operating Officer has oversight of the Trust's Emergency Planning, Response and Recovery (EPRR) functions, providing senior leadership for mitigating the impact of adverse incidents and undertaking horizon scanning to ensure services have robust business continuity plans in place to ensure the continued delivery of services.

Continued attendance at the EPRR conferences, Sussex Health responders Group and the Local Health Responders Group will continue to support the ongoing learning and shared best practice across all parts of the Sussex Health system.

6. Recommendation

The Board is asked to note the annual report on EPRR and that progress on actions will be overseen by the Quality and Safety Committee throughout 2026/27.

Kirsten Timmins
Chief Operating Officer
Queen Victoria Hospital
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11 December 2025

Dear Kirsten,

Re: NHS England EPRR Core Standards Assurance Process 2025 - Queen Victoria Hospital NHS Trust

Firstly, can I thank you and the team for all your hard work and close collaboration with the ICB's Emergency Preparedness, Resilience and Response (EPRR) team during the assurance process this year.

Following the review of Queen Victoria Hospitals (QVH's) self-assessment against the NHS England (NHSE) Core Standards for EPRR at the Local Health Resilience Partnership (LHRP) Executive Group on 18 November 2025, as part of the annual assurance process, we are writing now to formally confirm the outcome.

Please note that whilst NHSE have yet to formally approve the overall submission for Sussex Integrated Care System (ICS) following their own internal review process, they were present at the LHRP Exec meeting and agreed with our statement of assurance. It is therefore unlikely that the overall position or individual ratings for Sussex will change.

Outcome of the assessment process

As discussed at the final meeting in October 2026, QVH have been assessed as substantially compliant against the NHSE EPRR Core Standards.

QVH were fully compliant with 55 of the total 59 standards assessed, and partially compliant with four.

NHS England define substantially compliant as:

Compliance Level	Evaluation and Testing Conclusion
Substantial	The organisation is 89-99% compliant with all core standards they are expected to achieve. The organisation's Board has agreed with this position statement.

The rationale for the assessment and suggested actions for improvement are contained in the table below for those standards that were assessed as partially compliant.

Table 1 Partially compliant standards 2025

Ref	Core Standard	2025 rating	Rationale	Action
5	EPRR Resource		QVH resources have reduced this year, with no dedicated EPRR resource; this impacts on attendance at meetings to take forward EPRR areas.	QVH to review staffing levels to ensure there is dedicated resources for EPRR, including dedicated Accountable Emergency Officer resource expected to oversee, manage and report back on EPRR areas.
24	Training and Exercising		Training records were not available as part of this year's evidence.	EPRR training records to be produced and maintained
49	Business Continuity – DPST compliance		DPST currently at 'Approaching Standards' level.	To monitor the DPST compliance level with support from the IG team.
53	Business Continuity – Assurance of commissioned providers / suppliers BCPs		Further work is required to take this area forward.	To link in with the required teams to gain assurance that commissioned providers / suppliers have BCPs in place.

Next steps

Please check this letter and the final core standards spreadsheet sent with it to ensure it matches your understanding of the final outcome of this process and let us know, via the EPRR inbox, (sxicb.eprr@nhs.net), if anything does not correlate.

It would also be helpful if you could confirm to us when you will be taking the outcome of the core standards assurance process to your Board for review.

The ICB EPRR team will be working with your EPRR team to agree a SMART action plan to address the comments noted in the table above by the end of February 2026 for discussion at the Core Standards 2026 launch meeting in March. This will allow us to identify areas where collaborative working would be beneficial, and for those actions to be included in the ICS EPRR Workplan.

The action plan will then be reviewed on a monthly basis to help facilitate significant improvements throughout the year to support the core standards assurance process for 2026.

On behalf of the Sussex ICB, our thanks for your help and assistance in completing this year's annual EPRR assurance process.

Yours sincerely,

Nicki Smith
Director of EPRR

Claudia Griffith
Chief Commissioning Officer
Accountable Emergency Officer

On behalf of Sussex NHS ICB

Cc: EPRR team

Report cover-page					
References					
Meeting title:	Board of Directors				
Meeting date:	12/03/2026		**Agenda reference:**	**155-26**	
Report title:	Audit and risk assurance				
Sponsor:	Jagjit Dosanjh-Elton, Non-Executive director and committee Chair				
Author:	Jagjit Dosanjh-Elton, Non-Executive director and committee Chair Ellie Simpkin, Governance manager				
Appendices:	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	- In preparation for the Trust's next well-led review, a self-assessment has been completed which will support the development of the scope for the review and areas of focus. - The committee undertook a deep dive of the estates BAF noting the robust processes in place but recognising a broader perspective is required on the range of estate risks and their nuances to fully understand the residual risk being carried. - The committee agreed for Cyber to be detailed as a separate strategic risk on the BAF. Currently it is covered as part of the Digital risk. - Detailed discussion was had on the importance of providing evidence-led assurance in the areas of estate, cyber and compliance The committee has asked that the Executive team to further consider how it provides such assurance to the committees. - The draft Head of Internal Audit Opinion for 2025/26 is that the Trust has an adequate and effective framework of governance, risk management and internal control. The final opinion will be set out in the annual internal audit report after year end. - The committee has reviewed a first draft of the Annual governance statement (AGS) 2025/26 which is likely to conclude that no significant internal control issues have been identified during 2025/26 - The Trust's risk management framework continues to embed across the organisation. - An internal audit review of financial management received a 'reasonable assurance' outcome. - There is sustained progress reducing the use of single tender waivers.				
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 Estates 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: 155-26
Date of meeting: 12 March 2026
Report from: Jagjit Dosanjh-Elton, Non-Executive director and committee Chair
Report author: Jagjit Dosanjh-Elton, Non-Executive director and committee Chair
Ellie Simpkin, Governance manager
Date of report: 03 March 2026
Appendices: None

Sub-committee assurance report
Audit & risk committee – 2 March 2026

Key agenda items

- **Board Assurance Framework (BAF) (including deep dive on the estates BAF)**
- **Assurance on risk management framework**
- **Financial assurance**
- **External audit plan 2025/26**
- **Draft Annual Governance Statement 2025/26**
- **Review of changes to accounting policies**
- **Internal audit progress report**
- **Draft Internal audit Annual Report Head of Internal Audit Opinion 2025/26**
- **Annual internal audit plan 2026/27**
- **Local Counter Fraud progress report**
- **Local Counter Fraud annual work plan 2026/27**
- **Annual review of compliance with licence conditions**
- **Annual review of compliance with code of governance for NHS provider trusts**
- **Well-led self-assessment**
- **Committee effectiveness review**
- **Annual review of committee Terms of reference**
- **Committee work programme 2026/27**

Alert

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

were agreed in 2024, succession planning, establishing Equality, Diversity & Inclusion networks, embedding the triumvirate directorate structures and, although good progress has been made, further embedding the Trust's continuous improvement methodology. The committee has suggested that oversight of the effectiveness of the triumvirate and clinical leadership structures is provided by the Strategy & culture committee.

- The committee undertook a deep dive of the estates BAF. Whilst the committee acknowledged robust processes are in place to manage the risk, it noted the review required a broader perspective on the various types of estates risks. In particular there was a need to understand how the risks and the risk management differ by location/clinical area to clearly identify and assess the residual risk being carried.
- Detailed discussion was had on the importance of providing evidence-led assurance rather than reassurance in the areas of the estate, cyber and compliance. The committee has asked that the Executive team further considers how it provides such assurance.

Assure

- The draft Head of Internal Audit Opinion for 2025/26 is that the Trust has an adequate and effective framework of governance, risk management and internal control. The final opinion will be set out in the annual internal audit report after year end.
- The committee has reviewed a first draft of the Annual governance statement (AGS) 2025/26 which is likely to conclude that no significant internal control issues have been identified during 2025/26. The significant internal control issues identified in 2024/25 relating to weaknesses in governance arrangements have been addressed through the implementation of the key actions described within the 2024/25 Annual governance statement which have strengthened the internal control environment. The committee has received assurance throughout 2025/26 on the compliance with Trust's governing documents which demonstrates that the strengthened control environment is operating effectively.
- The Trust's risk management framework continues to embed across the organisation. There are areas of good practice including active corporate and clinical directorate risk champions and monthly risk surgeries. The Executive committee for quality and risk (ECQR) is maintaining oversight of local and organisation risk registers and regularly reviews the BAF. There is still work to do to ensure that controls and actions being added to the risk registers for all risks, assessments are being completed on the effectiveness of controls and actions owners are providing updates on their actions in a timely manner. The Trust's internal auditors are currently undertaking a review of the Trust's BAF and risk management practices; the outcome of this will be reported to the Audit and Risk committee in due course.
- An internal audit review of financial management received a 'reasonable assurance' outcome which demonstrates that process is designed and, in many parts, operating effectively. Management actions have been agreed to improve the uptake of budget holder training and ensure that Quality Impact Assessments (QIAs) for efficiency schemes are signed off early in the approval process.
- There continues to be good progress with completing the management actions arising from the internal audit reviews.
- There is sustained progress reducing the use of single tender waivers.
- The Trust's compliance with the code of governance for NHS provider trusts has materially improved since 2023/24 with the only area of non-compliance being in relation to Chair and Non-executive director pay. An explanation of

where the Trust has departed from the code will be included in the Annual report and accounts.
- The Trust awaits formal confirmation from NHS England that its additional licence conditions have now been removed. Compliance with the standard NHS licence conditions will be reported in the Annual report and accounts 2025/26 with evidence provided in the annual governance statement as required.
- An improvement in the uptake of counter fraud training means that the Trust's draft Counter fraud functional standards (CFFSR) return for 2025/26 has assessed the Trust as 'green'. The rating is subject to the completion of the current counter fraud work plan and activities and the final assessment will be reported in June 2026 as part of the Local Counter Fraud Services annual report 2025/26.

Advise
- The committee approved the Trust's internal audit plan for 2026/27 and the associated Internal Audit Charter. The plan has been developed in conjunction with the Executive leadership team and is based the Trust's corporate objectives, risk profile and assurance framework as well as other, factors affecting the organisation in the year ahead.
- The committee has reviewed and approved the Trust's Counter Fraud Work Plan for 2026/27.
- NHS England has released its 2025/26 accounting policies to support the closure of accounts for the year ending 31 March 2026. No new accounting standards or revisions to existing standards have been adopted in 2025/26.
- The committee has undertaken its annual self-assessment of committee effectiveness. The results were overall positive and the committee has discussed how it works with the Board sub-committees to best escalate and share relevant matters.
- The committee has undertaken the annual review of its terms of reference and will be recommending these to the Board for approval.

Risks discussed and new risks identified
The committee reviewed a summary of the current BAFs and supports the suggestion that a separate BAF is developed for the Trust's cyber risk. It was also suggested the risks and mitigations relating to the Trust's strategic partnership could be better reflected in the sustainability BAF.

The Audit and risk committee has specific responsibility for the oversight of the regulation BAF. The committee agrees with the current scoring and notes that the Trust's upcoming Well-led review will be key source of assurance for the BAF.

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

Report cover-page					
References					
Meeting title:	Board of Directors				
Meeting date:	12/03/2026	**Agenda reference:**	**156-26**		
Report title:	Quality & Safety committee assurance report				
Sponsor:	Jo Emmanuel, Non-executive director and committee Chair				
Author:	Jo Emmanuel, Non-executive director and 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 last committee meeting.				
Summary of key issues	– The target to achieve zero 65 week waits has not also been met in specialties outside of breast reconstruction. The committee noted the actions underway to prevent future patients tipping into 65 week waits. Clinical harm reviews have been performed on patients who will exceed a 65 week wait if they have not had a clock stop by 31 March 2026. Treatment has been brought forward for one patient with a reasonable possibility of moderate harm delay. – The committee noted significant operational pressures during December (M9) including industrial action, increased sickness and patient cancellations which adversely affected performance. Of particular concern, 62-day cancer performance deteriorated further in M8 and fell below 70%, driven by challenges within the skin cancer pathway in part due to a significant increase in urgent suspected cancer referrals in 2025. Actions include strengthening patient tracking list oversight, increasing teledermatology use, additional weekend activity, and pathway improvement work supported by the Surrey and Sussex Cancer Alliance but the position remains a concern. – The committee noted a further decrease in ethnicity reporting since M8 despite existing interventions. Work continues within the Health Inequalities (HI) Steering group to further improvement compliance. A HI dashboard has been developed to enable analysis targeted improvement in HI activity. – There are delays in issuing clinic letters in some specialities which has affected the timely supply of medicines in the community. Immediate mitigations have been implemented and sustainable improvements are expected through the digital transformation programme.				
Recommendation:	The Board is asked to **note** the contents of the report				
Action required	Approval	Information	Discussion	**Assurance**	Review
Link to key strategic objectives (KSOs):	**KSO1:**	**KSO2:**	**KSO3:**	**KSO4:**	**KSO5:**
	To deliver outstanding care	*To innovate and improve*	*To be an excellent employer*	*To deliver sustainable services*	*To collaborate with others*
Implications					
Board assurance framework:	None				
Organisational risk register:	None				
Regulation:	None				
Legal:	None				
Resources:	None				
Assurance route					

Previously considered by:				
	Date:		Decision:	
Next steps:				

Report to: Board of Directors
Agenda item: 156-26
Date of meeting: 12 March 2026
Report from: Jo Emmanuel, Non-executive director and committee Chair
Report author: Jo Emmanuel, Non-executive director and committee Chair
Katie Ally, Governance officer
Date of report: 26 February 2026
Appendices: None

Sub-committee assurance report
Quality & Safety committee - 26 February 2026

Key agenda items

- **Clinical policy trajectory and update**
- **Use of personal mobile phones**
- **Executive Committee for Quality and risk assurance report**
- **Integrated Quality and Performance report (month nine)**
- **65 week wait update incl. clinical harm reviews**
- **National safety standards for invasive procedures (NatSSIPS) compliance**
- **Quality Priorities Quarter 3 2025/2027**
- **Draft Quality Priorities – 2026/2027**
- **Emergency preparedness, resilience and response**
- **Assessment of addressing Health Inequalities**
- **Clinical audit plan for 2026/2027**
- **Board Assurance Framework and Organisational risk register**
- **Review of committee Terms of Reference**
- **Work programme 2026/2027**

Alert

- The target to achieve zero 65 week waits has not also been met in specialties outside of breast reconstruction. The committee noted the actions underway to prevent future patients tipping into 65 week waits. Clinical harm reviews have been performed on patients who will exceed a 65 week wait if they have not had a clock stop by 31 March 2026. Treatment has been brought forward for one patient with a reasonable possibility of moderate harm delay.
- The committee noted significant operational pressures during December (M9) including industrial action, increased sickness and patient cancellations which adversely affected performance. Of particular concern, 62-day cancer performance deteriorated further in M8 and fell below 70%, driven by challenges within the skin cancer pathway in part due to a significant increase in urgent suspected cancer referrals in 2025. Actions include strengthening patient tracking list oversight, increasing teledermatology use, additional weekend activity, and pathway improvement work supported by the Surrey and Sussex Cancer Alliance but the position remains a concern.

- The committee noted a further decrease in ethnicity reporting since M8 despite existing interventions. Work continues within the Health Inequalities (HI) Steering group to further improvement compliance. A HI dashboard has been developed to enable analysis targeted improvement in HI activity.
- There are delays in issuing clinic letters in some specialities which has affected the timely supply of medicines in the community. Immediate mitigations have been implemented and sustainable improvements are expected through the digital transformation programme.

Assure
- The committee was assured that positive progress is being made in addressing out-of-date policies. This remains a priority area for the Executive Team, and the committee requested a further update at its June meeting.
- The committee received a verbal update on the results of the internal audit of incident management and was assured that the four recommended actions will be addressed through the Executive sub-committee for quality. Outcomes will be reported back to the committee in May 2026.
- The committee noted assurance that actions are underway to address gaps in compliance with NICE guidance, including improving awareness of the suspected metastatic spinal cord compression protocol and enhancing monitoring processes within the directorate.
- The committee received reasonable assurance against National Safety Standards for Invasive Procedures (NatSSIPs), noting strong compliance in Team Brief, Sign In, Time Out, and Sign Out. Mitigations are in place to address identified risks, including inconsistent debrief completion, operational pressures (late starts, overruns, utilisation), and variation in Local Standards for Invasive Procedures (LocSSIPs) awareness among agency, temporary and new staff, especially in non-theatre areas.
- The committee was assured that progress against the Q3 Quality Priorities remains on track, with several milestones delivered as planned.
- The committee noted the proposed Quality Priorities for 2026/2027 and the staff engagement process underway. The final priorities will be presented to the committee for approval.
- The committee received the annual Emergency preparedness, resilience and response (EPRR) report and was assured that QVH is assessed as substantially compliant against the NHSE Core Standards, with full compliance against 55 of 59 standards and partial compliance in four.
- The committee noted assurance regarding the approach to developing the 2026/2027 Clinical Audit Plan and the core components included within it.

Advise
- The committee confirmed approval of the updated Terms of Reference, with specific changes highlighted as relevant to the Strategy & Culture committee.
- The committee reviewed and approved the 2026/2027 work programme.

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. The committee discussed the highest scoring organisational risk relating to the Sussex Pathology Network and acknowledged this is a system project and the Trust is working hard to move forward.

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

Report cover-page					
References					
Meeting title:	Board of Directors				
Meeting date:	12/03/2026	**Agenda reference:**	**157-26**		
Report title:	Strategy and culture assurance				
Sponsor:	Peter O'Donnell, Non-executive director and committee Chair				
Author:	Peter O'Donnell, Non-executive director and committee Chair Ellie Simpkin, Governance manager				
Appendices:	None				
Executive summary					
Purpose of report:	To alert, assure and advise the Board regarding matters considered at the last committee meeting.				
Summary of key issues	- A structured programme has been established to guide the next phase of partnership development. Six priority workstreams have been identified to ensure a well-coordinated and well-governed transition. Delivery will be driven by the QVH Partnership steering group and a joint Partnership working group. - The engagement and communication plan for the strategic partnership transition uses the comprehensive engagement that the Trust undertook throughout the development of the QVH Strategy 2025-2030 and the strategic partnership options as a foundation for further engagement. - Significant progress has been made on the delivery of the Trust's 2025/26 Key Strategic Objectives (KSO) priorities despite the challenging environment. - The committee has reviewed the proposed KSO priorities for Year 2 (2026/27). It is important that the Trust is clear on how these will support the delivery of both local and national priorities.				
Recommendation:	The Board is asked to **note** the contents of the report				
Action required	Approval	Information	Discussion	**Assurance**	Review
Link to key strategic objectives (KSOs):	**KSO1:**	**KSO2:**	**KSO3:**	**KSO4:**	**KSO5:**
	To deliver outstanding care	***To innovate and improve***	*To be an excellent employer*	***To deliver sustainable services***	***To collaborate with others***
Implications					
Board assurance framework:	None				
Organisational risk register:	None				
Regulation:	None				
Legal:	None				
Resources:	None				
Assurance route					
Previously considered by:					
	Date:		Decision:		
Next steps:					

Report to:	Board of Directors
Agenda item:	157-26
Date of meeting:	12 March 2026
Report from:	Peter O'Donnell, Non-executive director and committee Chair
Report author:	Peter O'Donnell, Non-executive director and committee Chair Ellie Simpkin, Governance manager
Date of report:	27 February 2026
Appendices:	None

Sub-committee assurance report
Strategy & culture committee – 25 February 2026

Key agenda items

- **Partnership implementation update**
- **Communication & engagement update**
- **Organisational culture assessment - update**
- **Board Assurance Framework & organisational risks**
- **Key Strategic Objectives 2026/27**
- **Annual review of committee terms of reference**

Alert

- A structured programme has been established to guide the next phase of partnership development. Six priority workstreams have been identified to ensure a well-coordinated and well-governed transition: programme alignment, corporate governance, communication and engagement, leadership and culture, clinical and corporate alignment and finance and planning alignment. Delivery will be driven by the QVH partnership steering group and a joint partnership working group which will include partners from Royal Surrey NHS Foundation Trust (RSFT) and Ashford and St Peter's Hospitals NHS Foundation Trust (ASPH). The committee discussed the importance of ensuring that there is shared understanding and clear communication of the benefits that the strategic partnership will bring to the organisation, including financial sustainability, opportunities for staff, patient experience and outcomes, as well as the benefits to the wider population.

Assure

- The committee has reviewed the engagement and communication plan for the strategic partnership transition. The plan uses the comprehensive engagement which the Trust undertook throughout the development of the QVH Strategy 2025-2030 and the strategic partnership options as a foundation for further engagement with staff and stakeholders. The committee is looking forward to seeing the outcome of the workshops with staff and key partners which will be taking place over the forthcoming months.
- Significant progress has been made on the delivery of the Trust's 2025/26 Key Strategic Objectives (KSO) priorities despite the challenging environment. Key achievements include delivery of the Electronic Patient Record, progress with the Research & innovation strategy and the development of the Children's model. The committee has reviewed the proposed KSO priorities for Year 2 (2026/27). It is important that the Trust is clear on how these will support the delivery of both local and national priorities.

Advise

- The QVH organisational culture assessment which was reported to the Board in November 2025 will be updated with the results from the 2025 staff survey, once

available. This allow the impact of actions and initiatives to be tracked. The assessment will be used to inform areas of similarity and difference between organisations as the strategic partnership progresses.

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. The committee noted that the recruitment plans for the Non-executive director roles which are coming to the end of their terms in June are in development.

A new organisational risk relating to the partnership not being deliverable by September 2026 due to extended timelines caused by requirements for governance and finance reviews is proposed.

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

Report cover-page					
References					
Meeting title:	Board of Directors				
Meeting date:	12/03/2026		**Agenda reference:**	**158-26**	
Report title:	Financial, workforce and operational performance assurance				
Sponsor:	Peter O'Donnell, Non-executive director & committee Chair				
Author:	Peter O'Donnell, Non-executive director & 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 last committee meeting.				
Summary of key issues	– There are number of challenges to hitting year end operational targets in particular the 65 week wait position is at risk. – Cancer performance improving but remains below target due to volume increase. – Financial outcome is breakeven year-to-date. Month 10 and forecast is in line with plan with the key uncertainty related to Sussex overall performance. – East Grinstead Community Diagnostic Centre (CDC) build, progress running 6-10 weeks behind plan. – Bognor CDC plan to transfer governance from QVH to a Community Interest Company via the Integrated Care Board. – Finalising the 2026/27 business plan: The detail behind the 2026/27 Cost Improvement Programme and NHS England central sign-offs are progressing well and a fuller update is expected by the end of March 2026.				
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:	158-26
Date of meeting:	12 March 2026
Report from:	Peter O'Donnell, Non-executive director & committee Chair
Report author:	Peter O'Donnell, Non-executive director & committee Chair Katie Ally, Governance officer
Date of report:	3 March 2026
Appendices:	None

Sub-committee assurance report
Finance & Performance committee – 2 March 2026

Key agenda items

- **65 week wait**
- **Cost Improvement Programme (CIP)**
- **Capital Spend 2025/2026 update incl. M10**
- **Community Diagnostic Centre – Bognor – Exit Strategy**
- **Community Diagnostic Centre – East Grinstead and Bognor**
- **Electronic Patient Records (EPR)**
- **Business Planning 2026/2027**
- **Green Plan**
- **Estate assurance – critical infrastructure delivery**
- **Local Security Management assurance**
- **Annual assurance to Audit & Risk committee**
- **Self-assessment of committee effectiveness (light)**
- **Review of committee's terms of reference**
- **Committee work programme 2026/2027**

Alert

- The committee noted the ongoing risk to achieving the 65-week RTT target and other operational targets for year end. Although February 2026 performance is expected to remain on plan, there is a potential impact in March in part due to a high volume of consultant annual leave requests. While close monitoring continues, further work is required to maintain delivery and mitigate slippage.
- Cancer Performance: Month 9 performance remains below the 75% standard. Key pressures relate to pathway capacity, 62-day backlog clearance, and increased demand.
- The committee noted delivery and financial risks to the East Grinstead Community Diagnostic Centre (CDC) build, with progress running behind plan and several cost pressures emerging linked to weather delays, design issues and additional construction requirements.
- CDC – East Grinstead activity remains behind plan at c80% with some modalities experiencing low demand. The committee discussed next year's activity plan and was assured it, reflected lessons learned from this year's activity levels.
- Theatre Utilisation: Reported utilisation figures appear inaccurate suspected due to Archie system reporting issues. December 2025 and January 2026 performance is expected to have dipped due to leave and sickness, but the scale of variation suggests data quality concerns that are being investigated. The committee will receive an update at the next meeting.
- Sickness and Workforce Pressures: Increased long-term sickness is expected to result in a rise in bank usage. Sickness and appraisal compliance were highlighted as areas requiring continued focus.

- The committee received a month 10 financial update noting £0.1m deficit at Month 10. The underlying position for the first ten months of the year is a deficit of £0.8m, which will gives a full year underlying position of a £1.6m deficit. The forecast shows the Trust delivering a breakeven position at Month 12 which delivers the QVH plan.
- Cash at month 10 was £12m which is a small increase from previous months. System-level engagement is essential to mitigate the £0.5m financial exposure risk linked to Sussex partner performance and Deficit Support Fund (DSF).
- The committee noted risks to finalising the 2026/27 business plan, with the position dependent on more detailed CIP planning, ongoing contract negotiations and NHS England's assessment of the first-cut plans. The plan is progressing and a fuller update is expected by the end of March 2026.

Assure

- Surrey & Sussex Cancer Alliance has reviewed the cancer pathways and identified no significant gaps. System improvement work is underway, supported by additional weekend capacity. Improvement was observed in Months 9 and 10.
- CDC pathways are also planned to move to ERS in month 11, facilitating a greater number of GP practices to access the services. Mutual aid is being offered to neighbouring Trusts to increase utilisation. Increased GP engagement will be a priority to support improved CDC activity
- EPR implementation has moved into the deployment phase and work continues as planned. The plans for PAS implementation will be reviewed at an upcoming meeting.
- The committee was assured all required 62-day clinical harm reviews are being completed.
- A Health Inequalities dashboard enabling analysis of captured ethnicity data will be available to inform quality priorities for next year.
- Theatre Transformation: A new Theatre Transformation Group has been established, led by the Clinical Director for Core Clinical & Community Services focusing on reducing late starts and enhancing throughput, including improved use of the third procedure room.
- The committee received assurance the Trust continues to deliver its financial plan and as a result is also forecasting full delivery of the efficiency programme for 2025/26. The Trust's efficiency programme for 2026/27 continues to be developed and progress has been made to firm up plans and reduce the value of unidentified savings. However, elements of the programme remain high risk with 25% of the total value either unidentified or based on a scheme that is considered high risk.
- The committee was assured that clear plans are in place for the transition of the Bognor CDC by March 2026, with arrangements established for transferring governance, capital funding and equipment via the ICB to a Community Interest Company (CIC). QVH will continue to provide full governance and oversight until the handover is complete.
- The committee was assured that critical infrastructure risks are being actively managed. Fire safety remains the primary concern, and mitigation actions covering infrastructure, evacuation processes and training are being overseen by the Quality & Safety committee. New estates leadership will provide an overview of residual risks and planned actions, and an updated summary of mitigations will be brought back to the committee.
- The committee was assured that the updated Green Plan is progressing, with a realistic five-year pathway for decarbonisation aligned to national programmes and forthcoming estates work, including boiler replacement. While longer-term solutions (5–10 years) remain uncertain due to funding and infrastructure

dependencies, the Trust continues to work with Sussex partners Care without Carbon, and plans to re-establish the internal green groups to support delivery. The plan is considered achievable within current estate constraints and will be taken forward for Board approval.

Advise

- The committee reviewed its terms of reference and agreed to recommend them to the Board for approval.
- The committee reviewed and approved its 2026/2027 Work Plan.

Risks discussed and new risks identified

The committee discussed the delays in the Sussex pathology network programme and noted QVH's actions are on track however delays outside of the Trust's control may result in misaligned and using outdated systems. It was noted that digital dependencies and national shortages in histopathologists present a strategic risk to long-term pathology sustainability. The committee requested a contingency option will be explored.

The committee requested clearer separation and focus of the cyber risk on the register.

The committee considered the estates risks. The February estates survey and associated actions are delayed. Ongoing risks were noted related to the theatre roof work which should become clearer over next few months as investigations continue.

Recommendation

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