# Bundle Public Board 14 May 2026

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

02.26 Draft minutes of the public meeting held on 12 March 2026
*Angela McNab, interim Trust Chair*
*Approval*
Minutes- PUBLIC Board meeting- 12 March 2026 DRAFT V1

03.26 Matters arising and actions pending from previous meeting
*Angela McNab, interim Trust Chair*
*Review*
03-26 PUBLIC Matters arising

04.26 Patient story
*Liz Blackburn, acting Chief nursing officer*
*Discussion*

05.26 Chair's report
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06.26 Chief executive's report
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*Review*
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08.26 Bi-annual assessment of addressing health inequalities
*Liz Blackburn, acting Chief nursing officer*
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09.26 Integrated quality and performance report
*Kirsten Timmins, Chief operating officer*
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09-26 Integrated Quality & Performance Report M11
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10.26 Business planning 2026/27
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10-26 Business planning 2026-27

11.26 Quality and safety assurance
*Russell Hobby, Non-executive director*
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11-26  Quality & safety committee assurance report May 2026

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

12-26 Finance & Performance committee assurance report May 2026

13.26 Strategy and culture assurance
*Peter O'Donnell, Non-Executive Director and committee Chair*
*Assurance*
13-26 Strategy & culture assurance report May 2026 FINAL

14.26 Freedom to Speak up report
*Jackie Doherty, Freedom to Speak Up Guardian*
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14-26 (FC) FTSU annual report May 2026
14-26.1 FTSU Annual report May 2026

15.26 Guardian of Safe Working report
*Jennifer O'Neill, Guardian of Safe Working*
*Assurance*
15-26 GoSW report to Board
15-26.1 GOSW Report Q3 2025-26
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16.26 Key Strategic Objectives 2026/27
*Kathy Brasier, acting Chief strategy officer*
*Approval*
16-26 QVH Strategy 2025-2030 year 1 delivery & KSOs 2026-27

17.26 Board Assurance Framework
*Jamie O'Callaghan, interim Company secretary*
*All executive directors*
*Assurance*
17-26 Board Assurance Framework (BAF) Board May 2026
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18.26 Company secretary's report
*Jamie O'Callaghan, interim Company secretary*
*- Compliance with licence conditions 2025/26*
*- Compliance with Code of governance for NHS provider trusts 2025/26*
*- Annual governance statement 2025/26*
*- Annual review of committee terms of reference*
*- Modern slavery statement*
*Approval*
18-26 Company secretary's report May 2026
18-26.1 ARC ToR 2026-27 DRAFT V1
18-26.2 FPC ToR 2026-27 DRAFT V2
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18-26.4 SCC ToR 2026-27 DRAFT V2
18-26.5 Modern Slavery Statement 2025-26 v1

19.26 Any other business (by application to the Chair)
*Angela McNab, interim Trust Chair*
*Discussion*

20.26 Questions from members of the public

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

# Business Meeting of the Board of Directors

## Thursday 14 May 2026

## Session in PUBLIC
## 10.00-12.00
## Learning & development centre (location 29), QVH

# MEMBERSHIP
# BOARD OF DIRECTORS
# May 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 |
| Acting Chief Strategy Officer | - | Kathy Brasier |
| Interim Company Secretary | - | Jamie O'Callaghan |

# Annual declarations by directors 2026/27

## Declarations of interests

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

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

To facilitate this duty, directors are asked on appointment to the Trust and thereafter at the beginning of each financial year, to complete a form to declare any interests or to confirm that the director has no interests to declare (a 'nil return'). Directors must request to update any declaration if circumstances change materially. By completing and signing the declaration form directors confirm their awareness of any facts or circumstances which conflict or may conflict with the interests of QVH NHS Foundation Trust. All declarations of interest and nil returns are kept on file by the Trust and recorded in the following register of interests which is maintained by the 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**<br>Interim Trust Chair | Non executive director / Vice Chair of Kent and Medway Integrated Care Board<br><br>Non executive of Dimensions UK Ltd | Shareholder (less than 5%) in Rapid Health | Nil | Nil | Nil | Nil | Nil | Member of Independent Reconfiguration Panel (NDPB) - Advisory |
| **Jagjit Dosanjh-Elton**<br>Non-Executive Director | Non-executive director for Social Investment Business Foundation<br><br>Non-executive director for The Social Investment Business Limited<br><br>Non-executive director for Public Relations Communications Association Limited<br><br>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.<br><br>Brother in law works as a Cardiac Consultant at Pembury Hospital Kent | |
| **Peter O'Donnell**<br>Non-Executive Director | Non-executive director for Nottingham Building Society<br><br>Non-Executive Director at OneFamily | Nil | Nil | Nil | Nil | Nil | Nil | Nil |

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|---|---|---|---|---|---|---|---|---|
| **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<br><br>Director of RVHB Ltd<br><br>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**<br>Chief Operating Officer | Nil | Nil | Nil | Nil | Nil | Nil | Nil | Nil |
|---|---|---|---|---|---|---|---|---|
| **Kathy Brasier**<br>Acting Chief Strategy Officer | Nil | Nil | Nil | Nil | Nil | Nil | Nil | Nil |
| **Aleema Shivji**<br>Associate Non-Executive Director | Director of 5 Westborne Villas Freehold Ltd and 5 Chatham Place Freehold Ltd | Nil | Nil | Co-Chair, Peace Direct (charity) | Nil | Nil | Nil | Nil |
| **Vivek Chaudhri**<br>Associate Non-Executive Director | Director of Global AI Leaders Network<br><br>Director of Purposeful AI<br><br>NED, East London NHS Foundation Trust (ELFT)<br><br>NED, National Highways | Nil | Nil | Nil | Nil | Nil | Nil | Nil |

## Fit and proper persons declaration

As established by regulation 5 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (“the regulations”), QVH has a duty not to appoint a person or allow a person to continue to be a 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**<br>Trust Chair | N/A | N/A | N/A | N/A | N/A | N/A | N/A |
| **Jagjit Donsanjh-Elton**<br>Non-Executive Director | N/A | N/A | N/A | N/A | N/A | N/A | N/A |
| **Peter O’Donnell**<br>Non-Executive Director | N/A | N/A | N/A | N/A | N/A | N/A | N/A |
| **Shaun O’Leary**<br>Non-Executive Director | N/A | N/A | N/A | N/A | N/A | N/A | N/A |
| **Russell Hobby**<br>Non-Executive Director | N/A | N/A | N/A | N/A | N/A | N/A | N/A |
| **Jo Emmanuel**<br>Non-Executive Director | N/A | N/A | N/A | N/A | N/A | N/A | N/A |
| **Tamara Everington**<br>Chief Medical Officer | N/A | N/A | N/A | N/A | N/A | N/A | N/A |
| **Simon Marshall**<br>Interim Chief Finance Officer | N/A | N/A | N/A | N/A | N/A | N/A | N/A |
| **Liz Blackburn**<br>Acting Chief Nursing Officer | N/A | N/A | N/A | N/A | N/A | N/A | N/A |
| **Abigail Jago**<br>Acting Chief Executive Officer | N/A | N/A | N/A | N/A | N/A | N/A | N/A |
| **Helen Edmunds**<br>Chief People Officer | N/A | N/A | N/A | N/A | N/A | N/A | N/A |
| **Kirsten Timmins**<br>Chief Operating Officer | N/A | N/A | N/A | N/A | N/A | N/A | N/A |
| **Kathy Brasier**<br>Acting Chief Strategy Officer | N/A | N/A | N/A | N/A | N/A | N/A | N/A |
| **Aleema Shivji**<br>Associate Non-Executive Director | N/A | N/A | N/A | N/A | N/A | N/A | N/A |
| **Vivek Chaudhri**<br>Associate Non-Executive Director | N/A | N/A | N/A | N/A | N/A | N/A | N/A |

**Business meeting of the Board of Directors**
**Thursday 14 May 2026**
**10.00-12.00**

| Agenda: session held in public | | |
|---|---|---|
| **WELCOME** | | |
| 01-26 | **Welcome, apologies and declarations of interest**<br>*Angela McNab, interim Trust Chair* | |
| **STANDING ITEMS** | | **Purpose** |
| 02-26 | **Draft minutes of the public meeting held on 12 March 2026**<br>*Angela McNab, interim Trust Chair* | *Approval* |
| 03-26 | **Matters arising and actions pending from previous meetings**<br>*Angela McNab, interim Trust Chair* | *Review* |
| 04-26 | **Patient Story**<br>*Liz Blackburn, acting Chief nursing officer* | *Discussion* |
| 05-26 | **Chair's report**<br>*Angela McNab, interim Trust Chair* | *Assurance* |
| 06-26 | **Chief Executive's report**<br>*Abigail Jago, acting Chief executive officer* | *Assurance* |
| **ANNUAL REPORTS** | | |
| 07-26 | **Staff survey results 2025**<br>*Helen Edmunds, Chief People Officer* | *Review* |
| 08-26 | **Bi-annual assessment of addressing health inequalities**<br>*Liz Blackburn, acting Chief nursing officer* | *Review* |
| **PERFORMANCE** | | |
| 09-26 | **Integrated quality and performance report**<br>*Kirsten Timmins, Chief operating officer* | *Assurance* |
| 10-26 | **Business plan 2026/27**<br>*Simon Marshall, interim Chief finance officer* | *Ratification* |
| **COMMITTEE ASSURANCE REPORTS** | | |
| 11-26 | **Quality and safety assurance**<br>*Russell Hobby, Non-executive director* | *Assurance* |
| 12-26 | **Financial, workforce and operational performance assurance**<br>*Peter O'Donnell, Non-Executive Director and committee Chair* | *Assurance* |

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| 13-26 | **Strategy and culture assurance**<br>*Peter O'Donnell, Non-Executive Director and committee Chair* | *Assurance* |
| **GOVERNANCE, STRATEGY & RISK** | | |
| 14-26 | **Freedom to Speak up annual report**<br>*Jackie Doherty, Freedom to Speak Up Guardian* | *Assurance* |
| 15-26 | **Guardian of Safe Working report**<br>*Jennifer O'Neill, Guardian of Safe Working* | *Assurance* |
| 16-26 | **QVH Strategy 2025-2030: 2025/26 year 1 delivery & Key Strategic Objectives 2026/27**<br>*Kathy Brasier, acting Chief strategy officer* | *Approval* |
| 17-26 | **Board Assurance Framework**<br>*Jamie O'Callaghan, interim Company secretary*<br>*All executive directors* | *Assurance* |
| 18-26 | **Company secretary's report**<br>*Jamie O'Callaghan, interim Company secretary*<br>- Compliance with licence conditions 2025/26<br>- Compliance with Code of governance for NHS provider trusts 2025/26<br>- Annual governance statement 2025/26<br>- Annual review of committee terms of reference<br>- Modern slavery statement | *Approval* |
| **MEETING CLOSURE** | | |
| 19-26 | **Any other business (by application to the Chair)**<br>*Angela McNab, interim Trust Chair* | *Discussion* |
| **MEMBERS OF PUBLIC** | | |
| 20-26 | **Questions from members of the public**<br>*We welcome relevant, written questions on any agenda item from our staff, our members or the public. To ensure that we can give a considered and comprehensive response, written questions must be submitted in advance of the meeting (at least three clear working days). Please forward questions to qvh.corporategovernance@nhs.net clearly marked "Questions for the board of directors". Members of the public may not take part in the Board discussion. Where appropriate, the response to written questions will be published with the minutes of the meeting.*<br><br>*Angela McNab, interim Trust Chair* | |

| | Minutes (DRAFT) | |
|---|---|---|
| **Meeting:** | **Board of Directors (session in public)**<br>**10.00-12.00 12 March 2026**<br>**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] |
| | Peter O'Donnell (POD) | Non-executive director (voting) |
| | Jo Emmanuel (JE) | Non-executive director (voting) |
| | Abigail Jago (AJ) | Acting Chief executive officer (voting) |
| | Simon Marshall (SM) | Interim Chief finance officer (voting) |
| | Tamara Everington (TE) | Chief medical officer (voting) |
| | Kirsten Timmins (KT) | Chief operating officer (voting) |
| | Helen Edmunds (HE) | Chief people officer (non-voting) |
| | Liz Blackburn (LB) | Acting Chief nursing officer (voting) |
| | Vivek Chaudhri (VC) | Associate Non-executive director (non-voting) |
| | Aleema Shivji (AS) | Associate Non-executive director (non-voting) [MS Teams] |
| **In attendance:** | Leonora May (LM) | Company Secretary |
| | Suzanne Hatter (SH) | Consultant Biomedical Scientist [for staff story] |
| **Apologies:** | Jane Dickson (JD) | Interim deputy Chief executive officer (non-voting) |
| **Members of the public:** | 6 members of staff, 11 governors | |
| **142-26** | **Welcome, apologies and declarations of interest**<br>The Chair opened the meeting welcoming members of the Board and those observing the meeting.<br><br>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.<br><br>Apologies were received from JD and the meeting was declared as quorate. RH and VC joined the meeting virtually.<br><br>There were no declarations of interest other than those already recorded on the register of interests. | |
| **143-26** | **Draft minutes of the public meeting held on 12 February 2026**<br>The Board **agreed** that the minutes of the public Board meeting held on 12 February 2026 are a true and accurate record of that meeting and **approved** them on that basis. | |
| **144-26** | **Matters arising and actions pending from previous meetings**<br>There were three pending actions and one closed action on the log.<br><br>Action 1 (compliance): The governance handbook is expected to be completed at the end of March 2026 at which point this action will be closed.<br><br>Action 3 (GP engagement): The Board suggested that this discussion is also picked up by the Strategy and culture committee for a broader discussion. **ACTION TE KB**<br><br>Action 4 (sexual safety and VPR): The Board noted that an update will be provided to the Strategy and culture committee at its next meeting. Action closed. | |

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| | Action 5 (quality impact assessments): The Board agreed it would be helpful to receive updates through the regular reporting from the Quality and safety committee. Action closed.<br><br>A Board member asked about reporting related to actions from patient stories to Board. LM confirmed that there is an annual patient story report scheduled to go to the Quality and safety committee and Board thereafter.<br><br>The Board **noted** the updates. |
| **145-26** | **Staff story**<br>The Board extended a warm welcome to Suzanne Hatter, Consultant Biomedical Scientist, who joined the meeting to share with the Board her experience of being a member of staff at QVH.<br><br>SH spoke about how her interest in science from a young age led her to study biology and take up a trainee biomedical scientist role. She is now one of few consultant biomedical scientists which means that she is able to confirm a patient's diagnosis using a sample.<br><br>SH shared that histopathology is a busy service. She enjoys her role and is very proud to work at QVH. She talked about working conditions and shared that the service has outgrown the space which has become cramped and is not fit for purpose.<br><br>A Board member asked about partnership opportunities for the future. In response, SH confirmed that the Trust's strategic partners have a histopathology department which may have similar challenges and that the team are considering how the teams across organisations can support each other and strengthen the services.<br><br>The Board extended thanks to SH for sharing her story and information about the histopathology service and consultant biomedical scientist profession.<br><br>[SH left the meeting] |
| **146-26** | **Chair's report**<br>AM presented the report to the Board, highlighting the following:<br>- The priority for the Board remains the implementation of the strategic partnership. AM and AJ are now meeting regularly with the Chair and Chief executive officer of the Royal Surrey and Ashford and St Peter's Hospitals NHS FT (RSASP) group<br>- RH, SOL and POD will come to the end of their terms as Non-executive directors (NEDs) for QVH at the end of June 2026. A recruitment process to fill NED roles will start shortly<br>- The Board completed its annual effectiveness review during February 2026. The Board will set aside time at its next Board seminar to review the detail and consider any learning<br><br>The Board **noted** the updates. |
| **147-26** | **Chief Executive's report**<br>AJ presented her report to the Board, highlighting the following:<br>- The Trust remains on track to deliver its financial plan for 2025/26, although this has been challenging. She extended thanks to all staff across the organisation who have supported reducing costs whilst maintaining a high quality of care<br>- The business plan for 2026/27 has been submitted. The team are focussed on working through the detail of the challenging cost improvement plans for 2026/27<br>- Key strategic objectives for 2026/27 have been developed, aligned to the national ten year plan and QVH specific strategic initiatives |

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| | - Partnership implementation planning continues with regular updates to the Strategy and culture committee and continued engagement with the Council of Governors<br>- The embargo for the NHS staff survey results 2025 has been lifted today and a detailed report will be presented to the Board at its next meeting<br>- AJ acknowledged that this was LM's last Board meeting as Company secretary for QVH. She extended thanks to LM for her significant contribution as Company secretary<br><br>Discussion was had about the Trust's provider capability assessment rating and AJ confirmed that that the Trust's submission had been reviewed by the regional and national team which had resulted in the rating of amber green. She thought that this demonstrates a stable organisation with some areas of improvement. The Board agreed that it would be helpful to receive an update on actions completed against areas of improvement. This would be reported to the Audit and risk committee. **ACTION AJ**<br><br>A Board member acknowledged that more cost savings were delivered non-recurrently during 2025/26 than the Trust would have liked. They asked about any related learning being taken into 2026/27. AJ shared that the team will need to continue to think innovatively in order to reduce the deficit further. There is a limit to what the organisation can deliver alone as a small entity and working in partnership is key to the delivery of the plan. The team will remain focussed on high impact areas.<br><br>The Board **noted** the contents of the report. |
| **148-26** | **Integrated quality and performance report**<br>KT presented the report to Board and provided an update on operational performance. She reported that December was a challenign month for performance due to high levels of annual leave, staff sickness and patient cancellations. There are some risks related to referal to treatment (RTT) for 52 and 18 week performance for months 11 and 12. The Trust is on track to meet its trajectory for 65 week waits as well as cancer faster diagnostic and 62 day standards.<br><br>The Board considered the updates and a Board member asked how annual leave is managed. In response, KT confirmed that the Trust sets an expectation that annual leave entitlements are urtilised within year and this is monitored. The Trust does see more annual leave being taken in February and March compared to the rest of the year. HE agreed that it would be helpful to encourage managers to monitor leave closely through the managers training programme.<br><br>A Board member asked when KT thought that Trust would reach its 65 week wait target. KT confirmed that the trajectory to reach zero is being worked through and agreed that she would share this with the Finance and performance committee. **ACTION KT** The Board noted that the independent review of waiting list oversight will start shortly and a Board member asked when the Board will recieve the report. In response, AJ confirmed that the report should be available at the end of April 2026.<br><br>In response to a question, KT confirmed that the diagnostic wait performance has dipped due to the issues with the Cone Beam CT scanner in year and is currently tracking at 90%. She confirmed that next year's target is 95%.<br><br>TE provided an update on quality and safety. She reported that the Trust is back on plan for delivery of the pathology network. Mental Capacity Act compliance has become business as usual. Quality priorities have been broadly achieved for 2025/26. |

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| | HE provided an update on workforce. She reported that there had been an increase in bank usage for month 10 linked to nursing staffing levels in theatres to support weekend activity. Sickness levels remain static with some reductions in long term sickness.<br><br>SM provided an update on finance. He reported that the Trust remains on track to meet its year end break even target.<br><br>A Board member asked how the Trust will improve CDC income and activity. In response, SM confirmed that next year's CDC plan is more realistic and achievable and the team is taking action to address the affordability issue for commissioners. SM thought that the engagement work with GPs continues to be important to support the level of referrals.<br><br><u>Research and Innovation strategy update</u><br>TE presented the report to the Board, outlining the positive progress made against the strategy since 2024. She thought that there would be opportunities to further research and innovation initiatives across the partnership.<br><br>Board members were pleased to note positive progress made against the strategy and extended thanks to TE and teams for their work.<br><br>A Board member asked how widely initiatives are shared and suggested an annual research conference to share impact and learning widely. TE supported this idea and agreed to consider it for the future.<br><br>A Board member asked about the governance and conflict of interest management for research and innovation and it was acknowledged that this needs further consideration. TE agreed to take this away for consideration.<br><br><u>Estates update</u><br>SM presented the report to the Board, outlining the critical infrastructure challenges and risks.<br><br>Board members thanked SM for the report which provided assurance about the management of the Trust's estate. The Board agreed that it would be helpful to have a discussion about the strategic approach to estates management at a future Board seminar.<br>**ACTION SM**<br><br>JDE confirmed that the Audit and risk committee have requested an overview of the residual risk related to the estate after mitigating works and how these are being managed.<br><br>The Board **noted** the contents of the reports. |
| **149-26** | **Green Plan**<br>SM presented the refreshed Green Plan to the Board for approval. He explained that the plan is intended to mark steps to a carbon free future. He thought that the challenge will be the ability to attract funding and he highlighted a need for national policy to enable change in this area.<br><br>The Board provided the following feedback on the contents of the plan. A Board member suggested that it might be helpful to include some targets for smaller initiatives where the Trust is already making progress for example reduction in outpatient appointments and business travel. There was a suggestion that consideration could be given to the impact of digital and AI on the Green Plan. SM agreed to consider this feedback ahead of finalising the plan. |

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| | TE confirmed that the team are embedding green thinking into improvement and cost saving initiatives.<br><br>The Board **approved** the Green Plan. |
| **150-26** | **Board of Directors work programme 2026/27**<br>LM presented the work programme to the Board.<br><br>A Board member requested that review of progress against the Green Plan be included on the planner for one years time.<br><br>Subject to the above amendment being made, the Board **approved** the Board of Directors work programme 2026/27. |
| **151-26** | **Annual report on the use of the Trust seal 2025/26**<br>LM presented the report to the Board who **noted** its contents. |
| **152-26** | **Constituion updates**<br>LM presented the report to the Board which sought approval of updates to the Trust's Constitution. She explained that the Council of Governors has approved an election process to fill vacant roles and the changes to the Constitution mean that governors will be able to serve a maximum of three terms as opposed to two. This will allow governors coming to the end of their second term to nominate themselves for re-election and support continuity.<br><br>The Board **approved** the changes to the Trust's Constitution. |
| **153-26** | **Board assurance framework (BAF)**<br>LM presented the report to the Board, highlighting the following:<br>- The risks have been reviewed in detail by the relevant sub-committees<br>- The Audit and risk committee completed a deep dive on the estates risk at its meeting in March 2026<br>- There have been no changes to risk scores since the Board's last review<br>- The BAF will be reviewed in line with the revised KSO's once agreed<br>- The Finance and performance committee and Audit and risk committee have suggested that cyber be seperated as its own risk to ensure the appropriate focus. The Board supported this suggestion and LM confirmed that this will be considered as part of the annual review<br><br>The Board:<br>- **Noted** the contents of the report<br>- **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 |
| **154-26** | **Emergency preparedness, resilience and response**<br>KT presented the report to the Board.<br><br>JE confirmed that the Quality and safety committee had considered this report in detail and the committee were assured by its contents. She confirmed that the committee will continue to have oversight of progress against actions.<br><br>The Board commended the handling of the recent business continuity incident related to water supply.<br><br>The Board **noted** the contents of the report. |
| **155-26** | **Audit and risk assurance** |

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| | JDE presented the report to the Board. She reported that the committee had received the draft Head of Internal Audit opinion which was that risk management and internal control is adequate. This reflects hard work to improve the control environment since quarter four of 2024/25. The committee has reviewed a first draft of the Annual governance statement which is aligned to this draft opinion.<br><br>The committee has requested more evidence led assurance related to estates, cyber and financial control.<br><br>The Board **noted** the contents of the report. |
| **156-26** | **Quality and safety committee assurance**<br>JE presented the report to the Board. She reported that the committee were notified about issues rrelated to clinic letter delays and have been reassured that digital opportunities will help to resolve this issue. The committee was pleased to note progress in relation to health inequalities recording and the developemnt of a dashboard. The committee are assured by a large amount of work being undertaken to address the challenge related to out of date policies and postive progress made.<br><br>The Board **noted** the contents of the report. |
| **157-26** | **Strategy and culture assurance**<br>POD presented the report to Board, reporting that there is a significant programme of activity ongoing related to the strategic partnership. The committee are supporting the team to maintain momentum on this between now and September 2026 as this is critical.<br><br>He reported that the committee have agreed the need to increase focus on the wider strategic agenda as well as current strategic priorities.<br><br>The Board **noted** the contents of the report. |
| **158-26** | **Financial, workforce and operational performance assurance**<br>POD presented the report to the Board and commended the executive team for progress made to date on the delivery of the 2025/26 plan which was challenging. The committee are continuing to have oversight of the 65 week wait position.<br><br>The East Grinstead CDC build is 6-10 weeks behind schedule which raises financial risk. The committee hope to have more certainty on the timeline for delivery at the next meeting. The committee have supported a proposal to hand over the management of the Bognor CDC.<br><br>The Board **noted** the contents of the report. |
| **159-26** | **Any other business (by application to the Chair)**<br>There was no further business and the meeting closed. |
| **160-26** | **Questions from members of the public**<br>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.<br><br>Question<br>Can we have an update on staff morale?<br><br>Response |

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| | AJ confirmed that the staff survey results 2025 demonstrate a decline in staff morale which was anticipated due to the cost improvement plans. This is in line with other organisations. The team are looking at the detailed analysis for each area to address any local issues where positive change can be made.<br><br>Question<br>Is the Trust still seeing the benefits of the electronic patient record (EPR)?<br><br>Response<br>TE responded to confirm that there are continued benefits. She cited paper scanning reducing by two thirds as a significant benefit as well as the simplifying of audit processes. She confirmed that some aspects of reporting are challenging but that the team are continuing to consider how further enhancements can be made.<br><br>Question<br>What are the benefits to patients which will arise from the strategic partnership?<br><br>Response<br>AM suggested that this is discussed at a future informal Council of Governors meeting. She explained that the Chairs and Chief executive officers have agreed that it would be beneficial to focus on two key areas in the first instance whereby service improvement could be delivered through the partnership.<br><br>Question<br>Has all asbestos been cleared from the site?<br><br>Response<br>SM confirmed that there is asbestos on the site which is safe as long as it is not disturbed. The team are tackling areas of high risk. There is a programme in place across multiple years to remove all asbestos from the site.<br><br>The lead governor expressed thanks to LM on behalf of the Council of Governors for all that she had done to support governors during her time in the Company secretary role. |

**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.<br>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.<br>November 2025: Training is being rolled out to budget holders which incl. policies and governing documents. The Governance handbook is in development<br>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<br>April 2026: First draft of the Governance handbook completed and scheduled to go through approval process and be shared with staff. | **Closed** |
| **2** | 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<br>March 2026: Update scheduled for Strategy and culture committee at its meeting in March 2026<br>April 2026: Update presented to the Strategy and culture committee at its meeting in April 2026. Overview included in committee assurance report to the Board. Action closed | **Closed** |
| **3** | 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<br>April 2026: Report presented to the May 2026 Quality and safety committee and overview is included in the committee assurance report to the Board. Action closed | **Closed** |
| **4** | February 2026 | 127-26 | EDI Annual report 2024/25 | Share learning and reflections from Equality Impact Assessments (EIA) completed | **HE** | **~~May 2026*~~**<br>**June 2026** | March 2026: To be shared with the Strategy and culture committee at its meeting in May 2026.<br>May 2026: A report covering EIA/QIA activity, key lessons, current application and future direction was presented to the May 2026 Quality and Safety Committee. EIAs and QIAs will be integrated into a single EQIA process by July 2026. | **Not yet due** |
| **5** | March 2026 | 144-26 | GP engagement | Hollistic report on Trust wide GP engagement to be presented to the Strategy and culture committee | **TE, KB** | **June 2026*** | April 2026: Item scheduled on the agenda for the June 2026 Strategy and culture committee meeting | **Not yet due** |
| **6** | March 2026 | 147-26 | Provider Capability Assessment | Update on Provider Capability Assessment gaps and actions to be presented to the Audit and risk committee | **AJ** | **June 2026*** | April 2026: Item scheduled on the agenda for the June 2026 Audit and risk committee meeting. | **Not yet due** |

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| **7** | March 2026 | 148-26 | 65 week waits | Share trajectory to reach zero 65 week waits with the Finance and performance committee | **KT** | **June 2026*** | May 2026: Forecast for Q1 shared and discussed at the May 2026 Finance and performance committeee. The trajectory for the remainder of 2026/27 will be shared with the committee for discussion at the June 2026 meeting. | **Not yet due** |
| **8** | March 2026 | 148-26 | Estates | Strategic overview of Trust's estate to be presented at a future Board seminar | **SM** | **April 2026*** | April 2026: Discussion had at Board seminar on 9 April 2026. Action closed | **Closed** |

<table>
<tr><th colspan="6">Report cover-page</th></tr>
<tr><td colspan="6">References</td></tr>
<tr><td>Meeting title:</td><td colspan="5">Board of Directors</td></tr>
<tr><td>Meeting date:</td><td colspan="2">14/05/2026</td><td colspan="2">Agenda reference:</td><td>05-26</td></tr>
<tr><td>Report title:</td><td colspan="5">Chair’s report</td></tr>
<tr><td>Sponsor:</td><td colspan="5">Angela McNab, interim Trust Chair</td></tr>
<tr><td>Author:</td><td colspan="5">Angela McNab, interim Trust Chair</td></tr>
<tr><td>Appendices:</td><td colspan="5">None</td></tr>
<tr><td colspan="6">Executive summary</td></tr>
<tr><td>Purpose of report:</td><td colspan="5">To update the Board of Directors on Chair, non-executive director and governor activities since the last meeting.</td></tr>
<tr><td>Summary of key issues</td><td colspan="5"><ul><li>During April, I undertook visits to the Charity, Prosthetics and Sleep Departments.</li><li>Progressing the strategic partnership remains the Board’s key priority, with ongoing engagement with the RSASP Group focused on developing partnership arrangements and potential benefits for clinical services.</li><li>The Non-Executive Director recruitment process is underway; longlisting was completed in April 2026, with interviews scheduled for early June 2026.</li><li>This Board meeting marks the final Board meeting for Peter, Shaun and Russell, providing an opportunity to formally recognise and thank them for their contribution.</li><li>A Board seminar was held in April 2026, focusing on Board development, CQC preparedness, and the strategic partnership.</li><li>The Council of Governors election process is underway to address forthcoming vacancies, with results due to be declared on 16 June 2026.</li></ul></td></tr>
<tr><td>Recommendation:</td><td colspan="5">The Board is asked to note the contents of the report.</td></tr>
<tr><td>Action required</td><td>Approval</td><td>Information</td><td>Discussion</td><td>Assurance</td><td>Review</td></tr>
<tr><td rowspan="2">Link to key strategic objectives (KSOs):</td><td>KSO1:</td><td>KSO2:</td><td>KSO3:</td><td>KSO4:</td><td>KSO5:</td></tr>
<tr><td>To deliver outstanding care</td><td>To innovate and improve</td><td>To be an excellent employer</td><td>To deliver sustainable services</td><td>To collaborate with others</td></tr>
<tr><td colspan="6">Implications</td></tr>
<tr><td colspan="2">Board assurance framework:</td><td colspan="4">None</td></tr>
<tr><td colspan="2">Organisational risk register:</td><td colspan="4">None</td></tr>
<tr><td colspan="2">Regulation:</td><td colspan="4">None</td></tr>
<tr><td colspan="2">Legal:</td><td colspan="4">None</td></tr>
<tr><td colspan="2">Resources:</td><td colspan="4">None</td></tr>
<tr><td colspan="6">Assurance route</td></tr>
<tr><td colspan="2">Previously considered by:</td><td colspan="4">NA</td></tr>
<tr><td colspan="2"></td><td>Date:</td><td></td><td>Decision:</td><td></td></tr>
<tr><td colspan="2">Next steps:</td><td colspan="4">NA</td></tr>
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|---|---|
| **Report to:** | Board of Directors |
| **Agenda item:** | 05-26 |
| **Date of meeting:** | 14 May 2026 |
| **Report from:** | Angela McNab, interim Trust Chair |
| **Report author:** | Angela McNab, interim Trust Chair |
| **Date of report:** | 05 May 2026 |
| **Appendices:** | None |

# Chair's report

## Introduction

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

During April, I undertook visits to the Charity, Prosthetics and Sleep Departments. These visits were valuable in strengthening understanding of services, staff priorities and current challenges, and form part of my ongoing commitment to maintaining visibility and engagement across the Trust.

The report also reflects the Board's continued focus on progressing the Trust's strategic partnership, alongside important work on Board succession, development and effectiveness. Engagement with governors has remained a priority, ensuring they are appropriately informed and supported in fulfilling their statutory role.

## Board of Directors

Progressing the Trust's strategic partnership remains the Board's key priority, with a clear focus on securing the long-term sustainability and resilience of our services. During this period, Abigail and I have continued to engage closely with the Group Chair and Chief Executive Officer of the Royal Surrey NHS Foundation Trust and Ashford and St Peter's Hospitals NHS Foundation Trust Group (RSASP Group). Discussions have focused on the developing partnership arrangements and the potential benefits for clinical services, ensuring the Board remains sighted on progress and emerging considerations as this work continues.

The recruitment process for Non-Executive Director roles is underway and is being progressed in partnership with the Council of Governors. The Appointments Committee met in April 2026 to undertake the longlisting exercise, which identified a strong field of candidates. Interviews are scheduled to take place in early June 2026.

Following completion of the recruitment process, I will bring proposals to the Board and the Council of Governors regarding Senior Independent Director arrangements from July 2026. I will also provide an update on the membership of Board committees and the Chairing arrangements for the Strategy and Culture Committee and the Finance and Performance Committee.

This Board meeting marks the final Board meeting for Peter, Shaun and Russell. I would like to place on record my sincere thanks for their outstanding commitment, leadership and contribution to the Trust during their time as Non-Executive Directors. Each has made a significant impact through their stewardship, challenge and support, and on behalf of the Board I extend our gratitude for the expertise, dedication and time they have given in service of the Trust.

A Board seminar took place in April 2026, providing an opportunity for focused discussion outside the formal Board meeting cycle. Key themes from the seminar included Board development, CQC preparedness, and the strategic partnership. The session supported collective reflection on Board effectiveness and capability, considered the Trust's ongoing readiness for CQC engagement, and provided space for deeper discussion on the strategic partnership and its implications for the Trust. The seminar was a constructive opportunity to strengthen shared understanding and inform the Board's forward focus.

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

The Council of Governors met on 21 April 2026. The public session focused on the Council's core statutory responsibilities, including receiving assurance from the Board and matters relating to the performance and governance of the Trust. In the private session, governors received an update on the Trust's strategic partnership to support their ongoing engagement and oversight.

As previously reported, a number of public and staff governors will reach the end of their terms of office in June 2026. Following agreement by the Council of Governors in February, an election process is underway to fill these forthcoming vacancies. Nominations opened on 21 April 2026, with election results due to be declared on 16 June 2026.

In line with the Trust's Constitution, pre-election briefing events were held on 30 April and 1 May 2026. These sessions provided prospective governors with an overview of the statutory roles and responsibilities of governors, information about the election process, and an update from the Lead Governor. This ensures candidates are appropriately informed before standing for election and supports effective governance.

On behalf of the Council of Governors, I would also like to recognise and thank those governors whose terms of office are concluding for their commitment and contribution to the Trust.

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

| Report cover-page | | | | | |
|---|---|---|---|---|---|
| **References** | | | | | |
| **Meeting title:** | Board of Directors | | | | |
| **Meeting date:** | 14/05/26 | | **Agenda reference:** | **06-26** | |
| **Report title:** | Chief Executive Officer (CEO) report | | | | |
| **Sponsor:** | Abigail Jago, Acting Chief Executive Officer | | | | |
| **Author:** | Kathy Brasier, Deputy Chief Strategy Officer<br>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 delivered the 2025/26 break even financial plan and therefore received £1.6m of non-recurrent deficit support funding.<br>• The Trust met year-end cancer standards, achieving both the Faster Diagnosis Standard and 62-day performance.<br>• The Trust was behind plan on the delivery of year end RTT targets for the number of patients waiting in excess of 52 weeks, 65 week waits outside breast reconstruction, and RTT 18 weeks. Actions are underway to strengthen the management of RTT.<br>• The Bognor Community Diagnostic Centre (CDC) programme transferred from QVH to Alliance for Better Care Community Interest Company (ABC CIC) on 1 April 2026.<br>• The 2025 NHS Staff Survey response rate was 56% (above the specialist trust average); patient care recommendation remained high at 90%, while recommendation as a place to work declined to 65%. Although this decline reflects a sector-wide trend, work is underway to understand the drivers, risk and required action.<br>• QVH is ranked 29/134 acute trusts in Q3 National Oversight Framework.<br>• The 2026/27 KSOs have been developed building on learning from 2025/26 and aligning with QVH Strategy 2025-2030, national and system priorities.<br>• Key organisational future risks relate to the financial constraint, estates, operational standard delivery and ongoing impact of industrial action.<br>• QVH three-year business plan has been accepted by NHS England. As we look to the year ahead there remains material financial challenge. | | | | |
| **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** | | | | | |

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| **Report to:** | Board of Directors |
| **Agenda item:** | 06-26 |
| **Date of meeting:** | 14 May 2026 |
| **Report from:** | Abigail Jago, Acting Chief Executive Officer |
| **Report author:** | Abigail Jago, Acting Chief Executive Officer<br>Allison Hunter, Strategy Support Officer<br>Kathy Brasier, Deputy Chief Strategy Officer |
| **Date of report:** | 07 April 2026 |
| **Appendices:** | None |

## Chief Executive Officer (CEO) report

### Alert

- QVH delivered the 2025/26 financial plan to breakeven and as a result received £1.6m additional funding taking the year end surplus to £1.6m. There remain substantial financial challenges as we plan for 2026/27 and beyond.
- The Trust was behind plan on the delivery of year end RTT targets for the number of patients waiting in excess of 52 weeks, 65 week waits outside breast reconstruction, and RTT 18 weeks. Actions are underway to strengthen RTT validation, management of the RTT waiting list and make improvements to cancer pathways in order to increase capacity for those on an elective pathway.
- Responsibility and accountability for the Bognor CDC project moved from QVH to Alliance for Better Care Community Interest Company (ABC CIC) on 1 April 2026.
- Key organisational future risks relate to the financial position, estates, operational performance standards and managing the impact of potential industrial action. While overall risk scores remain broadly unchanged, there is ongoing focus to improve the pace of risk mitigation and risks remaining outside of risk appetite.

### Assure

- The Trust delivered its 25/26 capital programme. Some substitution schemes were progressed at year-end to support slippage impact of East Grinstead CDC build. The Trust is working on delivering its planned 26/27 capital improvements within the expected financial envelope. This investment will allow us to continue to reduce many of our immediate high-level estate risks by the year end and accelerate the next stage of our digital programme. The Patient Administration System (PAS) replacement programme remains high risk due to supplier delivery challenges and tight timelines, with mitigating actions in place.
- The organisation has made strong progress against its KSOs in 2025/26, with key learning shaping priorities for year 2 of the QVH Strategy 2025–2030
- The Trust delivered all services during resident doctor industrial action from 7 to 13 April 2026. The trust continues to work with resident doctors to implement NHS England's 10 point plan targeted at improving their experiences wherever possible.
- The Trust achieved the Cancer Faster Diagnostic Standard (FDS) in M11 and the proportion of patients on a cancer pathway who were treated within 62 days met the Trust year end plan.
- Work is on track to progress the proposed strategic partnership with the Royal Surrey NHS Foundation Trust and Ashford and St Peter's Hospitals NHS Foundation Trust (RSFT/ASPH) group in December 2025.

### Advise

- The Trust's business plan was accepted with two RTT performance conditions affecting 2027/28 and 2028/29 which we continue to consider.

- East Grinstead Community Diagnostic Centre build continues with a planned opening date of the 1st October 2026. This is not expected to have a financial impact on activity income.

**Staff Survey**
The 2025 NHS Staff Survey (published March 2026) achieved a 56% response rate (693 staff), above the specialist trust average of 49% and broadly in line with QVH's 2024 result. 90% of respondents would recommend the care provided by QVH to family and friends, remaining above the specialist trust average. The most notable deterioration was in recommending QVH as a place to work (65%, down from 73% in 2024); this mirrors a sector-wide trend, with all specialist trusts seeing an average decline of 5%. Scores relating to staff experience and wellbeing also declined, while feelings of safety to speak up remained stable at the specialist-trust average (65%).

QVH continues to perform at or near the specialist trust average across the People Promise elements with notable strengths in diversity and equality, inclusion, safety and development, all scoring above comparator averages. Detailed department results have been shared with leadership teams with supporting workshops to prioritise local actions. The Executive Leadership Team will lead Trust-wide improvement activity, with continued focus on supporting managers through change and mitigating the impact of ongoing financial and operations pressures on staff wellbeing, morale and engagement

**National and Local Updates**
National Operational Standards for 2026/27
The NHS 2026/27 operational planning guidance set out in the Medium Term Planning Framework focusses on driving productivity, reduced waiting lists, and implementing the 10-year health plan reforms.

Key operational standards for QVH include a 7% improvement in the proportion of patients waiting below 18 weeks for treatment, a reduction to 1% of patients waiting for treatment over 52 weeks, improving performance for diagnostic waiting times so that 92% of patients have the outcome of their tests within 6 weeks, and a 5% improvement in the proportion of patients treated on a cancer pathway within 62 days.

NHSE have identified key priorities including technology-enabled productivity improvements such as ambient voice technology, and outpatient transformation to move away from traditional outpatient models through expansion of Advice and Guidance and a reduction in unnecessary follow-ups.

Provider Capability Assessment
The NHS Oversight Framework (NOF) 2025/26 outlines the approach to assessing integrated care boards (ICB), NHS Trusts and Foundation Trusts. QVH ranked 29th of 134 acute trusts nationally in the Q3 update of the National Oversight Framework, published in March, placing our organisation as the highest ranked acute trust across Surrey and Sussex.

The NHS Oversight Framework dashboard brings together performance across key services (including urgent and emergency care, elective services and mental health) and is refreshed quarterly to support transparency, improvement and oversight. We will continue to track QVH's NOF performance each quarter and use the dashboard metrics to identify and prioritise improvement opportunities, alongside maintaining safe, high quality care for patients

NHSE South East appointment of new regional chair
Professor Sir Jonathan Montgomery has been appointed as the new NHS England South East Regional Chair. The Regional Chair role is central to strengthening leadership across

the NHS at a time of significant change, supporting the delivery of the NHS's long-term priorities including shifting care closer to communities, improving productivity through digital transformation, and reducing health inequalities.

New NHS Surrey and Sussex ICB
On 1 April 2026 NHS Surrey Heartlands ICB and NHS Sussex ICB merged to form a NHS Surrey and Sussex Integrated Care Board (ICB). This merger follows government announced NHS reforms in March 2025 to strengthen roles and responsibilities, and reducing duplication, redirecting funding to frontline care

**NHS England 2026/27 Priorities**
Sir Jim Mackey, Chief Executive Officer of NHS England has written to ICB and Trust Chief Executives to recognise the collective leadership response over the past year in addressing the £4.5bn deficit, delivering the financial reset, and successfully navigating significant operating model changes, noting strong progress against RTT and UEC priorities and improving patient experience. Looking ahead, while aggregated plans for 2026/27 and beyond are in place, the letter emphasises the importance of maintaining delivery momentum while using the multi-year planning opportunity to drive more ambitious, sustainable system change aligned to the 10 Year Health Plan. ICBs are asked to strengthen their strategic commissioning narratives over the next three years, with particular focus on neighbourhood care and potential changes to financial flows.

**Finance and Performance**
For 2025/26 the Trust reported a surplus of £11k, in line with our plan. As a result the Trust was reallocated funding from other systems which did not achieve their financial plans of £1.6m, taking our final reported position to a £1.6m surplus

From an operational performance perspective, the Trust did not fully meet the year end plan for all RTT standards. RTT 18 week performance was 0.5% below plan (61.85% vs 62.3%). Patients waiting over 52 weeks decreased from 397 to 226 in year, this was 0.1% behind trajectory.

At year end, 31 patients were waiting over 65 weeks, a reduction from 48 in Month 11. Of these, 23 patients were within breast services and 8 were within other services. The non breast cases were attributable to a small number of late referrals, complex pathway delays (including safeguarding cases and external trust dependencies), and administrative corrections. All long waiter cohorts remain under active clinical and operational oversight.

For cancer services, the Trust met the year end targets for both the Faster Diagnosis Standard and 62 day performance.

Urgent Emergency Care (UEC) performance achieved 98% meeting the national standard, yet marginally missed the internal plan. Diagnostic Waiting time (DM01) performance delivered 89% and remains relatively stable, with plans to further improve diagnostic performance within the sleep service to improve the overall trust DM01 performance in 2026/27.

**Key Strategic Objectives (KSOs) Update**
The KSOs form the central mechanism through which delivery is driven, monitored and assured. In 2025/26, the focus was on establishing strong foundations across all KSOs, with sustained delivery, maintaining core standards and strengthening the position for future delivery.

The 2026/27 KSOs, to be approved at the May Public Board meeting, build on learning from 2025/26 and align with the *QVH Strategy 2025-2030*, national and system priorities. They are

designed to support system collaboration and partnership working, while strengthening the Trust's organisational foundations. The focus is on delivering high quality, patient centred care and improving patient outcomes.

**Quality and Safety**
The Quality Priorities for 2026/27 have been developed with the engagement of frontline staff. These are Clinical Outcomes and Evidence-Based Care, Reducing Health Inequalities and developing the Patient School Model. While overall quality indicators remain stable, some areas of patient experience (including elements of the PLACE assessment) and the timeliness of incident management processes require continued focus.

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**
We recently welcomed colleagues from Royal Surrey NHS Foundation Trust and Ashford and St Peter's Hospitals NHS Foundation Trust (RSFT/ASPH) Group to QVH, including members of their executive team, non-executive directors, and the Chair and CEO. The visit aimed to provide an overview of our services, offer the opportunity to meet out teams, and deepen understanding of the clinical synergies between our organisations.

Feedback from the visit was very positive, with a clear sense of clinical alignment and shared opportunities. It was an excellent platform to showcase QVH and to further explore potential areas for collaboration.

**Celebrating our QVH Team**
Values in Practice (VIP) Award Winners
The monthly Values in Practice (VIP) Awards continue to recognise colleagues who demonstrate our values through professionalism, compassion and teamwork, highlighting the everyday behaviours that strengthen our culture and improve the experience for patients and colleagues.

Our February winner was Kamila Gryczewska, Healthcare Support Worker in the Sleep Disorder Centre, who was recognised for being caring and inclusive (over all else). Kamila is described as kind and considerate, showing a genuine, non-judgemental commitment to supporting others in a way that makes a meaningful difference to patient experience.

The Plastics Skin Secretary Team became our first team winner for March, recognised for being caring and inclusive (over all else) for the compassion, resilience and kindness shown to one another in a demanding environment. The team has created a supportive culture with clear benefits for staff wellbeing and patient care.

We will shortly be opening nominations for our annual Star Awards, supported by Queen Victoria Hospital Charity, which will run alongside our monthly VIP awards.

Marking 14 years of support for people living with and beyond cancer
Our QVH Macmillan Cancer Information and Support Centre celebrated its 14th anniversary,

highlighting the growing impact of its wraparound support for people living with and beyond cancer. Over the last year, our Centre supported 2,657 people (patients, families, carers, friends and professionals), an increase on the previous year, and notably around half of those accessing support were not QVH patients, underlining its value as a wider community resource.

The team and volunteers continue to provide a broad offer including drop-in information and guidance, through to a range of complementary therapy, outreach, and wellbeing activities that support both prehabilitation and rehabilitation. I would like to thank the team for their dedication in helping people at every stage of their cancer journey and congratulate them on their anniversary.

**Connection with Teams**
I have greatly enjoyed spending time with teams across the organisation and continue to be impressed by the hard work, commitment, and dedication of our staff. During this period, I have had the opportunity to connect with a wide range of colleagues and volunteers, including our front desk volunteers, theatre leadership team, corneo-plastic administrative team, and colleagues in our Learning and Development Centre.

It was a pleasure to hear, whilst connecting with our new Head of Nursing, Kurt Micabel, and Danielle Burgess, Clinical Educator and T Level Placement Coordinator, about the fantastic work underway aligned to our anchor strategy ambitions. This is supporting local college students to complete their industrial placements in healthcare. I was also grateful for the insights shared by Hillary Lees regarding the work being undertaken with our teams to address issues raised in the staff survey, ensuring we respond effectively to areas of concern.

Finally, it was great to learn more from Uchechukwu Ajoku, who has recently joined us and is already making strong progress in optimising our management of clinical waste. This work is having a tangible impact, delivering both cost improvements and meaningful progress against our green agenda.

**Acknowledgement – Interim Deputy Executive Officer**
I would like to place on record my thanks to Jane Dickson who left QVH at the end of March. During her time with the Trust, Jane made a valued contribution through a period of significant strategic development, particularly in relation to the Community Diagnostic Centres, demonstrating consistent dedication, compassion and professionalism. On behalf of colleagues, I would like to thank her for her significant commitment and wish her every success in the future.

**Recommendation**
The Board is asked to:

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

| Report cover-page | | | | | |
|---|---|---|---|---|---|
| **References** | | | | | |
| **Meeting title:** | Board of Directors | | | | |
| **Meeting date:** | 14/05/2026 | | **Agenda reference:** | 07-26 | |
| **Report title:** | NHS 2025 Staff Survey QVH Report | | | | |
| **Sponsor:** | Helen Edmunds, Chief People Officer | | | | |
| **Author:** | Annette Byers, Head of OD & Learning | | | | |
| **Appendices:** | Appendix 1: Background comparator group responses<br>Appendix 2: All question data<br>Appendix 3: WRES/WDES data<br>Appendix 4: PP comparator scores against other providers<br>Appendix 5: All QVH PP scores and sub-scores table<br>Appendix 6: Team Response Rates<br>Appendix 7: Staff Group Scores / Improvement Scores<br>Appendix 8: Summary of work undertaken in 2025 to support wellbeing and inclusion | | | | |
| **Executive summary** | | | | | |
| **Purpose of report:** | Provide the Board with the outcome of the 2025 NHS Staff Survey results for substantive staff and bank workers at QVH. | | | | |
| **Summary of key issues** | • Survey participation remains comparatively strong compared to peers, with a 56% (696) response rate from substantive staff, above the national average, comparable to other specialist trusts and higher than proposed potential partners.<br>• Patient care remains a core strength, with 82% (571) of staff stating that care is the Trust's top priority and 90% (626) saying they would be happy with the standard of care provided if a family member or friend required treatment.<br>• Overall results are broadly comparable with other specialist trusts, with continued strengths in inclusion, team working and pride in making a difference for patients.<br>• Engagement and morale have declined compared to 2024, with increased fatigue, workload pressures and fewer staff recommending QVH as a place to work.<br>• Confidence in speaking up has reduced slightly, in line with national trends.<br>• Positive improvements are evident, including reduced pressure on staff with long-term conditions to attend work when unwell and improved indicators relating to bullying, harassment and violence.<br>• A strategic workforce risk remains, with sustained pressure and declining morale potentially impacting wellbeing, retention and delivery of transformation and future partnership ambitions.<br>• Executive leadership teams retain ownership of the Trust-wide priorities and triumvirate leadership teams having responsibility for their local responses. | | | | |
| **Recommendation:** | The committee are asked to note the report and the key areas of focus to inform next steps. | | | | |
| **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 - People | | | | |
| **Corporate risk register:** | None | | | | |
| **Regulation:** | None | | | | |
| **Legal:** | None | | | | |
| **Resources:** | None | | | | |
| **Assurance route** | | | | | |

| Previously considered by: | Strategy and Culture Committee | |
|---|---|---|
| | Date: 29/04/2026 | Decision: Paper to be presented to the Board |

**Report to:** Board of Directors
**Agenda item:** 07-26
**Date of meeting:** 14 May 2026
**Report from:** Helen Edmunds, Chief People Officer
**Report author:** Annette Byers, Head of OD and Learning
**Date of report:** 16 April 2026
**Appendices:** Appendix 1: Background comparator group responses
Appendix 2: All question data
Appendix 3: WRES/WDES data
Appendix 4: PP comparator scores against other providers
Appendix 5: All QVH PP scores and sub-scores table
Appendix 6: Team Response Rates
Appendix 7: Staff group scores / Improvement scores
Appendix 8: Summary of work undertaken in 2025 to support wellbeing and inclusion

# NHS 2025 Staff Survey QVH Report

## 1 Executive summary

Queen Victoria Hospital NHS Foundation Trust (QVH), alongside the wider NHS, continues to operate in an exceptionally challenging environment. The Trust must sustain high-quality, safe care for patients while delivering financial efficiencies, supporting elective recovery, responding to rising and increasingly complex demand, and managing significant organisational and system change, including preparation for proposed partnership arrangements with Royal Surrey NHS Foundation Trust and Ashford and St Peters Hospitals NHS Foundation Trust. In this context, the experience, engagement and wellbeing of staff remain critical to organisational resilience, quality and delivery of strategy.

The 2025 NHS Staff Survey provides an important insight into staff experience and organisational culture at QVH. Engagement in the survey remains comparatively strong, with a 56% (696) response rate from substantive staff, exceeding the national average and comparable specialist trusts. Results continue to demonstrate that patient care remains a clear organisational strength. A high proportion of staff report that care of patients and service users is the Trust's top priority, and the vast majority would be happy with the standard of care provided by QVH if a friend or relative required treatment. These results remain at or above comparator and national averages and reflect strong professional pride in the care delivered.

Overall results are broadly comparable with other specialist trusts. QVH continues to perform well in inclusion and diversity, team working and staff pride in making a positive difference. However, the survey also shows a decline in engagement, morale and workload-related indicators compared to 2024. Fewer staff would recommend QVH as a place to work, fatigue and stress measures have worsened, and confidence in speaking up has reduced slightly, although scores remain comparable with peers and are not the lowest within the benchmarking group. These trends reflect sustained operational pressure, workforce constraints and the impact of continued change and mirror national patterns across the NHS.

There are also important areas of improvement and reassurance. Staff with long-term conditions report significantly reduced pressure to attend work when unwell. Indicators relating to bullying, harassment and violence have improved, and overall diversity and inclusion scores remain strong. Engagement scores among bank workers has improved, although the response rate decreased in 2025. Taken together, the findings reinforce a strategic workforce risk: sustained pressure and declining morale may impact staff wellbeing, retention and the Trust's ability to deliver strategic priorities, transformation and partnership ambitions. Executive and triumvirate leadership teams will retain ownership of the key themes arising from the survey and lead targeted action at Trust, directorate and team level.

A table showing how QVH compares against its Sussex counterparts and alongside Royal Surrey NHS Foundation Trust and Ashford & St Peters Hospitals NHS Foundation Trust for 2025 and 2024 is available at Appendix 4.

## 2 Introduction

The NHS Staff Survey is a mandated annual survey for all NHS provider trusts in England and provides a consistent measure of staff experience, engagement and organisational culture. Results enable benchmarking across national, regional and peer-group organisations and inform workforce planning, risk management and improvement activity. QVH continues to work with Picker as its preferred survey provider.

For 2025, the survey ran from 6 October to 28 November, allowing an eight-week period for staff participation. During this time, weekly response-rate updates were shared across the Trust, and the Organisational Development and Learning (OD&L) team undertook proactive engagement through departmental meetings, communications, Team Talk sessions, drop-in sessions and walkabouts. Members of the Executive Leadership Team also supported uptake through departmental visits.

Picker worked with six of the thirteen specialist trusts in 2025, allowing meaningful benchmarking. New socio-economic background questions were introduced nationally in 2025 to support a broader understanding of staff experience.

The survey uses the NHS People Promise framework, which focuses on improving the working experience for NHS staff through seven key elements: compassionate and inclusive culture; recognition and reward; staff voice; safety and health; learning and development; flexible working; and teamwork. Each element is reported through individual sub-scores, alongside two overall themes of staff engagement and morale. The main survey included 124 questions, of which 110 are comparable to 2024. Results are reported where a minimum of ten responses were received. A separate bank worker survey comprising 53 questions was also conducted.

In 2025, 184 eligible bank workers were invited to participate, compared to 182 in 2024. 43 responses were received, equating to a response rate of 23.6%, a decrease from 37% in the previous year. There is no specific feedback explaining the reduction in bank worker participation.

## 3 Headline Results

### *3.1 Substantive staff*

Results continue to show strong staff commitment to patient care. 82% (571) of respondents agree that care of patients and service users is the organisation's top priority, remaining at comparator average, and 90% (626) would be happy with the standard of care provided by QVH if a friend or relative required treatment, which remains above comparator and national averages.

There has been a decline in staff advocacy, with 65% (452) of staff recommending QVH as a place to work, down from 73% (502) in 2024. This pattern mirrors national and local trends across Sussex and other specialist trusts.

Confidence in speaking up has reduced slightly, with 65% (452) of staff reporting they feel safe to raise concerns, down from 67% (460) in 2024, with the raising concerns sub-score falling from 6.8 to 6.5. Perceptions that concerns would be addressed have also declined.

Workload and wellbeing indicators highlight rising fatigue and pressure. At the same time, significant improvement has been seen for staff with long-term conditions, with fewer reporting pressure from managers to attend work when unwell.

Ethnically diverse staff continue to report higher engagement and overall scores compared to white staff. Results relating to bullying, harassment and violence show continued improvement.

Across the seven People Promise elements and the engagement and morale themes, scores have declined slightly compared to 2024 but remain broadly average or slightly below average for specialist trusts and above national averages. Key scoring areas as follows:

| QVH most improved scores in 2025 | 2025 | 2024 | Diff |
|---|---|---|---|
| **q10b.** Don't work any additional paid hours per week for this organisation, over and above contracted hours | 69% | ↑ 64% | 5% |
| **q14d.** Last experience of harassment/bullying/abuse reported | 54% | ↓ 50% | 4% |
| **q13a.** Not experienced physical violence from patients/service users, their relatives or other members of the public | 95% | ↓ 93% | 3% |
| **q14a.** Not experienced harassment, bullying or abuse from patients/service users, their relatives/ members of the public | 81% | ↑ 79% | 2% |
| **q16b.** Not experienced discrimination from manager/team leader or other colleagues | 93% | ↓ 92% | 1% |
| **QVH most improved scores in 2024** | **2025** | **2024** | **Diff** |
| **q10c**. Don't work any additional unpaid hours per week for this organisation, over and above contracted hours | ↓ 46% | ↑ 49% | -3% |
| **q7b**. Team members often meet to discuss the team's effectiveness | ↓ 62% | ↑ 66% | -4% |
| **q10b**. Don't work any additional paid hours per week for this organisation, over and above contracted hours | ↑ 69% | ↑ 64% | +5% |
| **q11d**. In last 3 months, have not come to work when not feeling well enough to perform duties | ↓ 51% | ↑ 56% | -5% |
| **q9a.** Immediate manager encourages me at work | ↓ 73% | ↑ 77% | -4% |

| People Promise elements | No of Respondents | 2025 Score | National Average 2025 | 2024 Score |
|---|---|---|---|---|
| We are compassionate and inclusive | 691 | 7.6 | 7.33 | 7.75 |
| We are recognised and rewarded | 692 | 6.0 | 5.95 | 6.26 |
| We each have a voice that counts | 684 | 6.7 | 6.63 | 6.95 |
| We are safe and healthy | 686 | 6.3 | 6.12 | 6.51 |
| We are always learning | 656 | 5.7 | 5.63 | 5.89 |
| We work flexibly | 689 | 6.4 | 6.31 | 6.63 |
| We are a team | 692 | 6.9 | 6.8 | 7.03 |
| Staff Engagement | 691 | 7.1 | 6.75 | 7.38 |
| Morale | 691 | 5.9 | 5.9 | 6.21 |

The tables below show the most improved and most declined results for 2025 and 2024. All of the most declined scores have been analysed and shared with departments via data packs for specific focus and prioritisation to support an improvement for staff.

| QVH most declined scores in 2025 | 2025 | 2024 | Diff |
|---|---|---|---|
| **q25c.** Would recommend organisation as place to work | 65% | ↓ 74% | -9% |
| **q12f.** Never/rarely feel every working hour is tiring | 53% | ↓ 61% | -8% |
| **q2a.** Often/always look forward to going to work | 53% | ↓ 61% | -8% |
| **q5c.** Relationships at work are unstrained | 42% | ↓ 49% | -7% |
| **q3h.** Have adequate materials, supplies and equipment to do my work | 56% | ↓ 64% | -6% |
| **QVH most declined scores in 2024** | **2025** | **2024** | **Diff** |
| **q19a.** Staff involved in an error/near miss/incident treated fairly | ↓ 58% | ↓ 62% | -4% |
| **q14d**. Last experience of harassment/bullying/abuse reported | ↑ 54% | ↓ 50% | +4% |
| **q25e**. Feel safe to speak up about anything that concerns me in this organisation | ↓ 65% | ↓ 67% | -2% |
| **q4b**. Satisfied with extent organisation values my work | ↓ 45% | ↓ 49% | -4% |
| **q8c**. Colleagues are polite and treat each other with respect | 73% | ↓ 73% | SAME |

**Key**: Red/Green arrows show whether scores have increased or decreased from the previous year

### *3.2 Bank workers headline results*

Bank worker results show improvements across all People Promise elements, engagement and morale compared to 2024. Interpretation is limited by the lower response rate in 2025.

## 4 Staff engagement / Staff Groups

Overall engagement decreased to 7.1 from 7.4 in 2024, placing QVH just below the specialist trust benchmarking average. Bank worker engagement increased to 8.0, from 7.7 in 2024.

Variation exists across staff groups, with healthcare scientists, nursing, medical and dental and additional clinical staff reporting higher engagement (to note however, the response rate from medical and dental was low at 29%). The largest declines are seen in Allied Health Professionals and Estates and Ancillary staff. Younger staff (aged 21–30), staff with long-term conditions, and some operational departments report lower engagement and morale. Patterns of lower engagement are most evident in Estates & Facilities, Corneo & Eye Bank, Plastics, Theatres, and Commerce & Finance.

Staff Group Scores / Improvement Scores are detailed at appendix 7.

## 5 2025 Local questions

Local questions focused on senior leadership and the behavioural framework show that 68% of staff are aware of the framework and 32% have used it. 55% agree leadership communicates clearly, and 45% report senior leaders are visible.

## 6 Overall summary themes

Key themes from the survey include:

- Continued strength in patient-centred care, inclusion and team working
- Improved outcomes relating to bullying, harassment and violence
- Reduced pressure on staff with long-term conditions to attend work when unwell
- Declining engagement, morale, fatigue and advocacy
- Variation in experience across staff groups and departments

The table at appendix 5 shows all QVH's sub-scores for each element and themes from the 2025 survey and the previous four years.

## 7 Workforce Race Equality Standards (WRES) / Workforce Disability Equality Standard (WDES) results

WRES and WDES data show positive trends in bullying, harassment, discrimination and staff reporting concerns. Further detailed analysis will be provided through the 2025 WRES and WDES reports. Significant work continues across equality, wellbeing, culture and retention, including EDI initiatives, wellbeing policies, manager development, culture diagnostics, behavioural framework implementation, and continuous improvement activity.

The WRES / WDES data is detailed at appendix 3.
The summary of work undertaken in 2025 to support wellbeing and inclusion is detailed at appendix 8.

## 8 Key areas of focus

Priorities include:

- Enhancing diversity and inclusion experiences
- Improving staff wellbeing and addressing workload pressures
- Strengthening executive and triumvirate ownership
- Improving psychological safety and staff voice
- Targeted cultural support for teams with greatest challenge
- Supporting local team ownership of results and improvement

Actions will be tracked through workforce metrics, pulse surveys and governance oversight.

The focus areas will include:

### *8.1 Enhance Diversity and Inclusion experiences*

- Focus for staff who declared a disability through a series of focus groups to help understand lived experiences and what QVH can do to improve working arrangements. Oliver McGowan Tier 2 is being rolled out across QVH from April 2026, which will help raise awareness and improve inclusion.
- Develop and deliver training workshops for those who complete Equality Impact Assessments to ensure robust, meaningful evaluations and to embed equality considerations into all decision-making across the Trust.
- Deliver neurodiversity awareness and menopause workshops in 2026 funded by the League of Friends. Deliver transgender awareness workshops in 2026 funded through the QVH Charity.
- Link with Royal Surrey NHS Foundation Trust and Ashford and St Peters Hospitals NHS Foundation Trust to access their staff networks for QVH staff.

### *8.2 Prioritise staff wellbeing and address workload pressure*

Morale, specifically around stress and burnout are areas of decline in the 2025 survey. Continued wellbeing support will be a priority for 2026/27 in order to improve work place experiences and morale. Triumvirate leadership teams will take responsibility for ongoing discussions and support in relation to staffing levels, rostering and workload redesign.

Re-launch Wellbeing Champions to act as local change agents and advocates QVH. Co-design QVHs Personal Support Profile to form a more holistic and meaningful reflection of the support needs and challenges our staff may face.

Improvements will be communicated via Team Talk, Connect, monthly wellbeing newsletter and promotions and continuous improvement huddles.

### *8.3 Executive and triumvirate ownership*

In order to demonstrate to staff that concerns raised in the staff survey are heard and action is being taken to address issues raised, executive and triumvirate leadership teams will have oversight and ownership of the trust level results and areas of priority. The Executive team are

working through a framework to ensure there is greater senior leadership visibility and connection across the trust.

### *8.4 Psychological safety and staff voice*

The Cultural Transformation Steering Group (CTSG) will have a restart and focus in 2026/27 on speaking up, psychological safety and experiences for those with a long term condition or illness. A specific work stream will be established to focus on improving confidence in speaking up, ensuring this links with the freedom to speak up guardian.

### *8.5 Culture priorities*

The culture diagnostic report will be reviewed and updated to reflect the changing landscape of staff experience, which will be shared with the Executive Leadership Team and the Trust Board in Q2 of 2026. Workforce and OD&L will collaborate with triumvirate leaders and managers to support teams with areas identified as having the greatest priority, identified through their data analysis and areas where scores have declined.

Workshops have taken place in March/April 2026 for managers, to help interpret the data, understand their role and discuss support available. Improvements will be tracked through an ongoing review of people metrics, and through the quarterly pulse surveys.

### *8.6 Team Ownership*

Results have been sent to teams to be reviewed and discussed. These results will include suggestions for areas of focus. OD&L workshops are in place to support managers with their areas needing focus to embed meaningful improvements. Departments that require most focus will be prioritised, with in depth support which is monitored through workforce metrics.

## 9 Strategic Risk

The People Board Assurance Framework (BAF) identifies a risk that sustained workforce pressure and organisational change could impact staff wellbeing, retention and the Trust's ability to deliver strategic objectives. While turnover has not worsened, declining morale and advocacy present a risk if not addressed. Continued visible leadership, wellbeing support and clear communication about partnership developments remain critical mitigations.

**Recommendation**

The Board is asked to note the report and key areas of focus to inform ongoing review and assurance.

# Appendix 1: Background comparator responses

## *Which of the following best describes you?*

| | Female | Male | Non-binary | Prefer to self-describe | Prefer not to say |
|---|---|---|---|---|---|
| Your org | 75.33% | 17.71% | 0.29% | 0.00% | 6.68% |
| Average | 73.25% | 22.07% | 0.29% | 0.09% | 4.23% |
| Responses | 689 | 689 | 689 | 689 | 689 |

## *Is your gender your identity the same as the sex you were registered at birth?*

| | Yes | No | Prefer not to say |
|---|---|---|---|
| Your org | 93.45% | 0.45% | 6.10% |
| Average | 95.62% | 0.40% | 3.87% |
| Responses | 672 | 672 | 672 |

## *Age:*

| | 16-20 | 21-30 | 31-40 | 41-50 | 51-65 | 66+ |
|---|---|---|---|---|---|---|
| Your org | 0.15% | 10.93% | 22.16% | 27.62% | 35.30% | 3.84% |
| Average | 0.49% | 16.06% | 26.75% | 25.56% | 28.55% | 1.85% |
| Responses | 677 | 677 | 677 | 677 | 677 | 677 |

## *Ethnic group:*

| | White | Mixed / Multiple ethnic background | Asian / Asian British | Black / African / Caribbean / Black British | Arab | Other |
|---|---|---|---|---|---|---|
| Your org | 79.32% | 2.53% | 13.39% | 2.98% | 0.74% | 1.04% |
| Average | 79.32% | 2.77% | 15.23% | 4.22% | 0.26% | 0.78% |
| Responses | 672 | 672 | 672 | 672 | 672 | 672 |

## *Sexual orientation:*

| | Heterosexual or straight | Gay or lesbian | Bisexual | Other | Prefer not to say |
|---|---|---|---|---|---|
| Your org | 87.05% | 1.46% | 2.33% | 0.29% | 8.88% |
| Average | 87.70% | 2.41% | 1.95% | 0.56% | 6.64% |
| Responses | 687 | 687 | 687 | 687 | 687 |

## *Religion or belief:*

| | No religion | Christian | Buddhist | Hindu | Jewish | Muslim | Sikh | Any other religion | I would prefer not to say |
|---|---|---|---|---|---|---|---|---|---|
| Your org | 39.47% | 44.44% | 0.88% | 2.34% | 0.29% | 2.63% | 0.15% | 0.73% | 9.06% |
| Average | 36.34% | 46.45% | 0.67% | 2.34% | 0.29% | 2.63% | 0.17% | 1.06% | 7.21% |
| Responses | 684 | 684 | 684 | 684 | 684 | 684 | 684 | 684 | 684 |

## *Long lasting health condition or illness:*

| | Do you have any physical or mental health conditions or illnesses lasting or expected to last for 12 months or more? |
|---|---|
| Your org | 26.57% |
| Average | 25.12% |
| Responses | 670 |

## *Parental/caring responsibilities:*

| | Do you have any children aged from 0 to 17 living at home with you or who you have regular caring responsibility for? | Do you look after or give any help or support to family members, friends, neighbours or others because of either: long term physical or mental ill health / disability, or problems related to old age. |
|---|---|---|
| Your org | 39.33% | 28.24% |
| Average | 39.44% | 30.73% |
| Responses | 684 | 680 |

## *How often do you work at/from home:*

| | Never | Rarely | Sometimes | Often | Always |
|---|---|---|---|---|---|
| Your org | 53.64% | 15.60% | 18.08% | 11.52% | 1.17% |
| Average | 49.38% | 14.82% | 20.51% | 16.96% | 1.50% |
| Responses | 686 | 686 | 686 | 686 | 686 |

## *Length of service:*

| | Less than 1 year | 1-2 years | 3-5 years | 6-10 years | 11-15 years | More than 15 years |
|---|---|---|---|---|---|---|
| Your org | 10.51% | 18.54% | 19.27% | 24.09% | 9.20% | 18.39% |
| Average | 8.40% | 17.41% | 22.46% | 19.54% | 10.60% | 19.98% |
| Responses | 685 | 685 | 685 | 685 | 685 | 685 |

## *Recruited from outside UK:*

| | Yes | No | Prefer not to say |
|---|---|---|---|
| Your org | 4.13% | 93.66% | 2.21% |
| Average | 4.82% | 93.23% | 1.18% |
| Responses | 678 | 678 | 678 |

## *Occupational Group:*

| | Registered Nurses and Midwives | Nursing or Healthcare assistants | Medical and Dental | Allied Health Professionals | Scientific and Technical | Social Care | Public Health | Commissioning | Admin and Clerical | Central Functions |
|---|---|---|---|---|---|---|---|---|---|---|
| Your org | 22.16% | 5.69% | 8.53% | 15.72% | 7.19% | 0.00% | 0.00% | 0.15% | 19.16% | 11.23% |
| Average | 23.77% | 5.29% | 7.35% | 13.62% | 8.90% | 0.05% | 0.18% | 0.12% | 19.16% | 7.85% |
| Responses | 668 | 668 | 668 | 668 | 668 | 668 | 668 | 668 | 668 | 668 |

| | Maintenance | General Management | Emergency Care Practitioners | Paramedics | Emergency Care Assistants | Ambulance Technicians | Ambulance Control Staff | Patient Transport Service | Other |
|---|---|---|---|---|---|---|---|---|---|
| Your org | 4.19% | 3.44% | 0.15% | 0.00% | 0.00% | 0.00% | 0.00% | 0.00% | 2.40% |
| Average | 2.68% | 4.02% | 0.00% | 0.00% | 0.00% | 0.00% | 0.00% | 0.00% | 3.52% |
| Responses | 668 | 668 | 668 | 668 | 668 | 668 | 668 | 668 | 668 |

## *Socio-economic background- five classes:*

| | Managerial, administrative, and professional | Intermediate | Small employers and own account workers | Lower supervisory and technical | Semi-routine and routine |
|---|---|---|---|---|---|
| Your org | 56.29% | 4.86% | 16.57% | 12.00% | 10.29% |
| Average | 54.84% | 4.96% | 16.57% | 12.34% | 10.29% |
| Responses | 350 | 350 | 350 | 350 | 350 |

# Appendix 2: All QVH 2025 results

| Section | Q | Comparator Information | QVH 2025 | QVH 2024 | QVH 2023 | Diff |
|---|---|---|---|---|---|---|
| YOUR JOB | q2a | Often/always look forward to going to work | **53.21%** | 61.14% | 63.97% | -7.9% |
| | q2b | Often/always enthusiastic about my job | **64.51%** | 71.24% | 73.77% | -6.7% |
| | q2c | Time often/always passes quickly when I am working | **74.05%** | 75.66% | 76.32% | -1.6% |
| | q3a | Always know what work responsibilities are | **84.52%** | 86.91% | 89.97% | -2.4% |
| | q3b | Feel trusted to do my job | **89.13%** | 89.20% | 89.60% | -0.1% |
| | q3c | Opportunities to show initiative frequently in my role | **71.74%** | 74.82% | 76.57% | -3.1% |
| | q3d | Able to make suggestions to improve the work of my team/dept | **71.45%** | 75.55% | 76.83% | -4.1% |
| | q3e | Involved in deciding changes that affect work | **48.98%** | 54.41% | 55.40% | -5.4% |
| | q3f | Able to make improvements happen in my area of work | **54.72%** | 56.64% | 60.58% | -1.9% |
| | q3g | Able to meet conflicting demands on my time at work | **43.15%** | 48.67% | 47.93% | -5.5% |
| | q3h | Have adequate materials, supplies and equipment to do my work | **56.48%** | 63.72% | 64.62% | -7.2% |
| | q3i | Enough staff at organisation to do my job properly | **30.58%** | 37.41% | 39.14% | -6.8% |
| | q4a | Satisfied with recognition for good work | **56.15%** | 57.96% | 61.62% | -1.8% |
| | q4b | Satisfied with extent organisation values my work | **45.23%** | 48.52% | 54.07% | -3.3% |
| | q4c | Satisfied with level of pay | **30.64%** | 32.05% | 31.35% | -1.4% |
| | q4d | Satisfied with opportunities for flexible working patterns | **60.81%** | 60.80% | 58.68% | 0.0% |
| | q5a | Have realistic time pressures | **23.51%** | 26.88% | 27.29% | -3.4% |
| | q5b | Have a choice in deciding how to do my work | **54.57%** | 55.24% | 58.78% | -0.7% |
| | q5c | Relationships at work are unstrained | **42.09%** | 49.41% | 51.22% | -7.3% |
| | q6a | Feel my role makes a difference to patients/service users | **89.34%** | 87.79% | 92.03% | 1.6% |
| | q6b | Organisation is committed to helping balance work and home life | **49.28%** | 53.69% | 56.77% | -4.4% |
| | q6c | Achieve a good balance between work and home life | **56.65%** | 58.05% | 61.89% | -1.4% |
| | q6d | Can approach immediate manager to talk openly about flexible working | **74.42%** | 74.00% | 75.04% | 0.4% |
| YOUR TEAM | q7a | Team members have a set of shared objectives | **72.03%** | 74.74% | 72.67% | -2.7% |
| | q7b | Team members often meet to discuss the team's effectiveness | **61.85%** | 66.32% | 60.94% | -4.5% |
| | q7c | Receive the respect I deserve from my colleagues at work | **72.11%** | 74.67% | 74.01% | -2.6% |
| | q7d | Team members understand each other's roles | **69.32%** | 75.37% | 73.52% | -6.0% |
| | q7e | Enjoy working with colleagues in team | **80.90%** | 83.56% | 83.43% | -2.7% |
| | q7f | Team has enough freedom in how to do its work | **56.44%** | 61.30% | 62.77% | -4.9% |
| | q7g | Team deals with disagreements constructively | **52.25%** | 56.93% | 58.60% | -4.7% |
| | q7h | Feel valued by my team | **70.52%** | 75.44% | 74.24% | -4.9% |
| | q7i | Feel a strong personal attachment to my team | **66.38%** | 70.67% | 69.56% | -4.3% |
| PEOPLE IN YOUR ORGANISATION | q8a | Teams within the organisation work well together to achieve objectives | **51.01%** | 56.41% | 56.62% | -5.4% |
| | q8b | Colleagues are understanding and kind to one another | **69.80%** | 74.93% | 76.41% | -5.1% |
| | q8c | Colleagues are polite and treat each other with respect | **73.27%** | 73.30% | 78.27% | 0.0% |
| | q8d | Colleagues show appreciation to one another | **67.34%** | 71.83% | 72.04% | -4.5% |
| YOUR MANAGERS | q9a | Immediate manager encourages me at work | **72.79%** | 76.78% | 73.48% | -4.0% |
| | q9b | Immediate manager gives clear feedback on my work | **66.33%** | 69.62% | 69.66% | -3.3% |
| | q9c | Immediate manager asks for my opinion before making decisions that affect my work | **63.01%** | 65.39% | 64.63% | -2.4% |
| | q9d | Immediate manager takes a positive interest in my health & well-being | **72.54%** | 75.11% | 74.58% | -2.6% |
| | q9e | Immediate manager values my work | **74.82%** | 76.25% | 74.81% | -1.4% |
| | q9f | Immediate manager works with me to understand problems | **71.35%** | 71.64% | 73.36% | -0.3% |
| | q9g | Immediate manager listens to challenges I face | **74.24%** | 75.41% | 75.95% | -1.2% |
| | q9h | Immediate manager cares about my concerns | **74.24%** | 74.48% | 74.12% | -0.2% |
| | q9i | Immediate manager helps me with problems I face | **69.94%** | 71.89% | 70.02% | -2.0% |
| YOUR HEALTH, WELL-BEING AND SAFETY AT WORK | q10b | Don't work any additional paid hours per week for this organisation, over and above contracted hours | **68.81%** | 64.04% | 59.78% | 4.8% |
| | q10c | Don't work any additional unpaid hours per week for this organisation, over and above contracted hours | **46.26%** | 49.40% | 42.44% | -3.1% |
| | q11a | Organisation takes positive action on health and well-being | **56.31%** | 61.00% | 62.33% | -4.7% |
| | q11b | In last 12 months, have not experienced musculoskeletal (MSK) problems as a result of work activities | **61.07%** | * | 72.17% | |
| | q11c | In last 12 months, have not felt unwell due to work related stress | **61.10%** | 67.95% | 66.41% | -6.8% |
| | q11d | In last 3 months, have not come to work when not feeling well enough to perform duties | **50.73%** | 55.93% | 52.45% | -5.2% |
| | q11e | Not felt pressure from manager to come to work when not feeling well enough | **81.21%** | 81.31% | 80.40% | -0.1% |
| | q12a | Never/rarely find work emotionally exhausting | **25.80%** | 31.76% | 30.90% | -6.0% |
| | q12b | Never/rarely feel burnt out because of work | **34.16%** | 39.09% | 42.07% | -4.9% |
| | q12c | Never/rarely frustrated by work | **19.42%** | 24.19% | 23.59% | -4.8% |
| | q12d | Never/rarely exhausted by the thought of another day/shift at work | **40.32%** | 43.97% | 45.88% | -3.7% |
| | q12e | Never/rarely worn out at the end of work | **20.67%** | 22.42% | 23.29% | -1.7% |
| | q12f | Never/rarely feel every working hour is tiring | **52.69%** | 60.91% | 62.86% | -8.2% |
| | q12g | Never/rarely lack energy for family and friends | **37.30%** | 41.53% | 41.37% | -4.2% |
| | q13a | Not experienced physical violence from patients/service users, their relatives or other members of the public | **95.22%** | 92.76% | 94.05% | 2.5% |
| | q13b | Not experienced physical violence from managers | **99.71%** | 100% | 99.83% | -0.3% |
| | q13c | Not experienced physical violence from other colleagues | **99.11%** | 98.77% | 98.65% | 0.3% |
| | q13d | Last experience of physical violence reported | **83.33%** | 84.44% | 85.29% | -1.1% |
| | q14a | Not experienced harassment, bullying or abuse from patients/service users, their relatives or members of the public | **80.99%** | 78.99% | 77.13% | 2.0% |
| | q14b | Not experienced harassment, bullying or abuse from managers | **91.95%** | 92.10% | 91.10% | -0.2% |
| | q14c | Not experienced harassment, bullying or abuse from other colleagues | **84.53%** | 83.18% | 82.24% | 1.3% |
| | q14d | Last experience of harassment/bullying/abuse reported | **54.35%** | 50.23% | 58.13% | 4.1% |
| | q15 | Organisation acts fairly: career progression | **54.41%** | * | 60.77% | |
| | q16a | Not experienced discrimination from patients/service users, their relatives or other members of the public | **94.91%** | 94.67% | 94.82% | 0.2% |
| | q16b | Not experienced discrimination from manager/team leader or other colleagues | **93.44%** | 91.74% | 93.56% | 1.7% |
| | q17a | Not experienced unwanted behaviour of a sexual nature from patients/service users, relatives or members of the public | **95.81%** | 94.39% | 94.51% | 1.4% |
| | q17b | Not experienced unwanted behaviour of a sexual nature from other colleagues | **96.08%** | 96.00% | 95.87% | 0.1% |
| | q18 | Not seen any errors/near misses/incidents that could have hurt staff/patients/service users | **71.98%** | 72.73% | 69.77% | -0.8% |
| | q19a | Staff involved in an error/near miss/incident treated fairly | **57.81%** | 62.45% | 71.26% | -4.6% |
| | q19b | Encouraged to report errors/near misses/incidents | **86.70%** | 90.64% | 93.42% | -3.9% |
| | q19c | Organisation ensure errors/near misses/incidents do not repeat | **67.40%** | 70.36% | 73.86% | -3.0% |
| | q19d | Feedback given on changes made following errors/near misses/incidents | **60.20%** | 62.01% | 64.22% | -1.8% |
| | q20a | Would feel secure raising concerns about unsafe clinical practice | **69.77%** | 72.71% | 74.89% | -2.9% |
| | q20b | Would feel confident that organisation would address concerns about unsafe clinical practice | **56.48%** | 61.80% | 64.01% | -5.3% |
| | q21 | Feel organisation respects individual differences | **74.96%** | 77.43% | 79.33% | -2.5% |
| | q22 | I can eat nutritious and affordable food at work | **64.31%** | 69.26% | 67.28% | -5.0% |
| YOUR PERSONAL DEVELOPMENT | q23a | Received appraisal in the past 12 months | **83.03%** | 84.93% | 87.76% | -4.4% |
| | q23b | Appraisal helped me improve how I do my job | **25.92%** | 26.28% | 27.26% | -0.4% |
| | q23c | Appraisal helped me agree clear objectives for my work | **36.15%** | 36.97% | 39.03% | -0.8% |
| | q23d | Appraisal left me feeling organisation values my work | **38.46%** | 39.51% | 40.94% | -1.0% |
| | q24a | Organisation offers me challenging work | **69.52%** | 72.21% | 71.84% | -2.7% |
| | q24b | There are opportunities for me to develop my career in this organisation | **50.58%** | 55.08% | 55.34% | -4.5% |
| | q24c | Have opportunities to improve my knowledge and skills | **73.88%** | 74.08% | 73.82% | -0.2% |
| | q24d | Feel supported to develop my potential | **60.81%** | 64.41% | 62.20% | -3.6% |
| | q24e | Able to access the right learning and development opportunities when I need to | **65.31%** | 67.21% | 70.53% | -1.9% |
| | q24f | Able to access clinical supervision opportunities | **52.36%** | 57.88% | * | -5.5% |
| YOUR ORGANISATION | q25a | Care of patients/service users is organisation's top priority | **81.74%** | 88.79% | 88.72% | -7.1% |
| | q25b | Organisation acts on concerns raised by patients/service users | **75.18%** | 79.50% | 80.64% | -4.3% |
| | q25c | Would recommend organisation as place to work | **64.64%** | 73.52% | 75.73% | -8.9% |
| | q25d | If friend/relative needed treatment would be happy with standard of care provided by organisation | **90.14%** | 93.21% | 92.65% | -3.1% |
| | q25e | Feel safe to speak up about anything that concerns me in this organisation | **64.64%** | 67.21% | 74.31% | -2.6% |
| | q25f | Feel organisation would address any concerns I raised | **52.54%** | 57.23% | 61.43% | -4.7% |
| | q26a | I don't often think about leaving this organisation | **43.91%** | 50.81% | 53.28% | -6.9% |
| | q26b | I am unlikely to look for a job at a new organisation in the next 12 months | **50.72%** | 55.90% | 60.40% | -5.2% |
| | q26c | I am not planning on leaving this organisation | **57.91%** | 63.61% | 68.50% | -5.7% |
| BACKGROUND INFORMATION | q31b | Disability: organisation made reasonable adjustment(s) to enable me to carry out work | **82.29%** | 83.53% | 84.62% | -1.2% |

This section contains data for each organisation required for the NHS Staff Survey indicators used in the Workforce Race Equality Standard (WRES) and the Workforce Disability Equality Standard (WDES). Data presented in this section are unweighted:

Full details of how the data are calculated are included in the Technical Document, available to download from the results website.

## Appendix 3a: Workforce Race Equality Standards (WRES)

This contains data for each organisation required for the NHS Staff Survey indicators used in the Workforce Race Equality Standard (WRES).

**Workforce Race Equality Standards (WRES)**

| Indicator | Qu No | Workforce Race Equality Standard |
|---|---|---|
| | | For each of the following indicators, compare the outcomes of the responses for white staff and staff from all other ethnic groups combined |
| 5 | Q14a | Percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 months |
| 6 | Q14b & Q14c | Percentage of staff experiencing harassment, bullying or abuse from staff in last 12 months |
| 7 | Q15 | Percentage believing that their organisation provides equal opportunities for career progression or promotion (2025 only) |
| 8 | Q16b | In the last 12 months have you personally experienced discrimination at work from any of the following? b) Manager/team leader or other colleagues |

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

| | 2021 | 2022 | 2023 | 2024 | 2025 |
|---|---|---|---|---|---|
| White staff: Your org | 20.00% | 19.15% | 20.66% | 19.14% | 20.23% |
| All other ethnic groups*: Your org | 15.38% | 28.00% | 26.11% | 28.13% | 15.11% |
| White staff: Average | 18.46% | 19.15% | 17.99% | 17.33% | 15.62% |
| All other ethnic groups*: Average | 17.13% | 20.77% | 18.52% | 19.43% | 17.57% |
| White staff: Responses | 515 | 496 | 494 | 533 | 529 |
| All other ethnic groups*: Responses | 91 | 100 | 101 | 128 | 139 |

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

| | 2021 | 2022 | 2023 | 2024 | 2025 |
|---|---|---|---|---|---|
| White staff: Your org | 19.57% | 17.98% | 19.90% | 20.22% | 17.58% |
| All other ethnic groups*: Your org | 35.96% | 30.00% | 19.65% | 25.20% | 22.46% |
| White staff: Average | 21.54% | 20.38% | 19.75% | 20.22% | 19.47% |
| All other ethnic groups*: Average | 27.81% | 27.32% | 24.23% | 25.20% | 26.32% |
| White staff: Responses | 516 | 495 | 492 | 534 | 529 |
| All other ethnic groups*: Responses | 89 | 100 | 101 | 127 | 138 |

*Percentage of staff believing that the organisation provides equal opportunities for career progression or promotion:*

| | 2025 |
|---|---|
| White staff: Your org | 55.93% |
| All other ethnic groups*: Your org | 50.36% |
| White staff: Average | 59.28% |
| All other ethnic groups*: Average | 48.34% |
| White staff: Responses | 531 |
| All other ethnic groups*: Responses | 139 |

**Note**: Due to changes in the question wording in 2025, previous years' results for WRES indicator 7 (Q15) are not reported. For more information, please refer to the *Technical Guide:* https://www.nhsstaffsurveys.com/survey-documents/

*Percentage of staff experienced discrimination at work from manager / team leader or other colleagues in last 12 months:*

| | 2021 | 2022 | 2023 | 2024 | 2025 |
|---|---|---|---|---|---|
| White staff: Your org | 5.33% | 5.47% | 3.99% | 6.86% | 4.36% |
| All other ethnic groups*: Your org | 18.28% | 21.78% | 17.54% | 13.28% | 13.87% |
| White staff: Average | 6.13% | 5.47% | 5.13% | 6.75% | 5.72% |
| All other ethnic groups*: Average | 16.71% | 16.42% | 15.38% | 13.65% | 15.15% |
| White staff: Responses | 525 | 494 | 526 | 525 | 528 |
| All other ethnic groups*: Responses | 93 | 101 | 114 | 128 | 137 |

# Appendix 3b: Workforce Disability Equality Standards (WDES)

This contains data for each organisation required for the NHS Staff Survey indicators used in the Workforce Disability Equality Standard (WDES).

## Workforce Disability Equality Standards (WDES)

| Metric | Qu No | Workforce Disability Equality Standard |
|---|---|---|
| | | For each of the following metrics, compare the responses for staff with a LTC* or illness vs staff without a LTC or illness |
| 4a | Q14a | Percentage of staff experiencing harassment, bullying or abuse from patients/service users, their relatives or other members of the public |
| 4b | Q14b | Percentage of staff experiencing harassment, bullying or abuse from managers |
| 4c | Q14c | Percentage of staff experiencing harassment, bullying or abuse from other colleagues |
| 4d | Q14d | Percentage of staff saying that the last time they experienced harassment, bullying or abuse at work, they or a colleague reported it |
| 5 | Q15 | Percentage believing that their organisation provides equal opportunities for career progression or promotion (2025 only) |
| 6 | Q11e | Percentage of staff saying that they have felt pressure from their manager to come to work, despite not feeling well enough to perform their duties |
| 7 | Q4b | Percentage staff saying that they are satisfied with the extent to which their organisation values their work |
| 8 | Q31b | Percentage of staff with a long lasting health condition or illness saying their employer has made reasonable adjustment(s) to enable them to carry out their work |
| 9a | theme_engagement | The staff engagement score for staff with LTC or illness vs staff without a LTC or illness |

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

| | 2021 | 2022 | 2023 | 2024 | 2025 |
|---|---|---|---|---|---|
| Staff with a LTC or illness: Your org | 30.08% | 28.46% | 28.16% | 24.24% | 23.30% |
| Staff without a LTC or illness: Your org | 16.56% | 18.30% | 19.84% | 19.88% | 17.35% |
| Staff with a LTC or illness: Average | 24.14% | 25.13% | 22.56% | 24.24% | 19.90% |
| Staff without a LTC or illness: Average | 17.31% | 18.22% | 15.24% | 16.05% | 14.52% |
| Staff with a LTC or illness: Responses | 133 | 130 | 139 | 165 | 176 |
| Staff without a LTC or illness: Responses | 483 | 470 | 456 | 503 | 490 |

**Note**: 2023 results for WDES metric 4a (Q14a) are reported using corrected data. Please see https://www.nhsstaffsurveys.com/survey-documents/ for more details.

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

| | 2021 | 2022 | 2023 | 2024 | 2025 |
|---|---|---|---|---|---|
| Staff with a LTC or illness: Your org | 13.53% | 14.62% | 15.74% | 11.59% | 9.66% |
| Staff without a LTC or illness: Your org | 7.88% | 7.07% | 6.39% | 6.60% | 7.23% |
| Staff with a LTC or illness: Average | 16.56% | 15.22% | 13.30% | 13.87% | 14.17% |
| Staff without a LTC or illness: Average | 9.13% | 9.64% | 8.18% | 7.77% | 7.89% |
| Staff with a LTC or illness: Responses | 133 | 130 | 139 | 164 | 176 |
| Staff without a LTC or illness: Responses | 482 | 467 | 453 | 500 | 484 |

**Note**: 2023 results for WDES metric 4b (Q14b) are reported using corrected data. Please see https://www.nhsstaffsurveys.com/survey-documents/ for more details.

*Percentage of staff experiencing harassment, bullying or abuse from other colleagues in last 12 months:*

| | 2021 | 2022 | 2023 | 2024 | 2025 |
|---|---|---|---|---|---|
| Staff with a LTC or illness: Your org | 22.56% | 24.22% | 23.66% | 20.12% | 19.21% |
| Staff without a LTC or illness: Your org | 15.56% | 14.13% | 14.13% | 15.23% | 14.23% |
| Staff with a LTC or illness: Average | 26.53% | 24.22% | 21.83% | 25.12% | 23.94% |
| Staff without a LTC or illness: Average | 16.48% | 15.43% | 14.32% | 15.23% | 14.23% |
| Staff with a LTC or illness: Responses | 133 | 128 | 139 | 164 | 177 |
| Staff without a LTC or illness: Responses | 482 | 467 | 453 | 499 | 485 |

**Note**: 2023 results for WDES metric 4c (Q14c) are reported using corrected data. Please see https://www.nhsstaffsurveys.com/survey-documents/ for more details.

*Percentage of staff saying that the last time they experienced harassment, bullying or abuse at work, they or a colleague reported it:*

| | 2021 | 2022 | 2023 | 2024 | 2025 |
|---|---|---|---|---|---|
| Staff with a LTC or illness: Your org | 55.77% | 46.30% | 52.76% | 44.44% | 51.72% |
| Staff without a LTC or illness: Your org | 47.29% | 59.52% | 60.97% | 54.11% | 55.37% |
| Staff with a LTC or illness: Average | 54.00% | 54.17% | 51.09% | 53.15% | 53.57% |
| Staff without a LTC or illness: Average | 48.81% | 52.53% | 51.72% | 54.88% | 53.06% |
| Staff with a LTC or illness: Responses | 52 | 54 | 61 | 63 | 58 |
| Staff without a LTC or illness: Responses | 129 | 126 | 118 | 146 | 121 |

**Note**: 2023 results for WDES metric 4d (Q14d) are reported using corrected data. Please see https://www.nhsstaffsurveys.com/survey-documents/ for more details.

*Percentage of staff who believe that their organisation provides equal opportunities for career progression or promotion:*

| | 2025 |
|---|---|
| Staff with a LTC or illness: Your org | 51.41% |
| Staff without a LTC or illness: Your org | 54.18% |
| Staff with a LTC or illness: Average | 47.64% |
| Staff without a LTC or illness: Average | 57.77% |
| Staff with a LTC or illness: Responses | 177 |
| Staff without a LTC or illness: Responses | 491 |

**Note**: Due to changes in the question wording in 2025, previous years' results for WDES metric 5 (Q15) are not reported. Please refer to the Technical Guide: see https://www.nhsstaffsurveys.com/survey-documents/.

*Percentage of staff who have felt pressure from their manager to come to work, despite not feeling well enough to perform their duties:*

| | 2021 | 2022 | 2023 | 2024 | 2025 |
|---|---|---|---|---|---|
| Staff with a LTC or illness: Your org | 31.76% | 21.98% | 22.68% | 31.82% | 18.33% |
| Staff without a LTC or illness: Your org | 17.68% | 20.00% | 17.50% | 12.31% | 18.32% |
| Staff with a LTC or illness: Average | 29.79% | 26.57% | 25.66% | 24.40% | 25.20% |
| Staff without a LTC or illness: Average | 20.42% | 20.13% | 17.67% | 18.10% | 18.54% |
| Staff with a LTC or illness: Responses | 85 | 91 | 97 | 88 | 120 |
| Staff without a LTC or illness: Responses | 181 | 195 | 200 | 195 | 202 |

*Percentage of staff satisfied with the extent to which their organisation values their work:*

| | 2021 | 2022 | 2023 | 2024 | 2025 |
|---|---|---|---|---|---|
| Staff with a LTC or illness: Your org | 40.74% | 41.98% | 45.33% | 34.55% | 35.39% |
| Staff without a LTC or illness: Your org | 51.81% | 54.14% | 57.08% | 53.59% | 48.27% |
| Staff with a LTC or illness: Average | 39.09% | 39.91% | 40.56% | 40.67% | 38.50% |
| Staff without a LTC or illness: Average | 48.92% | 51.03% | 51.34% | 53.17% | 50.51% |
| Staff with a LTC or illness: Responses | 135 | 131 | 150 | 165 | 178 |
| Staff without a LTC or illness: Responses | 496 | 471 | 487 | 502 | 491 |

*Percentage of staff with a long lasting health condition or illness saying their employer has made adequate adjustment(s) to enable them to carry out their work:*

| | 2022 | 2023 | 2024 | 2025 |
|---|---|---|---|---|
| Staff with a LTC or illness: Your org | 84.81% | 84.62% | 83.53% | 82.29% |
| Staff with a LTC or illness: Average | 76.36% | 74.73% | 77.67% | 79.72% |
| Staff with a LTC or illness: Responses | 79 | 91 | 85 | 96 |

*Staff engagement score (0-10):*

| | 2021 | 2022 | 2023 | 2024 | 2025 |
|---|---|---|---|---|---|
| Organisation average | 7.35 | 7.43 | 7.50 | 7.40 | 7.07 |
| Staff with a LTC or illness: Your org | 7.13 | 7.04 | 7.21 | 6.99 | 6.58 |
| Staff without a LTC or illness: Your org | 7.44 | 7.55 | 7.60 | 7.55 | 7.23 |
| Staff with a LTC or illness: Average | 6.92 | 6.98 | 6.99 | 6.96 | 6.69 |
| Staff without a LTC or illness: Average | 7.37 | 7.26 | 7.42 | 7.39 | 7.33 |
| Staff with a LTC or illness: Responses | 135 | 131 | 150 | 166 | 178 |
| Staff without a LTC or illness: Responses | 498 | 472 | 493 | 505 | 490 |

**Note**: Data shown in this chart are unweighted therefore will not match weighted staff engagement scores in other outputs.

## Appendix 4: People Promise scores and themes compared to other providers

| People Promise theme | Res Rate | PP 1: We are compassionate and inclusive | PP 2: We are recognised and rewarded | PP 3: We each have a voice that counts | PP 4: We are safe and healthy | PP 5: We are always learning | PP 6: We work flexibly | PP 7: We are a team | Theme: Staff Engagement | Theme: Morale | QVH Position | QVH Position | QVH Position |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **2025** | **2025** | **Score** | **Score** | **Score** | **Score** | **Score** | **Score** | **Score** | **Score** | **Score** | **Above** | **Avg.** | **Below** |
| **National** | 51.65% | 7.33 | 5.95 | 6.63 | 6.12 | 5.63 | 6.31 | 6.8 | 6.75 | 5.9 | 7 | 2 | 0 |
| **Queen Victoria Hospital NHS Foundation Trust** | **56.02%** | **7.6** | **6.03** | **6.71** | **6.27** | **5.67** | **6.43** | **6.85** | **7.08** | **5.93** | | | |
| **East Sussex Healthcare NHS Trust** | 46.85% | 7.29 | 5.89 | 6.55 | 6 | 5.57 | 6.15 | 6.75 | 6.67 | 5.84 | 9 | 0 | 0 |
| **Sussex Community NHS Foundation Trust** | 66.54% | 7.9 | 6.57 | 7.11 | 6.58 | 6.18 | 7.21 | 7.31 | 7.22 | 6.34 | 0 | 0 | 9 |
| **Sussex Partnership NHS Foundation Trust** | 44.56% | 7.32 | 6.17 | 6.47 | 6.01 | 5.47 | 6.92 | 6.95 | 6.49 | 5.71 | 6 | 0 | 3 |
| **University Hospitals Sussex NHS Foundation Trust** | 47.01% | 7.24 | 5.89 | 6.51 | 6.02 | 5.63 | 6.39 | 6.75 | 6.68 | 5.88 | 7 | 2 | 0 |
| **Ashford & St Peter's Hospitals NHS Foundation Trust** | 51.42% | 7.35 | 6 | 6.79 | 6.27 | 5.78 | 6.39 | 6.86 | 7.02 | 6.04 | 2 | 4 | 3 |
| **Royal Surrey County Hospital NHS Foundation Trust** | 47.41% | 7.69 | 6.31 | 6.99 | 6.33 | 5.96 | 6.46 | 7.06 | 7.26 | 6.17 | 0 | 1 | 8 |
| **Surrey and Sussex Healthcare NHS Trust** | 52.54% | 7.34 | 5.99 | 6.64 | 6.2 | 5.72 | 6.24 | 6.93 | 6.84 | 5.96 | 5 | 2 | 2 |
| **2024** | **2024** | **Score** | **Score** | **Score** | **Score** | **Score** | **Score** | **Score** | **Score** | **Score** | **29** | **9** | **25** |
| **National** | 50.90% | 7.35 | 5.99 | 6.69 | 6.17 | 5.67 | 6.31 | 6.8 | 6.85 | 5.96 | 9 | 0 | 0 |
| **Queen Victoria Hospital NHS Foundation Trust** | **57.64%** | **7.8** | **6.3** | **7** | **6.5** | **5.9** | **6.6** | **7** | **7.4** | **6.2** | | | |
| **East Sussex Healthcare NHS Trust** | 50.38% | 7.16 | 5.9 | 6.56 | 6 | 5.7 | 6.16 | 6.74 | 6.7 | 5.85 | 9 | 0 | 0 |
| **Sussex Community NHS Foundation Trust** | 71.42% | 7.77 | 6.47 | 7.05 | 6.57 | 6.13 | 7.07 | 7.24 | 7.2 | 6.29 | 1 | 1 | 7 |
| **Sussex Partnership NHS Foundation Trust** | 57.51% | 7.37 | 6.32 | 6.62 | 6.12 | 5.59 | 6.92 | 7.06 | 6.69 | 5.86 | 6 | 1 | 2 |
| **University Hospitals Sussex NHS Foundation Trust** | 46.48% | 7.1 | 5.8 | 6.46 | 5.86 | 5.48 | 6.28 | 6.69 | 6.59 | 5.7 | 9 | 0 | 0 |
| **Ashford & St Peter's Hospitals NHS Foundation Trust** | 42.16% | 7.26 | 5.97 | 6.77 | 6.26 | 5.64 | 6.39 | 6.77 | 7.02 | 6.05 | 9 | 0 | 0 |
| **Royal Surrey County Hospital NHS Foundation Trust** | 43.86% | 7.61 | 6.23 | 6.98 | 6.27 | 6 | 6.43 | 7.11 | 7.29 | 6.12 | 7 | 1 | 1 |
| **Surrey and Sussex Healthcare NHS Trust** | 47.51% | 7.3 | 5.88 | 6.58 | 6.17 | 5.77 | 6.21 | 6.86 | 6.84 | 5.93 | 9 | 0 | 0 |
| | | | | | | | | | | | **50** | **3** | **10** |

## Appendix 5: All People Promise scores / sub-scores based on all elements and themes

| Section | Q | Description | Organisation 2025 | Organisation 2024 | Organisation 2023 | Organisation 2022 | Organisation 2021 |
|---|---|---|---|---|---|---|---|
| **PP 1: We are compassionate and inclusive** | PP1_1 | Compassionate culture sub-score | 7.6 | 7.9 | 8.0 | 7.9 | 7.9 |
| | PP1_2 | Compassionate leadership sub-score | 7.2 | 7.3 | 7.3 | 7.2 | 7.2 |
| | PP1_3 | Diversity and equality sub-score | 8.7 | 8.4 | 8.5 | 8.4 | 8.4 |
| | PP1_4 | Inclusion sub-score | 7.0 | 7.2 | 7.2 | 7.2 | 7.0 |
| | **PP1** | **We are compassionate and inclusive score** | **7.6** | **7.8** | **7.8** | **7.7** | **7.6** |
| **PP 2: We are recognised and rewarded** | **PP2** | **We are recognised and rewarded score** | **6.0** | **6.3** | **6.3** | **6.2** | **6.2** |
| **PP 3: We each have a voice that counts** | PP3_1 | Autonomy and control sub-score | 6.9 | 7.1 | 7.2 | 7.2 | 7.1 |
| | PP3_2 | Raising concerns sub-score | 6.5 | 6.8 | 7.0 | 7.0 | 7.1 |
| | **PP3** | **We each have a voice that counts score** | **6.7** | **7.0** | **7.1** | **7.1** | **7.1** |
| **PP 4: We are safe and healthy** | *PP4_1* | Health and safety climate sub-score | 5.4 | 5.7 | 5.8 | 5.7 | 5.7 |
| | PP4_2 | Burnout sub-score | 5.2 | 5.5 | 5.5 | 5.5 | 5.4 |
| | *PP4_3* | Negative experiences sub-score | 8.3 | 8.2 | 8.1 | 8.2 | 8.2 |
| | **PP4** | **We are safe and healthy score** | **6.3** | **6.5** | **6.5** | **6.5** | **6.4** |
| **PP 5: We are always learning** | PP5_1 | Development sub-score | 6.5 | 6.7 | 6.7 | 6.5 | 6.5 |
| | PP5_2 | Appraisals sub-score | 4.7 | 5.0 | 5.3 | 5.0 | 4.8 |
| | **PP5** | **We are always learning score** | **5.7** | **5.9** | **6.0** | **5.8** | **5.6** |
| **PP 6: We work flexibly** | PP6_1 | Support for work-life balance sub-score | 6.5 | 6.7 | 6.7 | 6.5 | 6.3 |
| | PP6_2 | Flexible working sub-score | 6.4 | 6.6 | 6.5 | 6.3 | 6.3 |
| | **PP6** | **We work flexibly score** | **6.4** | **6.6** | **6.6** | **6.4** | **6.3** |
| **PP 7: We are a team** | PP7_1 | Team working sub-score | 6.7 | 6.9 | 6.8 | 6.8 | 6.7 |
| | PP7_2 | Line management sub-score | 7.0 | 7.2 | 7.2 | 7.1 | 7.0 |
| | **PP7** | **We are a team score** | **6.9** | **7.0** | **7.0** | **7.0** | **6.9** |
| **Theme: Staff Engagement** | E_1 | Motivation sub-score | 6.9 | 7.3 | 7.3 | 7.3 | 7.2 |
| | E_2 | Involvement sub-score | 6.8 | 7.0 | 7.1 | 7.1 | 7.0 |
| | E_3 | Advocacy sub-score | 7.5 | 7.9 | 8.1 | 8.0 | 7.9 |
| | **E_4** | **Staff Engagement Score** | **7.1** | **7.4** | **7.5** | **7.4** | **7.4** |
| **Theme: Morale** | M_1 | Thinking about leaving sub-score | 6.1 | 6.5 | 6.7 | 6.4 | 6.3 |
| | M_2 | Work pressure sub-score | 5.3 | 5.7 | 5.7 | 5.5 | 5.6 |
| | M_3 | Stressors (HSE index) sub-score | 6.4 | 6.6 | 6.6 | 6.6 | 6.5 |
| | **M_4** | **Morale score** | **5.9** | **6.2** | **6.3** | **6.2** | **6.1** |

# Appendix 6: Team Response Rates

| | 2024 | | | 2025 | | | |
|---|---|---|---|---|---|---|---|
| Locality 4 | E | R | % | E | R | % | |
| *BOARD, STRATEGY & COMMUNICATIONS | * | * | * | 23 | 21 | 91.3% | |
| CHIEF MEDICAL OFFICER | N/A | N/A | N/A | 17 | 17 | 100.0% | |
| BUS DEVELOPMENT & PROCUREMENT | 17 | 16 | 94.1% | 20 | 14 | 70.0% | 2 |
| FINANCE & SNR MANAGEMENT | 15 | 12 | 80.0% | 22 | 19 | 86.4% | -7 |
| DIGITAL | 28 | 22 | 78.6% | 29 | 21 | 72.4% | 1 |
| BUILDING & ENGINEERING | 10 | 2 | 20.0% | 14 | 9 | 64.3% | -7 |
| DOMESTICS & PORTERING | 37 | 15 | 40.5% | 39 | 20 | 51.3% | -5 |
| OTHER ANCILLARY | 20 | 7 | 35.0% | 24 | 15 | 62.5% | -8 |
| HON & NURSE MANAGEMENT | 27 | 18 | 66.7% | 18 | 11 | 61.1% | 7 |
| MACMILLAN CENTRE | 15 | 12 | 80.0% | 14 | 11 | 78.6% | 1 |
| *PROFESSIONAL DEVELOPMENT & RISK | * | * | * | 15 | 11 | 73.3% | |
| HUMAN RESOURCES | 37 | 36 | 97.3% | 31 | 28 | 90.3% | 8 |
| *APPOINTMENTS, RTT & OP MNGT TEAMS | * | * | * | 23 | 15 | 65.2% | |
| *CANCER TEAM | * | * | * | 12 | 6 | 50.0% | |
| CDC | 15 | 10 | 66.7% | 19 | 12 | 63.2% | -2 |
| *COMMUNITY & PSYCHOTHERAPY | * | * | * | 13 | 5 | 38.5% | |
| HEALTH RECORDS | 18 | 13 | 72.2% | 18 | 10 | 55.6% | 3 |
| MINOR INJURIES UNIT | 13 | 6 | 46.2% | 13 | 7 | 53.8% | -1 |
| PHARMACY | 14 | 11 | 78.6% | 18 | 17 | 94.4% | -6 |
| THERAPIES | 53 | 33 | 62.3% | 53 | 35 | 66.0% | -2 |
| HISTOPATHOLOGY | 13 | 10 | 76.9% | 16 | 12 | 75.0% | -2 |
| MED PHOTOGRAPHY & RADIOGRAPHY | 52 | 27 | 51.9% | 50 | 32 | 64.0% | -5 |

| | 2024 | | | 2025 | | | |
|---|---|---|---|---|---|---|---|
| Locality 4 | E | R | % | E | R | % | |
| SLEEP STUDIES | 43 | 34 | 79.1% | 48 | 32 | 66.7% | -11 |
| CORNEOPLASTIC NURSING | 19 | 14 | 73.7% | 23 | 16 | 69.6% | 1 |
| CORNEOPLASTICS, EYE BANK & OPTICAL | 36 | 20 | 55.6% | 35 | 15 | 42.9% | -1 |
| HEAD & NECK WARD | 12 | 7 | 58.3% | 12 | 5 | 41.7% | 14 |
| PROSTHETICS LABORATORY | 14 | 5 | 35.7% | 16 | 6 | 37.5% | 15 |
| MAXILLOFACIAL | 56 | 22 | 39.3% | 64 | 21 | 32.8% | -12 |
| MAXILLOFACIAL NURSING | 28 | 17 | 60.7% | 30 | 15 | 50.0% | 5 |
| ORTHODONTICS | 22 | 13 | 59.1% | 26 | 11 | 42.3% | 4 |
| ANAESTHETICS | 37 | 22 | 59.5% | 38 | 17 | 44.7% | -6 |
| CRITICAL CARE UNIT | 26 | 11 | 42.3% | 23 | 16 | 69.6% | -5 |
| SITE PRACTITIONERS | 15 | 11 | 73.3% | 15 | 10 | 66.7% | 1 |
| PAEDIATICS | 25 | 19 | 76.0% | 24 | 13 | 54.2% | 15 |
| DAY SURGERY | 36 | 18 | 50.0% | 27 | 14 | 51.9% | 1 |
| PRE ASSESSMENT | 14 | 7 | 50.0% | 14 | 8 | 57.1% | -2 |
| RECOVERY | 17 | 11 | 64.7% | 18 | 4 | 22.2% | 8 |
| THEATRES | 103 | 47 | 45.6% | 116 | 53 | 45.7% | -48 |
| BURNS CENTRE | 33 | 23 | 69.7% | 32 | 22 | 68.8% | -12 |
| CANADIAN WING | 33 | 23 | 69.7% | 49 | 17 | 34.7% | -10 |
| MAIN OUTPATIENTS | 53 | 24 | 45.3% | 21 | 12 | 57.1% | 5 |
| PLASTIC SURGERY ADMIN | 19 | 12 | 63.2% | 35 | 21 | 60.0% | 14 |
| PLASTIC SURGERY M&D | 101 | 33 | 63.2% | 70 | 18 | 25.7% | -6 |
| | 1185 | 684 | 57.7% | 1237 | 694 | 56.1% | |

* unable to compare to 2024 as some teams changed directorates/localities

| Staff Group | Eligible | 2025 Responses | Response Rate | Difference | Eligible | 2024 Responses | Response Rate |
|---|---|---|---|---|---|---|---|
| Add Prof Scientific and Technic | 33 | 20 | **60.60%** | **-6** | 38 | 26 | **68.40%** |
| Additional Clinical Services | 175 | 94 | **53.70%** | **-5** | 175 | 99 | **56.60%** |
| Administrative and Clerical | 377 | 259 | **68.70%** | **-3** | 359 | 262 | **73.00%** |
| Allied Health Professionals | 98 | 65 | **66.30%** | **+12** | 97 | 53 | **54.60%** |
| Estates and Ancillary | 66 | 36 | **54.55%** | **+14** | 60 | 22 | **36.70%** |
| Healthcare Scientists | 41 | 26 | **63.40%** | **+10** | 28 | 16 | **57.10%** |
| Medical and Dental | 190 | 56 | **29.50%** | **-6** | 179 | 62 | **34.60%** |
| Nursing & Midwifery registered | 242 | 129 | **53.30%** | **-11** | 235 | 140 | **59.60%** |
| Students | 15 | 8 | **53.30%** | **+4** | 14 | 4 | **28.60%** |
| **Total** | 1237 | 693 | **56.10%** | **+9** | 1185 | 684 | **58%** |

**Key**: E=eligible and R=no of respondents

**Appendix 7: Staff Group Scores / Improvement Scores**

***Staff groups engagement scores:***
The best engagement scores were from the following staff groups:
- Healthcare Scientists (7.6) 63% (n=26) response rate
- Add. Clinical (7.2) 54% (n=94) response rate
- Medical & Dental (7.2) 29.5% (n=56) response rate
- Nursing (7.3) 53% (n=129) response rate

***Staff group headlines:***
- Allied Health Professionals (66% response rate n=65)) and Estates & Ancillary staff (55% n=36 response rate) have shown the largest drop in overall engagement (-0.6).
- Estates and Ancillary results have also dropped in involvement (5.4 vs 5.9) and advocacy (6.9 vs 7.7).
- Staff groups particularly thinking about leaving (Morale) include Allied Health Prof, admin and clerical (69% n=259 response rate) and estates staff. However, to note, the turnover for staff at QVH hasn't worsened during the reporting period.
- Age: 66+ age group results are higher than other groups including engagement (7.7 vs org average of 7.1). 21–30 continues to have the lowest overall scores including overall engagement scores (6.5 vs 7.1). Motivation in the 21-30 age range is below the Trust score (5.8 vs 7.1). Morale – thinking about leaving, is also a low score for the 21-30 age range (5.3 vs 6.1).
- Disability: Respondents with a long term illness or condition continue to be less engaged than those without across all areas. The highest sub-score is advocacy (7.1 vs 7.6).
- Ethnicity: Staff from a Mixed, Multiple, Asian, Asian British, Black, African, Caribbean, Black British or Other Ethnic Group are more engaged than those from a White background (7.6 vs 7.1). In particular, African (8.3), Pakistani (8.3) and Indian (8.4) staff are more motivated compared to White staff (6.8). African staff are also more involved than staff from a white background (8.4 vs 6.7).
- Gender identity: Male/female groups are comparable to organisation average but those who prefer not to say are less engaged than those who declare (5.4 vs 7.1).
- Sexual orientation: results have dropped slightly compared to 2024 (7.1 vs 7.1) for staff who declare as Bisexual (6.4) or who do not declare (5.9) are lower than those who declare as Heterosexual or Straight (7.2).
- Religion: Hindu (8.4) and Muslim (7.9) staff continue to be more engaged than other staff groups. In addition Hindu staff are more engaged in involvement (7.8 vs 7.0). Christian staff members (7.3) and those who specified no religion (6.9) were comparable to the organisation average although these groups have the largest demographic.
- Medical and Dental: The response rate for completion of the staff survey was lowest in the medical and dental staff group at 29.5% (n=56).
- Patterns of lower engagement and multiple below-average scores are most evident in Estates & Facilities, Corneo & Eye Bank, Plastics, Theatres and Commerce & Finance.

***Improvement scores:***
QVH maintained and improved some results including:
- Strong performance in Inclusion and Diversity, with the Diversity & Equality subscore remaining high (8.7) – feeds into the positive compassionate and inclusive theme (PP1)Survey
- Percentage of staff who felt pressure from their manager to come to work, despite not feeling well enough to perform their duties has significantly improved for staff who declare LTC or illness (18.3% (n=693) down from 31.8% (684)) in 2024 (equates to 91 people).

- Notable improvements in staff safety indicators, with increased staff reporting no harassment, bullying or physical violence (falling to 30.5% vs 35.4%) and higher rates of incident reporting (54.3% vs 50.2%) across QVH in 2025 (PP4 – We are Safe and Healthy)
- Mixed/ Multiple ethnic groups, Asian/ Asian British, Black/ African/ Caribbean/ Black British, Other ethnic groups consistently report higher engagement and satisfaction
- Question (6a) relating to "Role makes a difference" remains very strong (89.8% vs 87.8%) and feeds in to the positive compassionate and inclusive theme (PP1)
- Teamworking remains a cultural strength, with high scores for enjoying working with colleagues and PP7 ('We are a team') remaining aligned to benchmark averages
- Several directorates. including Diagnostics, HR, Sleep, and Board & Strategy continue to show high engagement and strong team cohesion relative to the Trust average
- Some of QVH's biggest improvements relate to violence and aggression and bullying and abuse (negative experiences sub-score). Q13a - not experienced physical violence from patients/service users, their relatives or other members of the public and q14a - not experienced harassment, bullying or abuse from patients/service users, their relatives or members of the public.

**Appendix 8: Summary of work undertaken in 2025 to support wellbeing and inclusion**

***Equality, Diversity and Inclusion (EDI) objectives:***

- Launching bespoke surveys to understand the unique experiences of our staff, such as the Wellbeing & Inclusion Survey 2025 and Neurodiversity and Apprenticeships Survey 2026. This has led to specific development opportunities being commissioned.
- Overhaul of our Equality Impact Assessment process and documents to embed co-design principles and emphasise the value of collaboration and lived experience in identifying impacts and correcting historic non-inclusive practices.
- Supporting formation of QVH's Armed Forces Network, working collaboratively with the Network Chair to embed governance, establish aims and advocate for member needs. Applying for the silver award for the Defence Employer Recognition Scheme (currently have bronze level award).
- Launching the first annual QVH Sexual Safety Report, with the aim to monitor and evaluate progress against the NHS England Sexual Safety Charter. The trust are now over 90% compliant with the self-assessment which monitors adherence to the charter.
- Collaboration with the Trusts' catering team to develop a schedule of cultural celebration-based menus that reflect the diversity of our staff, patients and local community, with positive feedback being received from staff and patients.
- Delivering EDI training as part of the QVH Care Certificate programme to support inclusivity and positive behaviours.
- Visual awareness workshops delivered internally for staff and successfully bid for and delivered Sign Language Level 1 training following patient feedback to support knowledge and skills and enhance patient care.

***Health and wellbeing initiatives:***

- Publication of the Trust's Managing Stress and Wellbeing at Work Policy and associated line manager's guide to manage work-related stressors, which has received positive feedback in relation to ease of understanding.
- Menopause Cafes for staff facilitated by Wellbeing and Inclusion Manager to support staff and their wellbeing and provide more knowledge for all staff.
- Launching monthly newsletters and bulletins in digital and print formats to increase awareness and reach of QVH's staff wellbeing offer.
- Promoting staff wellbeing options in the QVH Care Certificate Programme to ensure staff are aware of what's available across the trust.
- Developing bespoke cultural listening exercises in teams that have identified wellbeing and inclusion challenges, providing psychologically safe space for staff to share experiences of their departments, where positive practices can be nurtured and where improvements can be made. Positive outcomes have been reported following team and 1-2-1 developments.
- Launching the Managers' Essentials Programme, with specific modules dedicated to developing inclusive and compassionate cultures. Feedback has been positive, with managers feeling more equipped to undertake their roles and support their staff.

***Culture and retention work:***

- A culture diagnostic was completed and presented to the Trust Board in 2025 using triangulated data from the 2024 staff survey, the People Pulse results, listening to action focus groups, staff wellbeing and inclusion survey and WRES and WDES findings. An updated diagnostic will be undertaken in Q2 of 2026.
- Workshops promoting the behavioural framework and toolkit delivered to staff to enhance a positive culture and support challenging of poor behaviours.
- Managing and leading change workshops offered to all staff alongside other initiatives to support the current changes underway, including resilience workshops.
- The Speak Up service from the Guardian Service promoted through Team Talk, screensavers and Connect, with guardian attendance to promote the service at meetings and induction.
- Continuous improvement (CI) programme (The QVH Way) continues across the organisation and is communicated at Corporate Induction via a new video. This links to staff having a voice and being able to make suggestions.

- Apprenticeships and widening participation continue to be offered to support recruitment and retention in needed areas, with an ongoing focus to increase diversity of apprentices.
- HR continues to undertake culture reviews across some of the Trust directorates. From these there is development and support in place for managers and their teams to improve workplace wellbeing.

| Report cover-page | | | | | |
|---|---|---|---|---|---|
| **References** | | | | | |
| **Meeting title:** | Board of Directors | | | | |
| **Meeting date:** | 14/05/2026 | | **Agenda reference:** | **08-26** | |
| **Report title:** | Annual assessment of addressing Health Inequalities | | | | |
| **Sponsor:** | Liz Blackburn, Acting Chief Nursing Officer | | | | |
| **Author:** | Ellie Winter, Strategy Programme Manager | | | | |
| **Appendices:** | None | | | | |
| **Executive summary** | | | | | |
| **Purpose of report:** | To provide the Board with an update on progress against the Trust's 2025/26 Health Inequalities priorities, highlight areas of assurance, and set out proposed priorities for 2026/27. | | | | |
| **Summary of key issues** | • Good progress has been made in 2025/26 to strengthen the foundations for addressing health inequalities, including improved ethnicity data completeness, development of the Health Inequalities Dashboard, and increased visibility of variation in access by deprivation and demographic factors.<br>• The programme has primarily focused on building data, insight and capability; translation into measurable improvements in patient outcomes is now the key priority for 2026/27.<br>• Proposed priorities for 2026/27 focus on reducing inequalities in access, improving data quality and digital capability, building workforce capability, and improving accessibility for patients with additional needs. | | | | |
| **Recommendation:** | The Board is asked to **note** the content of this report, including the health inequalities priorities for 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:** | None | | | | |
| **Organisational risk register:** | None | | | | |
| **Regulation:** | None | | | | |
| **Legal:** | None | | | | |
| **Resources:** | | | | | |
| **Assurance route** | | | | | |
| **Previously considered by:** | ECQR<br>Quality & Safety Committee | | | | |
| | Date: | 20/04/2026<br>05/05/2026 | Decision: | Noted | |
| **Next steps:** | | | | | |

**Report to:** Board of Directors
**Agenda item:** 08-26
**Date of meeting:** 14 May 2026
**Report from:** Liz Blackburn, Acting Chief Nursing Officer
**Report author:** Ellie Winter, Strategy Programme Manager
**Date of report:** 08 April 2026
**Appendices:** None

## Assessment of addressing Health Inequalities: Q4 and Year-End Report


### Executive Summary

This report provides a year-end assessment of progress against Queen Victoria Hospital's (QVH) 2025/26 Health Inequalities priorities and sets out proposed priorities for 2026/27.

During 25/26, the Trust has made significant progress in strengthening the foundations required to address health inequalities. This includes improvements in ethnicity data completeness, development of the first Health Inequalities Dashboard, and enhanced understanding of variation in access, experience and outcomes across different population groups.

Key achievements include:

- A 4.1 percentage point improvement in ethnicity data completeness (year average), although performance remains below the Trust's ambition of 95%
- Development of analytical capability to identify variation in access, including DNAs and long waits by deprivation, age, gender and ethnicity
- Identification of a deprivation gradient in key data areas
- Progress in system collaboration, including sharing of data insights and co-production approaches
- Executive approval of a co-produced Health Inequalities Learning Resource to support workforce capability

The year has primarily focused on establishing the data, insight and infrastructure required to understand inequalities. While this represents a significant step forward, translation into measurable improvements in patient outcomes is now a key priority for 26/27. Therefore upcoming focus is on moving from insight to action, embedding data into routine reporting, targeting actions to tackle identified inequalities in access, strengthening workforce capability, and improving accessibility for patients with additional needs.


### Background

QVH's Health Inequalities Programme forms part of the Trust's statutory duty to reduce inequalities in access, experience and outcomes, aligned with the NHS Long Term Plan, Core20PLUS5 framework, and the Sussex Integrated Care Strategy.

The Trust's 2025/26 priorities focused on:

- Ethnicity data collection
- Variation in long waiters
- Did Not Attend (DNA) and cancellations
- Cancer staging and late presentation
- Making Health Inequalities Everyone's Business
- Accessible Information Standard (AIS) compliance

Progress against these priorities has been monitored through the Health Inequalities Steering Group and reported quarterly to the Executive Committee for Quality and Risk.

**Progress against 2025/26 priorities**

**1. Ethnicity Data Collection**
Significant progress has been made in improving the completeness of ethnicity data, strengthening the Trust's ability to identify and address inequalities. Ethnicity data completeness improved from an average of 79.8% in 2024/25 to 83.9% in 2025/26, representing a 4.1 percentage point increase. Performance plateaued toward the end of the year, with a slight reduction to 83.9% in March 2026.

Improvement was driven through structured continuous improvement activity, including organisation-wide task and finish groups using A3 continuous improvement methodology to identify root causes and target actions across services and patient pathways. A targeted communications campaign supported both staff and patients, including guidance on how to ask about ethnicity and materials explaining the purpose of data collection. These resources have been adopted by other Sussex providers, demonstrating wider system impact.

Improvement has not yet been fully sustained and remains influenced by consistency of practice. Digital system limitations, including the inability to mandate data entry, continue to constrain progress. As such, this priority remains foundational, with further work required to achieve the ICB and Trust's ambition of 95%.

**2. Variation in Long Waiters**
During 2025/26, the Trust developed its capability to analyse variation in waiting times across different population groups. For the first time at QVH, RTT data has been analysed by age, gender, ethnicity and deprivation, enabling a more comprehensive understanding of inequalities in access to elective care.

Analysis indicates:

- No consistent evidence of variation in long waits by ethnicity, age or gender
- A clear deprivation gradient, with patients from more deprived communities more likely to experience longer waits

This aligns with emerging national evidence highlighting inequalities in elective access between more and less deprived populations.

The year has focused on establishing visibility and understanding of variation. The Trust is now positioned to move into targeted action to address identified inequalities in waiting times.

**3. Did Not Attend (DNA), Cancellations and WNBs**
The development of the Health Inequalities Dashboard has enabled, routine analysis of attendance patterns by demographic factors. Analysis has identified:

- A clear deprivation gradient, with higher DNA rates among patients from more deprived communities
- Higher DNA rates among working-age adults, consistent with national trends
- No significant variation in paediatric or older patient groups
- No meaningful variation by gender

These findings highlight that deprivation is the primary driver of inequality in attendance, rather than age or gender. 2025/26 has focused on building the evidence base and analytical capability required to understand these patterns. This provides a strong platform for targeted interventions in 2026/27.

**4. Cancer Staging and Late Presentation**
The Trust has maintained a strong performance in cancer staging data completeness, consistently achieving top quartile performance across 2025/26 (this continues into 2026/27). Staging data has

been shared with primary care partners to support earlier identification of patients at risk of late presentation, particularly within head and neck cancer pathways.

In addition, work has been undertaken to improve patient information and self-management support, including development of educational content via the Patient Knows Best platform. This priority has now reached a level of maturity where it can transition into business as usual, with ongoing monitoring and system collaboration continuing as part of routine delivery.

**5. Making Health Inequalities Everyone's Business**

Progress in embedding health inequalities into everyday practice has been varied during 2025/26. Early activity focused on exploratory approaches, including task and finish groups linked to ethnicity data improvement. While this supported awareness within specific workstreams, it did not deliver a sustainable organisation-wide approach.

In Q4, significant progress was made in establishing a more structured approach. Work was undertaken to develop and secure approval for a co-produced Health Inequalities Learning Resource. This included development of a project framework, governance, participant model and funding approach, using an Experience-Based Co-Design methodology to ensure the training is grounded in lived experience. Executive Leadership Team approval was secured in March 2026 to proceed with the project. In parallel, the Trust has contributed to a Sussex-wide training programme focused on improving protected characteristic data collection.

This work establishes a strong foundation for embedding health inequalities into everyday practice, with delivery of the training programme planned for 2026/27.

**6. Accessible Information Standard (AIS) Compliance**

Progress on Accessible Information Standard (AIS) compliance has focused on establishing governance, improving staff awareness, and identifying opportunities to better capture and respond to patients' communication needs. AIS was recognised as a key priority aligned to improving patient experience and safety, particularly for patients with sensory impairments, learning disabilities and language barriers. Initial work centred on embedding AIS considerations into existing processes and systems, including leveraging process mapping from the EPR rollout to identify points in the patient pathway where communication needs can be captured and acted upon.

Progress has included strengthening governance and engagement through the Additional Needs Forum, with representation from roles such as the Eye Care Liaison Officer (ECLO), providing specialist insight into the needs of visually impaired patients. Training resources were also identified via the eLearning for Health platform to support staff in confidently asking patients about their communication needs and applying appropriate adjustments. Early engagement with administrative teams indicated increasing confidence in having these conversations, building on learning from ethnicity data collection initiatives.

Delivery remains ongoing, with further work required to translate AIS work into consistent, measurable improvements in patient experience and accessibility across services.

**Priorities for 2026/27**

In 2025/26, the Trust established the data, insight and infrastructure required to identify inequalities in access, experience and outcomes. Priorities for 2026/27 will focus on translating this insight into targeted action and measurable improvement.

1. **Reduce Inequalities in Access to Care**

**Outcome:** Reduction in unwarranted variation in access to care, demonstrated by a narrowing of the gap between the most and least deprived populations.

**Mechanism:** Use data from the Health Inequalities Dashboard and IQPR to target operational improvement, supported by outpatient transformation initiatives and pathway-level interventions.
**Metric:** Reduction in gap between IMD deciles for DNA rates, Cancellations and Long waits (52+ weeks)

2. **Strengthen Data Quality and Digital Capability**

**Outcome:** Improved completeness and usability of demographic data to support identification and monitoring of inequalities.
**Mechanism:** Deliver ethnicity data improvement plan, embed health inequalities requirements into PAS optimisation, and strengthen integration of metrics into IQPR.
**Metric:** Ethnicity data completeness ≥95%, reduction in unknown/not stated data, and routine reporting of inequalities metrics within IQPR

3. **Build Workforce Capability**

**Outcome:** Increased staff capability to recognise and respond to inequalities in practice.
**Mechanism:** Deliver co-produced Health Inequalities Learning Resource and embed within workforce development.
**Metric:** Delivery of training programme, staff engagement and feedback, evidence of use in improvement activity and service development

4. **Improve Access for Patients with Additional Needs**

**Outcome:** Improved accessibility of services and information for patients with additional needs.
**Mechanism:** Identify and address key accessibility gaps, align with AIS workstreams, and continue rollout and optimisation of Patient Knows Best.
**Metric:** Increased availability of accessible information, uptake of digital resources, patient and staff feedback

**Recommendation**
The Board is asked to **note** the progress made against the Trust's 2025/26 Health Inequalities priorities and the Health Inequalities priorities for 2026/27.

| Report cover-page | | | |
|---|---|---|---|
| **References** | | | |
| **Meeting title:** | Trust Board | | |
| **Meeting date:** | 14/05/2026 | **Agenda reference:** | 09-26 |
| **Report title:** | Integrated Quality and Performance Report Month 11 | | |
| **Sponsor:** | Kirsten Timmins, Chief Operating Officer | | |
| **Author:** | Allison Hunter, Strategy and Partnership Project Support Officer | | |
| **Appendices:** | Appendix – Integrated Quality and Performance Report (IQ&PR) M11 slide pack | | |
| **Executive summary** | | | |
| **Purpose of report:** | To discuss the Month 11 Integrated Quality and Performance Report 2025/26 | | |
| **Summary of key issues:** | **KSO1** - The Trust continues to prioritise cancer services and urgent and emergency care, ensuring patients with the most urgent needs receive timely and safe treatment. However, challenges remain in elective care waiting times.<br>• The Trust did not meet the year end plan for RTT. The Trust was 0.5% below plan for 18ww RTT performance (61.85 vs 62.3%), and while the number of patients waiting over 52 weeks reduced in 2025/26 from 397 in April 25 to 226 at end March 2026, the trust was 0.1% off plan for 52ww (1.1% vs 1%).<br>• For 65ww, the Trust had 31 patients at the end of March waiting over 65 weeks. 23 of these patients were within breast service, 8 were in other services. Of the 8 in non-breast services, 2 were late referrals within dermatology received over 52 weeks, 1 was a facial palsy referral received over 52 weeks, 3 patients due to pathway delays including one complex safeguarding case, one patient in OMFS delayed by the prison service, and a further patient in OMFS who had an incorrect clock stop applied.<br>• Key areas of focus to recover performance in RTT by the end of Q1 is on improving visibility, oversight and consistency of patient tracking and pathway management to enable earlier identification and escalation of patients at risk of delay to their treatment.<br>• The Trust exceeded the cancer performance targets for the year end. At the end of M12, 73 patients (10.7% of the cancer PTL) had waited over 62 days, including 24 patients waiting over 104 days. The trust remains focussed on increasing the proportion of patients treated within the 62-day standard, reducing avoidable delays at key pathway stages, including diagnostic turnaround, multidisciplinary team (MDT) review, and treatment scheduling. Clinical harm reviews continue to be undertaken for all patients waiting over 62 days, and no harm was identified during this period.<br>• Urgent and Emergency Care performance remains strong and above national standards<br>• Waiting times for diagnostic tests remained stable and delivered 89% at year end, supporting faster diagnosis and treatment.<br><br>**KSO 2** – Research governance is on track against strategy.<br>• Draft Quality Priorities for 2026/27 which are aligned to Trust key strategic objectives (KSOs) including outcomes measurement, health inequalities and a patient school, are in consultation.<br>• Draft Audit Plan for 2026/27 aligned to national and local requirements and objectives has been produced and quarterly measures for improvement are being identified.<br>• Continuous improvement programme extended using NHS Impact Team to train operational staff delivering key improvements. Refresh of improvement huddles following ward relocations is underway.<br>• Following an improvement project a new database has been established to support resident doctors. There has been investment in Specialty, Associate Specialist, and Specialist (SAS) doctor development with good feedback and, QVH has delivered bespoke regional plastic surgical training using cadavers | | |

<table>
<tr><td></td><td colspan="5">KSO 3 – There was a decrease in temporary staffing use in M11 compared to M10. Bank usage decreased by 3.4 whole time equivalent (WTE) and agency by 1.5 WTE. The highest bank usage was in peri-operative, mainly due to additional weekend theatre lists. Bank and agency increased in M12, which was forecast in the plan (bank +14.57 WTE; agency +0.57 WTE).<br><br>Sickness absence remained at 4.1%, driven by long-term cases. In M11, 1.96% of overall Trust sickness absence is short term and 2.15%is long term. There was a marginal increase in sickness to 4.2% in M12, with long-term absence continuing to be the driver of this.<br><br>Time to hire increased in M11 to an average of 44.7 days. This was a range from 8 days to 96 days. The increase was due to an overseas reference taking time to be verified and a medical appointee taking time to provide references. In M12 this increased to 50.4 days, with 4 applicants taking 72-96 days due to various onboarding queries, and an applicant subsequently withdrawing. Removing these 4 would have given a time to hire of 28.4 days in M12.<br><br>Appraisal completion decreased from 81.7% in M10 to 80.3% in M11. The number of appraisals outstanding >3 months increased to 129 in M11. In M12, completion increased to 83%, with overdue appraisals decreasing by 30. There is focussed leadership from Executive Directors and triumvirate leadership teams to improve this position.<br><br>There has been a wide range of inclusion and wellbeing initiatives undertaken, including promoting the QVH Progress Pride Pledge, strengthening post-incident staff support, advancing compliance with the NHSE Sexual Safety Charter (at 91% in April 2026) developing the Armed Forces Network, creating Ramadan guidance, and arranging Menopause and Trans-Inclusive Healthcare workshops.<br><br>KSO 4 – At the close of February 2026, the Trust reported an Income and Expenditure position slightly ahead of the planned position and had a cash balance of £19.4m. For the full year the Trust delivered a breakeven position. This was adjusted to a £1.6m surplus following the reallocation of deficit support funding from systems who did not achieve their plan.<br><br>Archie Electronic Patient Record (EPR) optimisation, planning for PAS migration and other priority digital transformation activity is progressing.</td></tr>
<tr><td>Recommendation:</td><td colspan="5">The Trust Board is requested to review the Month 11 IQ&PR position</td></tr>
<tr><td>Action required</td><td>Approval</td><td>Information</td><td>Discussion</td><td>Assurance</td><td>Review</td></tr>
<tr><td rowspan="2">Link to key strategic objectives (KSOs):</td><td>KSO1:</td><td>KSO2:</td><td>KSO3:</td><td>KSO4:</td><td>KSO5:</td></tr>
<tr><td>To deliver outstanding care</td><td>To innovate and improve</td><td>To be an excellent employer</td><td>To deliver sustainable services</td><td>To collaborate with others</td></tr>
<tr><td colspan="6">Implications</td></tr>
<tr><td colspan="2">Board assurance framework:</td><td colspan="4">BAF 1 – Outstanding patient Care.<br>BAF 4- long term sustainability (the IAF supports the delivery of the Trust's strategy<br>BAF5- compliance</td></tr>
<tr><td colspan="2">Organisational risk register:</td><td colspan="4">The IQPR reflects the risks on the organisational risk register.</td></tr>
<tr><td colspan="2">Regulation:</td><td colspan="4">ICS, NHS England, CQC</td></tr>
<tr><td colspan="2">Legal:</td><td colspan="4">None</td></tr>
<tr><td colspan="2">Resources:</td><td colspan="4">None</td></tr>
<tr><td colspan="6">Assurance route</td></tr>
<tr><td colspan="2">Previously considered by:</td><td colspan="4">Finance and Performance Committee<br>Quality and Safety Committee</td></tr>
</table>

| | Date: | 05/05/26 | Decision: | Progress to Board |
|---|---|---|---|---|
| **Next steps:** | N/A | | | |

KSO 1

To deliver outstanding care

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

QVH

KSO 2

To innovate and improve

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

QVH

KSO 3

To be an excellent employer

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

QVH

KSO 4

To deliver sustainable services

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.

QVH

KSO 5

To collaborate with others

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.

QVH

Queen Victoria Hospital

# Integrated Quality and Performance Report

**Month 11: March 2026**

# BALANCED SCORECARD

| 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 | Feb-26 | £0.49m (deficit) | £0.28m (deficit) | £0.13m (deficit) | The Trust's Income and Expenditure position was favourable to the planned in month surplus (£0.21m) | |
| RTT> 52 weeks as a proportion of waiting list | 1% | Feb-25 | 1.20% | 1.27% | 1.29% | Not achieving target in month, delivery of year-end target off plan. | |
| Cancer 62 days | 75% | Jan-26 | 71.0% | 74.86% | 73.20% | Achieving target in month. Common cause – no significant change | |
| % Overall FFT Recommendation Rate | 90% | Feb-26 | 90% | 94.53% | 94.77% | Achieving target. Special cause - concerning variation. | |
| Trust vacancy rate (excluding bank and agency) | 8% | Feb-26 | 7% | 6.4% | 6.8% | 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)<br>On track (Bognor) | | Steel works completed and slab works in progress on East Grinstead site. Engagement continues with University of Chichester regarding next steps for the Bognor site. |
| To deliver the Sussex Pathology Network Programme | | On revised schedule | | On track for revised schedule, further delay remains a risk. |
| To implement year one of the Electronic Records Programme (EPR) | | PAS timescales at risk | | Optimisation and Patient Administration system (PAS) activities have commenced. PAS go live for November at risk with a number of workstreams including BI, data migration and integration. |

# CEO SUMMARY

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**

- For patients on a Referral to Treatment (RTT) waiting list, the Trust was behind plan in reducing the number of patients waiting over 18 weeks, and reducing the proportion of patients over 52 weeks awaiting treatment. The Trust continues to have over 65 week waits in breast reconstruction and in other services outside of breast and did not meet the M11 trajectory for 65ww due to pathway delays and late tertiary referrals. Risks remain for year end delivery of 52ww, 65ww and 18 week performance due to late external referrals, oncology demand, and reduced capacity linked to consultant annual leave. The Trust is focussed on bringing forward treatment dates for patients wherever possible, increasing validation of all pathways and scheduling additional activity to meet demand.
- In M10 the Trust cancer performance improved against both the Faster Diagnosis Standard and 62 day treatment standard, meeting the trust plan. The Trust continues to have a high proportion of patients which have been waiting over 62 days (11.8%) due to complexity, late referrals, patient choice and capacity challenges. The Trust is working closely with the Surrey and Sussex Cancer Alliance and spoke site trusts to review pathway improvements and capacity to provide more timely treatment for patients.
- Community Diagnostic Centre (CDC) activity continues to be behind plan in M11 with reduced levels of demand in some modalities. The year to date (YTD) position for CDC as at M11 was 82% 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. The Trust has agreed a revised CDC activity plan for 2026/27.
- Ethnicity recording for February is 84.46%, a slight increase from January which was 84.21%, and remains below the Trust target of 95%.
- Venous Thromboembolism (VTE) assessment compliance has significantly dropped to 53% this decrease continues to be driven by a change in process through the introduction of the Trust EPR and changes to the process in the VTE assessment. Risk of harm is being actively monitored and none have been identified to date.

**Assure**

- The Trust achieved the planned performance trajectories for RTT first appointment in 18 weeks, Urgent and Emergency Care (UEC) performance in our Minor Injuries Unit, Cancer Faster Diagnosis Standard (FDS) and Cancer 62 day performance.
- Archie Electronic Patient Record (EPR) optimisation and planning for Patient Administration System (PAS) migration together with other priority digital transformation activity is underway. November go live for Patient Administration System (PAS) at risk due to data migration, integration, and BI/Reporting

**Advise**

- From a partnership perspective the Royal Surrey NHS Foundation Trust and Ashford and St Peter’s Hospitals NHS Foundation Trust (RSFT/ASPH) group, provides an established way of working that is aligned with the QVH intention to enhance our sustainability whilst retaining our specialist role. A period of shared planning, analysis and assurance is now underway to make sure a new partnership will provide a credible route to sustainability, resilience, and strategic integration, while preserving and improving each organisations’ identity and specialisms. This phase is important as it aligns with good governance, where specific processes need to be followed to ensure each Board has the necessary assurance in place in order to finalise next steps.
- The Trust’s Income and Expenditure year to date (YTD) position was slightly favourable with the plan and had a cash balance of £19m. The main risks remain the delivery of better 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.
- The 2025 staff survey results will be available from March 2026. Excel data tables, posters, and other resources will be shared with senior leaders and departmental managers. Workshops will be provided by the Organisational Development team from April 2026 to support managers with their prioritisation of areas of focus for their teams.
- Negotiations continue with University of Chichester on Heads of Terms for the Bognor CDC programme. The steel framework installation has been completed and the laying of concrete at the East Grinstead Community Diagnostic Centre (CDC) site is in progress.
- Work continues to progress to develop the single point of access for elective services across Sussex. This will enable digital patient pathway development for a number specialities, including Ear, nose and throat (ENT).

**Abigail Jago**
Acting Chief Executive Officer

# KEY STRATEGIC OBJECTIVES – SUMMARY

## KSO1

- The Trust was on plan for cancer performance and urgent and emergency care, and diagnostics performance improved compared to the previous month.
- For patients on a RTT waiting list, the Trust was behind plan in reducing the number of patients waiting over 18 weeks, and reducing the proportion of patients over 52 weeks awaiting treatment. The Trust continues to have long waits over 65 weeks in breast reconstruction and in other services outside of breast. Risks remain for year end delivery of 52ww, 65ww and 18 week performance due to late external referrals, oncology demand, and reduced capacity linked to consultant annual leave. The Trust is focussed on bringing forward treatment dates for these patients wherever possible.
- M11 income (excluding CDC) delivered 97.90% of plan. CDC activity remains below plan, with a year-end forecast of c.80% income vs plan. The Trust remains on plan to deliver a break-even position taking in to account the CDC shortfall in income. Transformation work in CDC continues, including eRS go-live which should make it easier for primary care to make referrals to QVH CDC pathways.

## KSO2

- Research governance is on track against strategy. Enhanced process to ensure timely opening of and recruitment to clinical trials has been put in place.
- Draft Quality Priorities for 2026/27 which are aligned to Trust key strategic objectives (KSOs) including outcomes measurement, health inequalities and a patient school, are in consultation.
- Draft Audit Plan for 2026/27 aligned to national and local requirements and objectives has been produced and quarterly measure for improvement are being identified.
- Training for 25 operational staff by NHS Impact team to support improvement approach in addressing Trust priorities. Refresh of improvement huddles following ward relocations is underway.
- Following an improvement project a new database has been established to support resident doctors. There has been investment in Specialty, Associate Specialist, and Specialist (SAS) doctors' development with good feedback. Bespoke training for Kent, Surrey and Sussex (KSS) plastic surgeons including cadaveric teaching at Guildford and Brighton has been led by the Trust for the region.

## KSO3

- There was a decrease in temporary staffing use in M11 compared to M10. Bank usage decreased by 3.4 whole time equivalent (WTE) and agency by 1.5 WTE. The highest bank usage was in peri-operative, mainly due to additional weekend theatre lists. Sickness absence remained at 4.1%, driven by long-term cases. In M11, 1.96% of overall Trust sickness absence is short term and 2.15% is long term.
- The Trust's time to hire increased in M11 to an average of 44.7 days. This remains below the key performance indicator (KPI). In M11 this was a range from 8 days to 96 days. The increase was due to an overseas reference taking time to be verified and a medical appointee taking time to provide references. By removing these, the average time to hire would have been 36.89 for M11.
- Appraisal completion decreased from 81.7% in M10 to 80.3% in M11. The number of appraisals outstanding >3 months increased to 129 in M11. With logging of appraisal completion now being via ESR Manager Self Service, there is data cleansing being undertaken to ensure reporting is accurate.
- There has been a wide range of inclusion and wellbeing initiatives undertaken, including promoting the QVH Progress Pride Pledge, strengthening post-incident staff support, advancing compliance with the NHSE Sexual Safety Charter, developing the Armed Forces Network, creating Ramadan guidance, and arranging Menopause and Trans-Inclusive Healthcare workshops.

## KSO4

- At the close of February 2026, the Trust reported an Income and Expenditure position slightly ahead of the planned position and had a cash balance of £19.4m. 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, planning for PAS migration and other priority digital transformation activity is progressing.
- Freedom of Information (FOI) requests responded to within 20 days decreased in M11 report to 78.7% compared with 82.4% at M10.

## KSO5

- The steel framework installation has been completed and the laying of the concrete 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.
- Work continues to progress to develop the single point of access for elective services across Sussex. This will enable digital patient pathway development for a number specialities, including ENT.

# 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

**Health inequalities**
Ethnicity recording showed a small increase in M11. The Trust is part of Sussex ICB led improvement work focussed on training staff on the importance of recording ethnicity data. The Trust has also approved the development of Experience-based Co-design (EBCD) Health Inequalities learning resource. This aims to improve equitable access, experience and outcomes by strengthening staff understanding of how inequalities appear in care.

**Quality and safety**
Venous Thromboembolism (VTE) assessment compliance noted a significant deterioration to 53%, this decrease continues to be driven by a change in process through the introduction of the Trust Electronic Patient Record (EPR) and changes to the process in the VTE assessment. A task and finish group has been created with both clinical staff and members of the EPR team. Live dashboards continue to flag VTE compliance within inpatient areas where compliance is high. Risk of harm is being actively monitored and none have been identified to date.

There is a special cause of variation noted in the Trust overall Friends and Family Test (FFT) recommendation rate, this aligns with the increase noted in complaints as compared to previous years and is a national trend. FFT results are fed back to the service leads and staff are being empowered to encourage patients to respond.

Compliance with complaints being responded to within the 30 day timeframe has reduced slightly, this is driven by the delay in the response to one complaint due to annual leave.

**Children's model**
The Children's Model Task & Finish group is drawing together a full suite of evidence including evaluation against standards, review of overnight longitudinal trends, quality and equality impact assessments, safeguarding perspectives, and outputs of consultation work. This will be aligned to the Trust's strategic direction with adaptations to ensure children and young adults in need of specialist intervention have continuity in getting the care they need. Final outputs from this task and finish work will be presented in May 26.

**Activity and Access standards**
From an operational performance perspective, the Trust was on plan for Cancer performance and Urgent and Emergency Care. For patients on a RTT waiting list, the Trust was behind plan in reducing the number of patients waiting over 18 weeks, over 52 weeks and over 65 weeks awaiting treatment.

**Elective Care**- Performance against the RTT 18-week incomplete standard was 0.1% below plan and the Trust missed the 52ww trajectory by 3 patients (255 vs trajectory of 252). In M11, the Trust had 48 patients waiting in excess of 65 weeks against a forecast trajectory of 46 patients, with 12 patients waiting in excess of 78 weeks. 43 patients were awaiting treatment within Plastic surgery (14 of whom were outside breast reconstruction) and 5 patients were awaiting Oral and Maxillofacial services (OMFS). These patients have waited in excess of 65 weeks due to a combination of cancer demand, late external referrals, and capacity constraints internal to the trust. Services continue to prioritise bringing treatment dates forward wherever possible. Meeting the year end targets for RTT remains at risk due to staff sickness, annual leave, late referrals from external providers, cancer demand, and pathway delays. All services continue to focus on validation, strengthening oversight of the Patient Tracking List (PTL), scheduling weekend activity, and progressing pathway improvement initiatives to improve the timeliness with which patients can access our services.

The Trust has patients waiting for specialist services which are not on an RTT pathway. At the end of M11, there was 187 patients waiting for immediate provision, replacement or revision of a maxillofacial prosthesis, appliance, or custom-made medical device, with the longest waiter at 162 weeks. The Trust has requested mutual aid from other trusts, but those trusts are also facing their own challenges with long waits. The Trust had 338 patients on waiting lists for a first consultation within therapist led clinics, with the longest wait at 13 weeks.

***Continued on slide 7***

# KSO1 EXECUTIVE SUMMARY

In M10 the Trust cancer performance improved against both the Faster Diagnosis Standard and 62 day treatment standard. The Trust achieved the Cancer Faster Diagnostic Standard (FDS) and Trust plan, achieving 82.4% which meant an increased proportion of patients were told if they had cancer, or not, within 28 days. The proportion of patients who were treated as a result of a cancer diagnosis within 62-days improved from 73% in M9 to 74.9% in M10 and was on plan. At the end of M11, 75 patients (11.8% of the cancer PTL) had waited over 62 days, including 24 patients waiting over 104 days (3 breast, 5 head and neck, and 16 skin). Clinical harm reviews continue to be undertaken for all patients waiting over 62 days, and no harm was identified during this period.

The Trust opened an additional local anaesthetic room in M11 to create additional capacity to treat patients on a skin cancer pathway in the most cost-effective setting. The improvements to the Teledermatology pathway is showing improvements in terms of more rapid progression of patients through the pathway. Skin cancer performance continues to be challenged by high levels of referrals and the Trust is working with the Surrey and Sussex Cancer Alliance to review pathways and identify opportunities to improve the patient pathway and improve access for patients.

Urgent and Emergency Care (UEC) performance remained strong, achieving 98.83%, above both the national standard and planned trajectory. Diagnostic Waiting Time (DM01) performance continued to improve in M11 with performance improving from 89% to 91.9% of patients waiting less than 6 weeks for diagnostic tests.

The Trust reported income (excluding CDC activity) of 97.8% of plan in M11, impacted in part by theatre estates works in M11. The CDC activity remained below plan due to lower demand than forecast and delivered 70% of planned activity in month. As of M11, the CDC year-end forecast remained approx. 80%.

**Kirsten Timmins**
Chief Operating Officer

**Liz Blackburn**
Acting Chief Nursing Officer

# KSO1 BALANCED SCORECARDS

## QUALITY & SAFETY METRICS

| Metric | Latest Month | Target | Variation | Assurance | Actual | Actual Previous Month | Mean | LCL | UCL | Summary |
|---|---|---|---|---|---|---|---|---|---|---|
| Ethnicity recording | Feb-26 | 95% | | | 84.46% | 84.21% | 81.01% | 78.36% | 83.66% | Special Cause - improving variation |
| Smoking Status | Feb-26 | 95% | | | 99.18% | 99.39% | 99.12% | 98.03% | 100.21% | Common cause - no signficant change |
| Falls per 1,000 Occupied Bed Days | Feb-26 | 7 | | | 4.2 | 1.3 | 3.93 | -3.25 | 11.11 | Common cause - no signficant change |
| Hospital Aquired PU Per 1,000 Occupied Bed Days | Feb-26 | 0 | | | 0.0 | 0.0 | 0.72 | -1.76 | 3.21 | Common cause - no signficant change |
| % Complaints Responded On Time | Feb-26 | 90% | | | 83.33% | 85.71% | 92.26% | 67.44% | 117.09% | Common cause - no signficant change |
| Safer Staffing Compliance | Feb-26 | 90% | | | 100.00% | 100.00% | 99.64% | 98.50% | 100.78% | Common cause - no signficant change |
| % Overall FFT Recommendation Rate | Feb-26 | 90% | | | 94.53% | 94.77% | 95.25% | 94.42% | 96.09% | Special Cause - concerning variation |
| Overall FFT Response Rate | Feb-26 | 25% | | | 19.56% | 19.95% | 20.44% | 17.28% | 23.59% | Common cause - no signficant change |
| FFT Recommendation Rate - Inpatients | Feb-26 | 90% | | | 100.00% | 100.00% | 99.68% | 98.28% | 101.08% | Common cause - no signficant change |
| FFT Response Rate - Inpatients | Feb-26 | 25% | | | 23.64% | 23.71% | 36.06% | 17.07% | 55.05% | Common cause - no signficant change |
| FFT Recommendation Rate - Inpatients Children | Feb-26 | 90% | | | 100.00% | 100.00% | 99.64% | 98.33% | 100.96% | Common cause - no signficant change |
| FFT Response Rate - Inpatients Children | Feb-26 | 25% | | | 26.14% | 44.19% | 29.15% | 2.83% | 55.47% | Common cause - no signficant change |
| FFT Recommendation Rate - MIU | Feb-26 | 90% | | | 96.10% | 91.07% | 92.65% | 87.54% | 97.76% | Common cause - no signficant change |
| FFT Response Rate - MIU | Feb-26 | 25% | | | 18.49% | 19.72% | 27.25% | -23.71% | 78.21% | Special Cause - concerning variation |
| FFT Recommendation Rate - Outpatients | Feb-26 | 90% | | | 93.80% | 94.38% | 94.94% | 93.91% | 95.97% | Special Cause - concerning variation |
| FFT Response Rate - Outpatients | Feb-26 | 25% | | | 17.38% | 17.56% | 17.42% | 15.11% | 19.73% | Common cause - no signficant change |
| Readmissions< 30 Days | Feb-26 | 2% | | | 2.09% | 1.76% | 2.15% | 0.91% | 3.39% | Common cause - no signficant change |
| VTE Risk Assessment | Feb-26 | 95% | | | 53.35% | 70.03% | 94.14% | 85.87% | 102.41% | Special Cause - concerning variation |

# KSO1 BALANCED SCORECARDS

## QUALITY & SAFETY METRICS

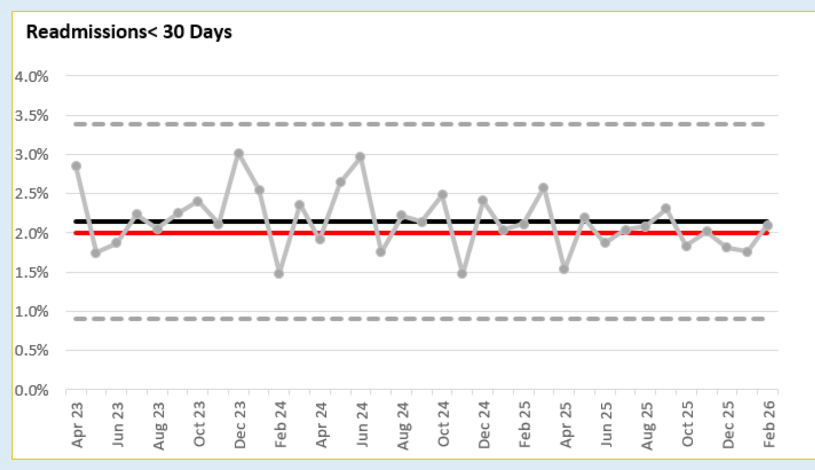
| Metric | Feb-25 | Mar-25 | Apr-25 | May-25 | Jun-25 | Jul-25 | Aug-25 | Sep-25 | Oct-25 | Nov-25 | Dec-25 | Jan-26 | Feb-26 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Number of Complaints | 7 | 4 | 6 | 7 | 6 | 9 | 9 | 9 | 9 | 6 | 6 | 10 | 8 |
| Number of Open CAS Alerts | 0 | 0 |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

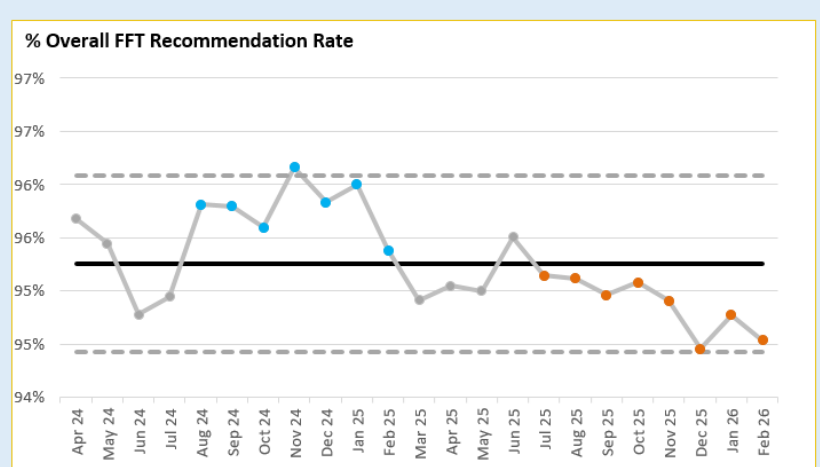
# KSO1 BALANCED SCORECARDS

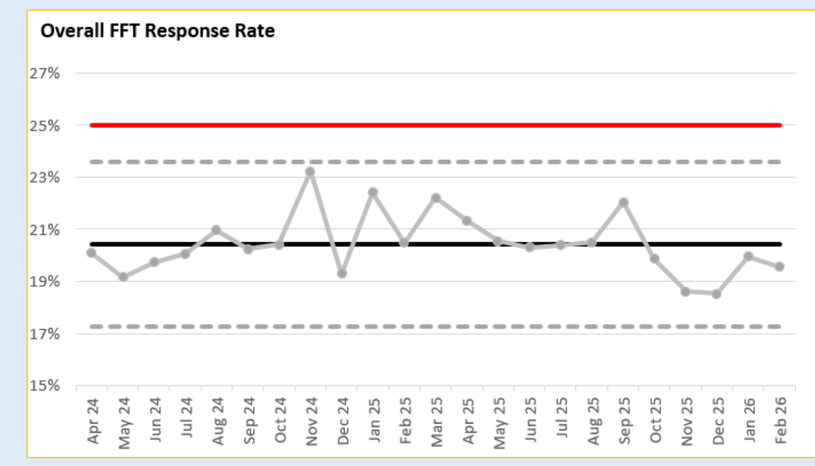
## OPERATIONAL PERFORMANCE METRICS

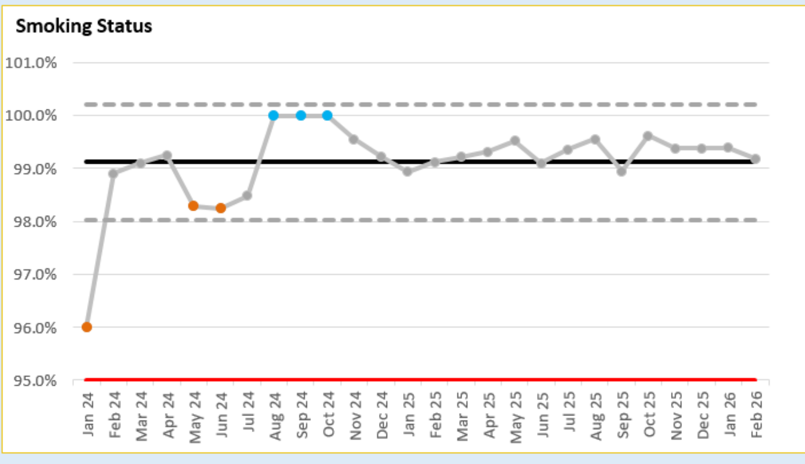
| Metric | Latest Month | Target | Variation | Assurance | Actual | Actual Previous Month | Mean | LCL | UCL | Summary |
|---|---|---|---|---|---|---|---|---|---|---|
| RTT 18 week wait performance - first appointment | Feb-26 | 75.32% | | | 76.44% | 75.28% | 72.98% | 69.32% | 76.64% | Special Cause - improving variation |
| RTT 18 Week Wait Performance | Feb-26 | 62.35% | | | 60.85% | 59.57% | 60.25% | 57.33% | 63.17% | Common cause - no signficant change |
| RTT Waiting List | Feb-26 | - | | | 20,036 | 19,915 | 18491.37 | 17771.53 | 19211.21 | Special Cause - concerning variation |
| RTT >52 Weeks | Feb-26 | - | | | 255 | 257 | 392.29 | 317.49 | 467.08 | Special Cause - improving variation |
| RTT >52 Weeks as a proportion of Waiting List | Feb-26 | 1.00% | | | 1.27% | 1.29% | 2.13% | 1.76% | 2.50% | Special Cause - improving variation |
| CDC activity vs plan | Feb-26 | 100.00% | | | 69.59% | 75.00% | 87.50% | 45.39% | 129.60% | Common cause - no signficant change |
| % Income Vs Plan | Feb-26 | 100.00% | | | 97.90% | 102.98% | 99.76% | 89.22% | 110.29% | Common cause - no signficant change |
| Cancer 28 Day FDS | Jan-26 | 80.00% | | | 82.36% | 81.79% | 81.84% | 70.45% | 93.23% | Special Cause - improving variation |
| Cancer 62 Days | Jan-26 | 75.00% | | | 74.86% | 73.20% | 76.95% | 63.64% | 90.26% | Common cause - no signficant change |
| Outpatient Productivity - Patient Initiated Follow Ups (PIFU) | Feb-26 | 2.00% | | | 1.85% | 1.69% | 1.82% | 1.27% | 2.37% | Common cause - no signficant change |
| Outpatient Productivity - Missed Appointment Rate | Feb-26 | 4.00% | | | 5.37% | 5.36% | 5.29% | 4.66% | 5.92% | Common cause - no signficant change |
| Diagnostics 6 Week Wait Performance | Feb-26 | 95.00% | | | 91.89% | 88.79% | 86.52% | 78.54% | 94.50% | Special Cause - improving variation |
| UEC 4 Hour Performance | Feb-26 | 98.00% | | | 98.83% | 99.66% | 99.20% | 97.69% | 100.71% | Common cause - no signficant change |
| Theatre Productivity - % of Cancellations on the Day | Feb-26 | 5.00% | | | 5.02% | 6.08% | 4.96% | 1.05% | 8.87% | Common cause - no signficant change |
| Theatre Elective Utilisation - QVH Site (Capped) | Feb-26 | 85.00% | | | 79.41% | 79.15% | 82.21% | 77.19% | 87.23% | Special Cause - concerning variation |
| NHS App appointments available | Feb-26 | 70.00% | | | 84.51% | 84.95% | 84.59% | 82.94% | 86.25% | Common cause - no signficant change |

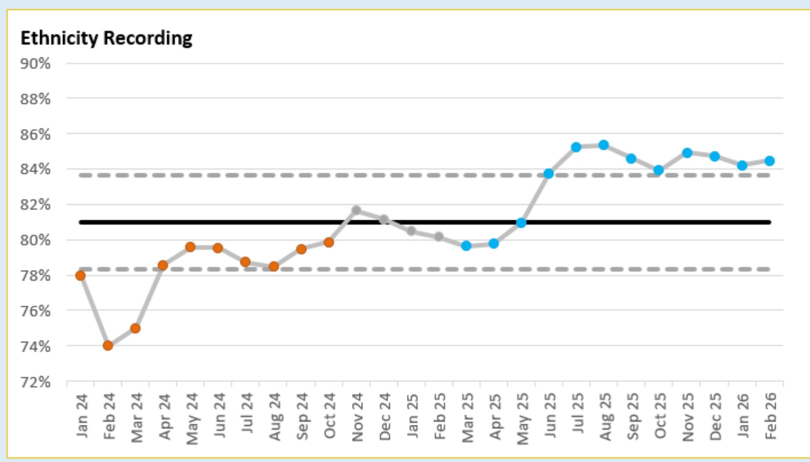
# QUALITY & SAFETY METRICS



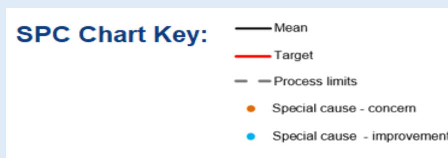



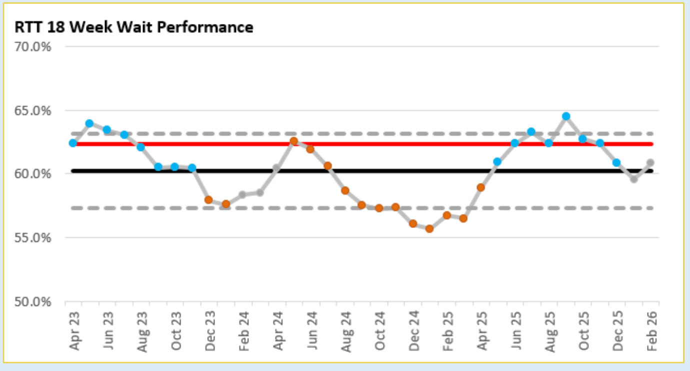



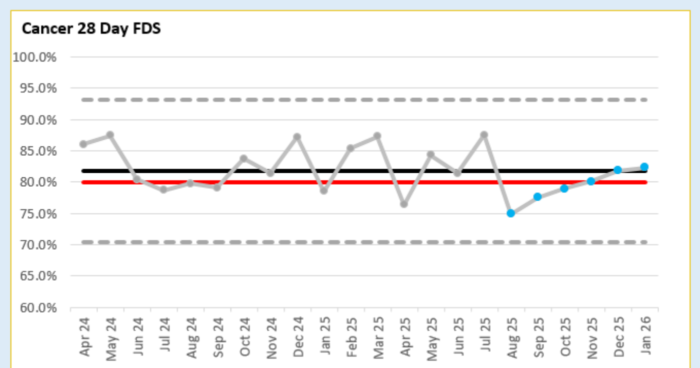

## Safer Staffing Compliance - Trust

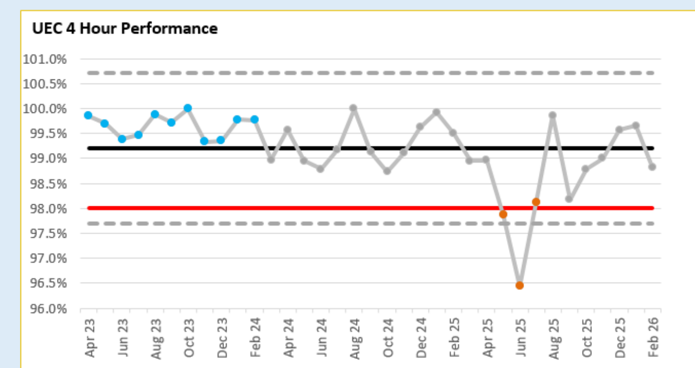
| | Planned staff | | | Actual staff | | | February 2026 |
|---|---|---|---|---|---|---|---|
| **DAY** | RN | NA | HCA | RN | NA | HCA | |
| | 3,427.00 | 92.00 | 1,230.50 | 3,427.00 | 92.00 | 1,230.50 | *Total Hrs Planned and Actual* |
| | | | | 100.0% | 100.0% | 100.0% | *% Planned Hrs Met* |
| | | | 4,749.50 | | | 4,749.50 | *Total Hrs Planned & Actual - Combined reg & support* |
| | | | | | | 100.00% | *% Planned Hrs Met - Combined reg & support* |
| **NIGHT** | RN | NA | HCA | RN | NA | HCA | |
| | 3,070.50 | 46.00 | 621.00 | 3,070.50 | 46.00 | 621.00 | *Total Hrs Planned and Actual* |
| | | | | 100.0% | 100.0% | 100.0% | *% Planned Hrs Met* |
| | | | 3,737.50 | | | 3,737.50 | *Total Hrs Planned & Actual - Combined reg & support* |
| | | | | | | 100.00% | *% Planned Hrs Met - Combined reg & support* |
| **Combined** | RN | NA | HCA | RN | NA | HCA | |
| | 6,497.50 | 138.00 | 1,851.50 | 6,497.50 | 138.00 | 1,851.50 | *Total Hrs Planned and Actual* |
| | | | | 100.0% | 100.0% | 100.0% | *% Planned Hrs Met* |
| | | | 8,487.00 | | | 8,487.00 | *Total Hrs Planned & Actual - Combined reg & support* |
| | | | | | | 100.00% | *% Planned Hrs Met - Combined reg & support* |

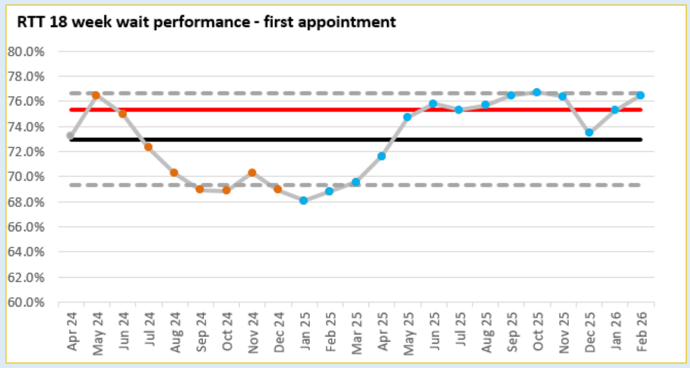


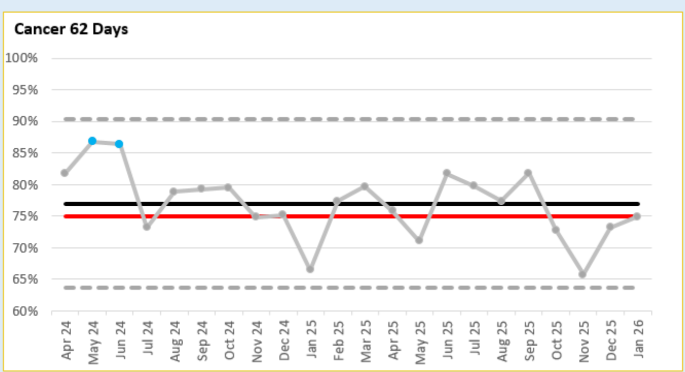
# OPERATIONAL PERFORMANCE METRICS

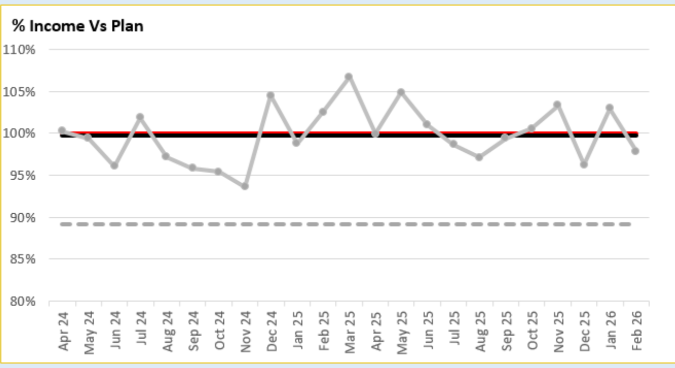


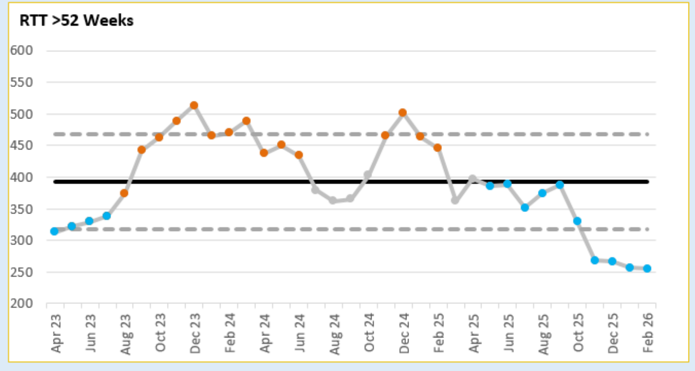



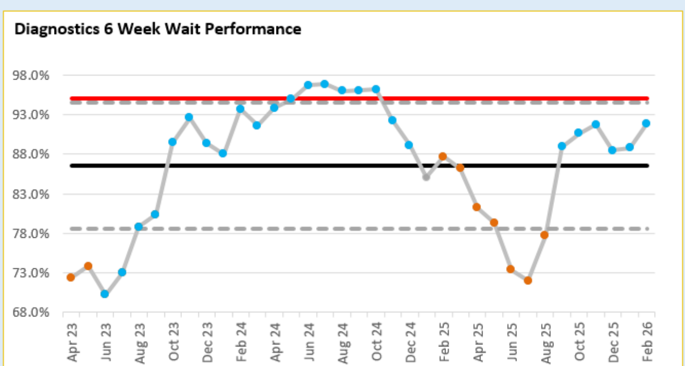



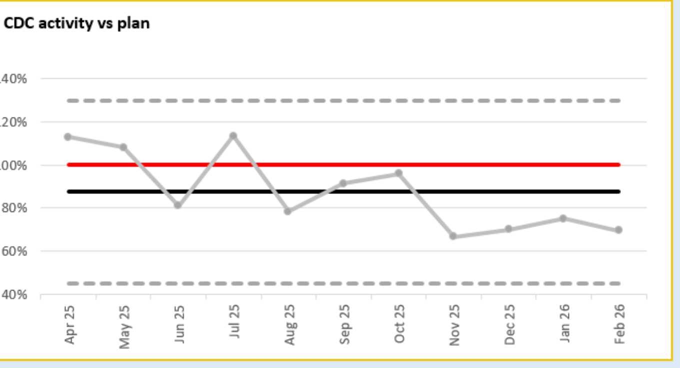



# KSO1 AREAS OF FOCUS

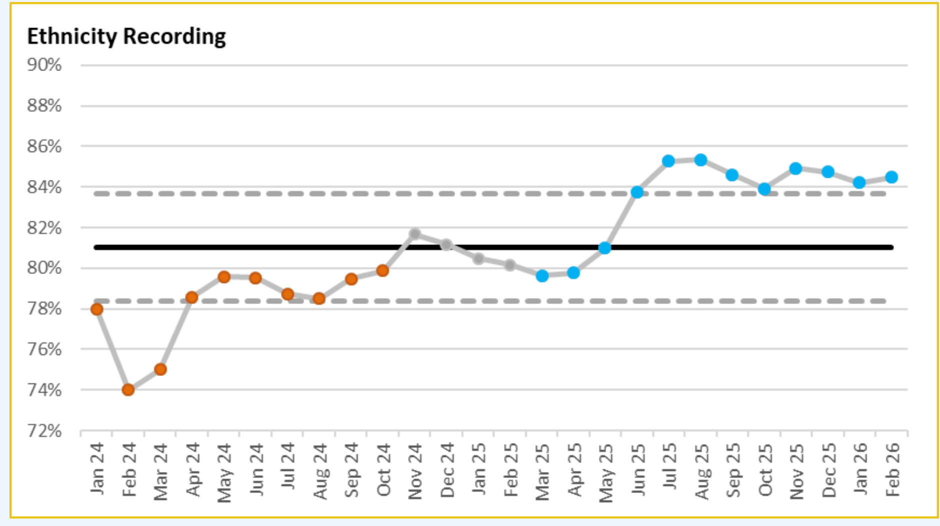
| Area | Summary, impact and actions |
|---|---|
| Ethnicity Recording | There is a small increase noted in ethnicity recording, approval is in progress for a Trust Experience-based Co-design Health Inequalities learning tool. This will aim to strengthen staff understanding of how inequalities appear in everyday care, using lived experience from patients, community partners. It will build staff confidence to address inequality, support more personalised care, embed patient and community voice in learning, and contribute to culture change through reflective practice. The trust is also part of Sussex ICB led improvement work focussed on training staff on the importance of recording ethnicity data. |
| Smoking Status | Smoking status recording remains at 99% compliance. |
| Falls | 3 falls noted in month, all with no harm. 2 inpatient falls with no themes. 1 fall related to the use of stairs within outpatient department. |
| Pressure ulcers | Zero pressure ulcers reported in M11. |
| % Complaints Responded On Time | 5 out of 6 complaints responded to within the 30 day target. |
| Safer Staffing Compliance | Safe staffing levels were maintained across all inpatient areas, with a fill rate at 100%. Ward reconfigurations commenced in M11 with staff deployment being managed on a daily basis. |
| Never Events | Zero never events reported in M11 |
| Mortalities | Zero mortalities reported in M11 |
| % Overall FFT Recommendation Rate | This metric remains above the 90% trust target yet is flagging as 'concerning variation' given a number of months below the average trust performance. This aligns with the national trend of an increase in the number of complaints received as compared to previous years, and will continue to be monitored to ensure performance remains above 90%. The Trust continues to triangulate the FFT performance with other patient feedback mechanisms including complaints and patient surveys. |
| VTE Risk Assessment | Compliance with VTE assessments has significantly dropped following the transfer of the assessment on to Archie EPR system. The process has been remodelled with further digital development, and there is ongoing improvement work to restore compliance via a task and finish group. Risk of harm is being actively monitored and none have been identified to date. |

# KSO1 AREAS OF FOCUS

| Area | Summary, impact and actions |
|---|---|
| RTT> 65 weeks | The Trust reported 48 patients waiting in excess of 65 weeks at the end of M11, of which 12 patients were waiting over 78 weeks, versus a trajectory of 46. Plastics reported 43 long waiters in M11, Oral and Max Fax services reported 4 patients and Corneo 1. In total, 19 patients waited over 65ww in specialties outside breast, due to late referrals from other trusts, pathway delays, validation reviews and skin cancer demand. The Trust will continue to work with NHS England (NHSE) to review a longer-term solution to address demand and capacity for patients waiting delayed breast reconstruction services. |
| RTT >52 Weeks % | The Trust did not achieve the planned trajectory in M11 of patients waiting over 52 weeks making up 1.1% of the waiting list. The Trust reached 1.2% with 255 patients waiting over 52 weeks against a trajectory of 252 patients. As part of the NHSE 52ww Q4 sprint, the trust is mobilising insourcing of MOHS capacity and outsourcing a small number of breast patients to support the 52ww position, but there remains risk in achieving 1% target at year end, particularly as the waiting list is below plan reducing the denominator of the percentage calculation making achievement of the target more challenging. |
| RTT - 18 week wait - first appointment | The Trust exceeded the internal trajectory by 1%, reaching 76.4% of patients who had their first appointment within 18 weeks of referral. The trust is on plan to achieve the year-end target. |
| RTT 18 Week Wait Performance | The Trust missed the internal trajectory in M11 of 60.97% by 0.1% achieving 60.85%, and there is a risk in meeting the year-end target. Teams are focussed on increasing validation in Q4, in addition to increased senior oversight of the PTL and the continuation of weekend activity to improve the timeliness with which patients access our services. |
| RTT Waiting List | The RTT Waiting List showed an increase in month by 121 from 19,915 to 20,036 and remains on plan. |
| Cancer 28 Day FDS | There was continued improvement in FDS performance reaching 82.4% (M10) exceeding the national FDS standard of 80% and internal trajectory of 80.3%. The Trust is on plan to meet the year-end trajectory. |
| Cancer 62 Days | The Trust reported an increase in performance in M10 from 73.2% to 74.9% exceeding the internal target of 71.1%, with an expectation that performance in M11 will meet the Trust plan. Skin cancer performance improved from 77.6% to 84.6% in month and head and neck remained challenged this month at 44.6% due to pathways challenges, consultant sickness, complex diagnostic pathways. At the end of M11, 75 patients (11.8% of the Cancer PTL) were patients waiting over 62 days for treatment, of those patients, 24 had been waiting over 104 days (3 breast patients, 5 Head and Neck patients and 16 skin patients). Clinical harm reviews are done for all patients waiting over 62 days and no harm was found during the period. |
| Diagnostics 6 Week Wait Performance | DM01 performance showed improvement in M11 reaching 91.89%. |
| MIU 4 Hour Performance | The Trust performance in M11 was 98.83% exceeding the national standard (95%) and the internal trajectory. |
| % Income Vs Plan | The Trust reported 97.9% income vs plan for M11. |
| % CDC activity vs plan | As of M11, the year-end forecast remained approximately 80% CDC income vs plan. The teledermatology pathway is working well and the Trust is ensuring CDC pathways can be booked directly through e-Referral Service (eRS) to make it simpler for GPs to refer patients. The service continues to offer mutual aid across Sussex for services that have available capacity. |
| Theatre capped utilisation | Theatre utilisation reported 79.65% in M11. Since the launch of Archie EPR, the Trust reporting of theatre utilisation has been impacted, reporting below the Trust usual performance. Work is underway to try to resolve this and should improve by M12. The Trust has relaunched the theatre transformation work, focussed on activity, utilisation and the opening of a third Local Anaesthetic Unit in M11, with a focus on increasing MOHS micrographic surgery capacity and identifying opportunities to move activity from main theatres to a more appropriate setting. |

| Area | Summary and actions |
|---|---|
| Data Improvement | The Trust ethnicity data collection for February is 84.46%, a slight increase from January which was 84.21%, and remains below the Trust target of 95%.<br><br>QVH is participating in the co-design of Sussex wide ethnicity improvement training to develop a suitable resource to train staff in the importance of ethnicity data collection. This initiative is led by the integrated care board. |

Ethnicity data collection




| Area | Summary and actions |
|---|---|
| Mental Capacity Act (MCA) | The task and finish group will complete in April having reviewed pathways, processes, training and understanding to inform best practice around MCA. A monthly audit cycle has been established around use of MCA in relation to the care of patients with dementia to enable continuous learning and improvement in practice. The CMO working with the safeguarding team will continue to oversee outputs in 26/27 to ensure sustained progress. |

# KSO2

## To innovate and improve

**Ambition**

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

**Board Assurance Framework**

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

**2025/26 Annual Objectives**

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

**2025/26 Annual goals**

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

# KSO2 EXECUTIVE SUMMARY

**Research & Innovation (R&I):**
A full bi-annual update was provided to the last Trust Board. There is ongoing recruitment to a range of research studies with no adverse events or incidents reported during this period. A revised process for logging trial activity on the national EDGE research management programme database has been introduced with strengthened internal processes to reduce the time from expression of interest to study opening and recruitment in line with National Institute for Health and Care Research (NIHR) and NHSE requirements. Contractual arrangements with the University of Sussex Department of Biomechanical Engineering are being finalised in month to enable progress of a collaborative microsurgery research project supported by joint funding from an academic grant and our QVH Trust Charity.

**Quality priority: Evidence through measurable outcomes**
Engagement and communication with frontline staff to refine the proposed quality priorities has taken place in Month 11.  Quality Priority areas proposed are measurement of clinical outcomes and evidence-based care building on last year's priority, reducing health inequalities including the Accessible Information Standards compliance workstreams and, the development of the Patient School Model, a model currently in use in specific areas which could be developed to be used across the Trust.

The quarterly Measures for Improvement for the Clinical Audit Programme for 2026/27 are being produced.

**Embed continuous improvement (CI):**
A collated report summarising progress, learning and achievements from Year 2 of our partnerships with PA Consulting and Lean Enabled is in draft for presentation in May / June 26. This will include impact and differences observed since introducing the QVH Way and action-focused future recommendations for Year 3 of the partnership where QVH will be leading most of the deliverables. Actions are being closely aligned with NHS Impact and operational priorities with focus on re-energising improvement huddles, utilising QVH Way trained staff resource and embedding leadership for improvement within normal working. In month, 25 QVH operational and clinical staff were trained by the NHS Impact team to enable facilitation of chosen priority improvement workstreams.

**Medical Education:**
February resident doctors' induction was well received by those in attendance. This was the first induction following EPR rollout and some teething issues were experienced during the handover period, however all issues relating to completion of training and system access were resolved quickly and learning is being incorporated into future inductions.

Following a green belt continuous improvement project, the Medical Education team are rolling out a database to record, monitor, and feedback on all issues and concerns raised from resident doctors and supervisors, to ensure that these are captured and resolved efficiently.

QVH received some ring-fenced funding to support SAS doctors in 2025-26, which has been used to arrange the fourth annual SAS away day – offering team building and continuing professional development (CPD) opportunities for our SAS colleagues. We have also been able to put on an additional development course in house and, have funded several colleagues who bid for support for individual CPD.

The medical education team has supported the KSS school of surgery with arranging bespoke regional plastics teaching for the KSS cohort. This has been very well received, with cadaveric teaching taking place in both Guildford and Brighton.

**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

### 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

M11 whole time equivalent (WTE) is at 1080.89 (increase from 1075.92 WTE in M10). Temporary staffing has decreased in M11 with bank decreasing by 3.4 WTE and agency by 1.5 WTE.  The Trust continues to be 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 M11.

Overall sickness absence levels saw no change again in M11 and remains at 4.1%, which is below average across the Sussex Integrated Care System (ICS) and comparable to rates across the South-East Region. Long-term sickness continues to drive the overall sickness rate over the rolling 12-month period. Cases are being managed in line with the Trust's Managing Sickness Absence Policy by managers with advice and support from the Employee Relations team. The system target is 4% in the national operational planning guidance with a keen focus on mental health and musculoskeletal problems which will continue to be addressed by the newly formed Sussex sickness absence reduction and health & wellbeing community of practice group (from April 2026), This will be chaired by the QVH Head of Employee Relations and Wellbeing.

Time to hire has increased slightly from M10 (43.3) to 44.7in M11 however is still below KPI of 53. Work continues to find improvements to bring key performance indicator (KPI) down incrementally to 30 days from 1 April 2026. This was a range of 8 days to 96 days (delays due to overseas referee delays / other referencing delays).

The Organisational Development team have produced a series of staff survey reports for directorates, departments and individual teams for managers to review the results for their areas and share the findings with their teams. A poster for each team (where a report is available) has been shared with managers to display in a prominent location. Workshops have been arranged, starting on 16 April for managers to look at the staff survey and understand the expectations required from them.

In M11 the wellbeing and inclusion team has promoted Pride Month by encouraging staff to sign the QVH Progress Pride Pledge and has been working with the Violence Prevention and Reduction (VPR) Group to formalise post-incident support for staff. Efforts continue toward meeting NHSE Sexual Safety Charter requirements, including awareness-raising during Sexual Abuse and Sexual Violence Awareness Week. Support for the Armed Forces Network is being strengthened as it develops into a more formalised group, while collaboration across QVH has produced guidance for supporting staff fasting during Ramadan. Additionally, workshops have been arranged focusing on Menopause and Trans-Inclusive Healthcare

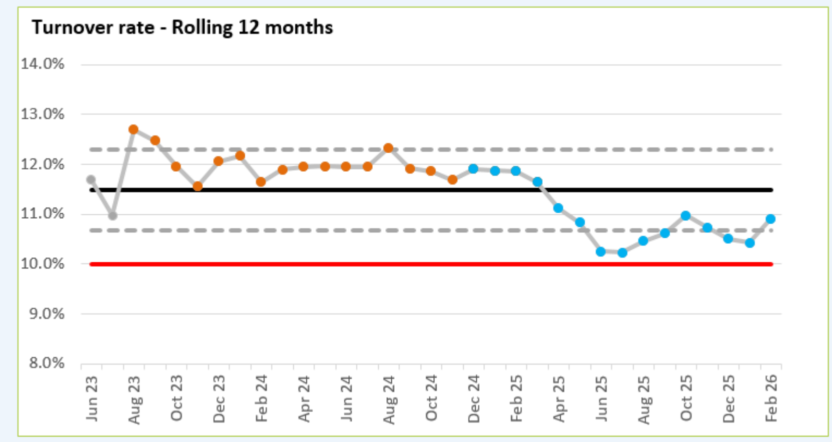
Focussed work is ongoing for specific areas of mandatory and statutory training (MAST) compliance.  MAST rates decreased for clinical, non-clinical and bank workers in M11. Overall appraisal completion also saw a small decrease in M11. Appraisals outstanding by >3months saw an increase from 108 in M10 to 129 in M11, with data cleansing a priority.  There is an ongoing focus for managers to complete their staff appraisals. Hot spot areas are being followed up by senior managers for completion.

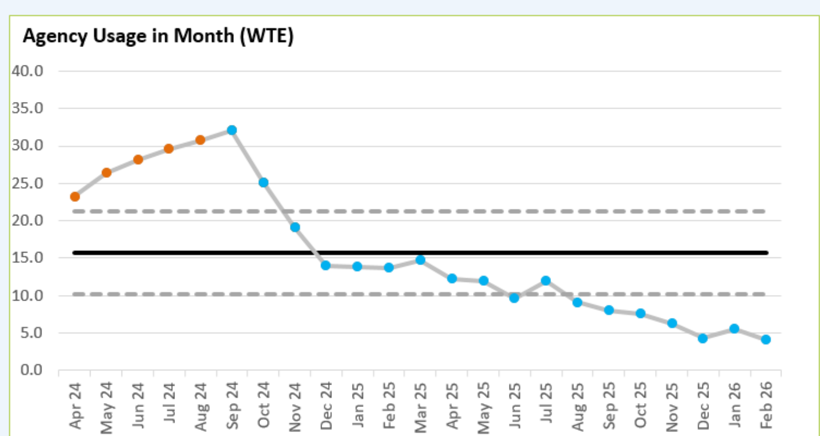
**Helen Edmunds**
Chief People Officer

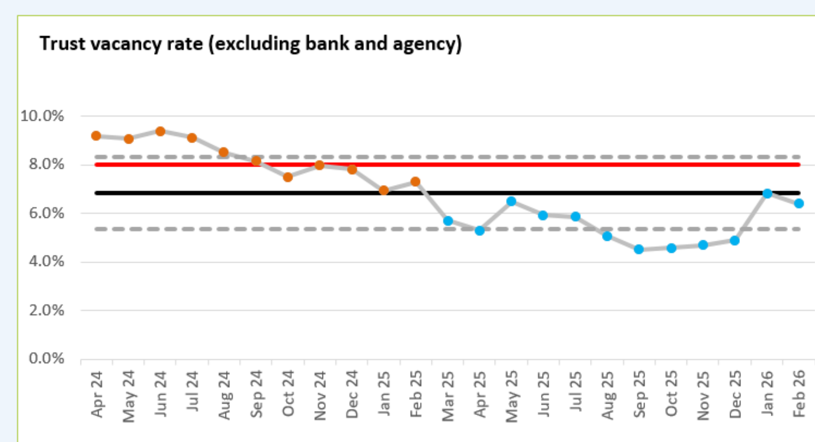
# KSO3 BALANCED SCORECARD

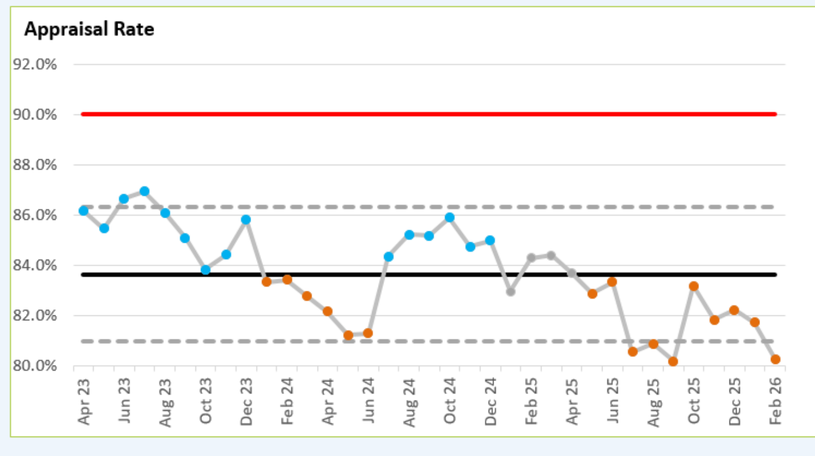
| Metric | Latest Month | Target | Variation | Assurance | Actual | Actual Previous Month | Mean | LCL | UCL | Summary |
|---|---|---|---|---|---|---|---|---|---|---|
| Trust vacancy rate (excluding bank and agency) | Feb-26 | 8% | | | 6.4% | 6.8% | 6.8% | 5.4% | 8.3% | Special Cause - improving variation |
| Vacancies - Incl Bank & Agency | Feb-26 | 8% | | | 3.0% | 3.2% | 1.9% | -0.1% | 3.9% | Common cause - no signficant change |
| Average Time to Hire - Days | Feb-26 | 53 | | | 44.7 | 43.3 | 56.87 | 24.20 | 89.54 | Special Cause - improving variation |
| Turnover rate - Rolling 12 months | Feb-26 | 10% | | | 10.9% | 10.4% | 11.5% | 10.7% | 12.3% | Special Cause - improving variation |
| Sickness absence rate - Rolling 12 months | Feb-26 | 3% | | | 4.1% | 4.1% | 3.8% | 3.7% | 4.0% | Special Cause - concerning variation |
| Appraisal Rate | Feb-26 | 90% | | | 80.3% | 81.7% | 83.7% | 81.0% | 86.3% | Special Cause - concerning variation |
| Statutory & Mandatory Training Compliance | Feb-26 | 90% | | | 90.7% | 92.2% | 91.9% | 90.7% | 93.1% | Special Cause - concerning variation |
| Agency Usage in Month (WTE) | Feb-26 | - | | | 4.1 | 5.6 | 15.73 | 10.18 | 21.28 | Special Cause - improving variation |
| Bank Usage in Month (WTE) | Feb-26 | - | | | 66.3 | 69.7 | 75.79 | 59.19 | 92.39 | Special Cause - improving variation |
| Annual Leave Taken | Feb-26 | - | | | 89.8% | 78.1% | 48.7% | 28.6% | 68.8% | Special Cause - improving variation |

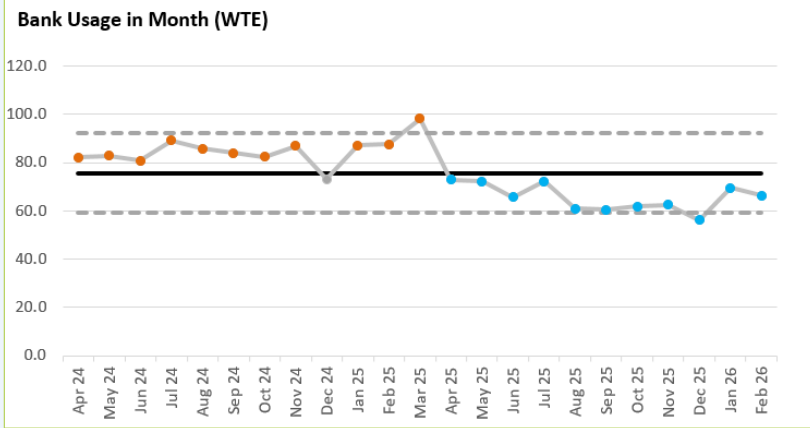
# EXCELLENT EMPLOYER KEY METRICS

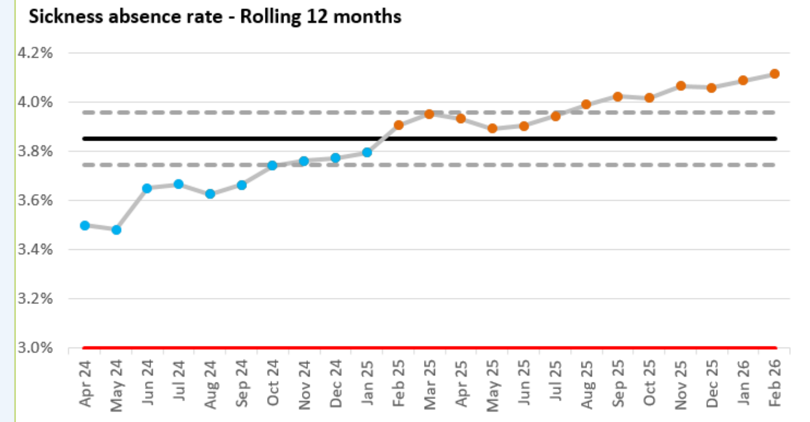


# KSO3 AREAS OF FOCUS

| Area | Summary, impact and actions |
|---|---|
| Trust vacancy rate<br>(excluding bank and agency) | M11 shows WTE at 1080.89 with vacancies (including Bank and Agency) decreasing minimally to 3% (from 3.2% in M10). The Trust continues to be in in a good position against plan and performing well compared to other Sussex providers. |
| Average Time to Hire (TTH) - Days | Slight increase from 43.3 in M10 to 44.7 in M11. This ranged from 8 days average to 96 days. Delays in Sleep (89 days due to overseas referee details hard to verify), Theatres (96 days due to candidate being moved from old vacancy and clock started in October) and Plastic Surgery (70 days due to OH Medic appointment needed and candidate not providing all referee details). By removing these few the average TTH would be 36.89 for M11. |
| Sickness Absence Rate - Rolling 12 Months | This measure shows 'concerning variation' as performance has been above the mean for a period of time at a current level of 4.1%. The Employee Relations team continue to support managers with absence management in line with the Trust's Managing Sickness Absence Policy. In M11 the highest sickness rates are within Medical Photography, Clinical Coding and the RTT Team. 1.96% of overall Trust sickness absence is short term and 2.15% is long term. |
| Agency Usage In Month (WTE) | M11 has seen a decrease from 5.6 in M10 to 4.12 with usage between Peri-Op at 3.98 (AHP, NMC and M&D) and 0.14 in Core Clinical & Community Services (CCCS) Allied Health Professional (AHP) in Therapies. Peri-op usage was split between Theatres, Recovery, Day Surgery and Medics Anaesthetics. |
| Bank Usage In Month (WTE) | Bank usage has decreased from 69.7 in M10 to 66.33. Peri-op shows a minimal decrease (0.26) but remains the highest at 29.72 (this is mainly attributable to additional weekend theatre lists) with CCCS next at 12.21. Nursing and Midwifery, Additional Clinical Services and Admin and Clerical remain the highest bank usage (18.98, 10.94 and 17.23 respectively). |
| Grievances raised | 0 grievances raised in M11. |
| % Job plans complete | 84% of job plans are currently agreed / signed off, with focussed work underway to continue to improve the completion rate. |
| Turnover rate | Turnover increased minimally from 10.4% in M10 to 10.9% |
| Statutory and mandatory training | M11 has seen a small decrease in mandatory and statutory training (MAST) compliance from 92.2% in M11 to 90.7%. Emergency Planning training and Fire Evacuation training continue to be areas of focus. This metric will continue to be monitored to ensure performance continues to meet the trust 90% target. |
| Appraisal rate | There is ongoing work to reach 90% appraisal completion rate, with continued focus with managers and highlighting outstanding areas. M11 had a small decrease from 81.7% in M10 to 80.3%. The number of appraisals outstanding >3 months has increased from 108 to 129 in M11, with focused work underway with senior managers to follow up in areas where rates of completion are low. Of the 129, 57 are out of date by 3 months, 32 by 6 months and 40 by more than 9 months. Due to a change over to Electronic Staff Record (ESR) Manager Self Service, data cleansing is being undertaken. |

# KSO4

# To deliver sustainable services

## Ambition

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

**Board Assurance Framework**

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

**2025/26 Annual Objectives**

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

**2025/26 Annual goals**

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

# KSO4 EXECUTIVE SUMMARY

At the close of February 2026, the Trust reported a year to date (YTD) Income and Expenditure position £0.2m favourable to planned deficit (£0.5m) and had a cash balance of £19.4m. Whilst a position ahead of plan for the YTD remains positive, there is a higher contribution required for March and 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 M11 by £0.3m YTD, mainly due to £0.7m underperformance in CDC activity, £0.2m depreciation funding adjustment and £0.1m device recharges income with Industrial Action funding from NHSE covering the shortfall in main activity income. This underperformance is partly being offset by additional commissioner funding relating to digital and CDC pathway development. The main YTD areas of activity under-performance relate to Ophthalmology daycases and outpatients and Plastics inpatients 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.

Other Income was £0.3m favourable to plan this month and £0.2m for the YTD due to catch up in education and training income (£0.2m) mainly in respect of study expenses claimed and a YTD recharge in respect of space rented to Sussex Community Trust.

Pay was adverse to plan in month (£0.2m) and £0.3m adverse for the YTD with the YTD position driven by non-delivery of better value schemes (£0.8m), offset by underspends relating to CDC. The in month position included c£0.1m of prior period costs mainly within bank spend. Agency spend continues to be within the 2% target of overall budget and broadly in line with trend of recent months. Reported workforce WTE increased slightly compared to the YTD average in part due to an increase in weekend working.

Non-pay was adverse to plan in month (£0.2m) and underspent for the YTD (£0.9m), mainly within corporate areas and the CDC (£0.4m). The M11 adverse position is driven by clinical supplies and services due to increased outsourcing costs, theatre expenditure and some catch up costs within histopathology. Other Non-pay is mainly adverse to plan due to increased spend in digital areas and non operational expenditure is adverse in month (£60k) following a YTD adjustment to the Public Dividend Capital Charge.

At the end of M11, the Trust reported YTD delivery of £6.8m efficiencies which is on plan. Pay related schemes are off plan (£0.8m) 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 M11 but has seen an increase from previous months with the remaining spend expected in M12.

Freedom of Information (FOI) requests responded to within 20 days has decreased in the M11 report to 78.7% compared with 82.4% at M10. 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 BALANCED SCORECARD

| Metric | Latest Month | Target | Variation | Assurance | Actual | Actual Previous Month | Mean | LCL | UCL | Summary |
|---|---|---|---|---|---|---|---|---|---|---|
| Breakeven YTD | Feb-26 | -£0.49m | | | -£0.28m | -£0.13m | -0.38 | -0.99 | 0.23 | Common cause - no signficant change |
| Cash at Bank YTD | Feb-26 | | | | £19.40m | £12.00m | 8.94 | 2.50 | 15.38 | Special Cause - improving variation |
| Capital Spend YTD | Feb-26 | £10.10m | | | £10.10m | £7.30m | 4.30 | -2.33 | 10.93 | Special Cause - improving variation |
| Efficiencies YTD | Feb-26 | £6.80m | | | £6.80m | £6.10m | 3.99 | 1.23 | 6.74 | Special Cause - improving variation |
| BPPC (NHS & Non NHS) - volume | Feb-26 | 95% | | | 90.4% | 90.0% | 0.91 | 0.88 | 0.95 | Common cause - no signficant change |
| BPPC (NHS & Non NHS) - value | Feb-26 | 95% | | | 92.4% | 92.6% | 90.4% | 85.7% | 95.0% | Common cause - no signficant change |
| Agency spend <2% total pay bill | Feb-26 | £1.40m | | | £0.69m | £0.63m | 0.44 | 0.28 | 0.59 | Special Cause - improving variation |
| Agency spend 40% less than 24/25 forecast | Feb-26 | £1.40m | | | £0.69m | £0.63m | 0.44 | 0.28 | 0.59 | Special Cause - improving variation |
| Agency staff spend as % of total staff spend | Feb-26 | 2% | | | 0.97% | 0.98% | 1.03% | 0.45% | 1.60% | Common cause - no signficant change |
| Bank spend reduction of 10% of Total Pay Bill | Feb-26 | £4.10m | | | £3.00m | £2.70m | 1.68 | 0.98 | 2.38 | Special Cause - improving variation |
| Total Pay cost per Worked WTE | Feb-26 | | | | £5,701.25 | £5,627.12 | 5667.86 | 5425.41 | 5910.31 | Common cause - no signficant change |
| Subject Access Requests - Total Received | Feb-26 | | | | 91 | 92 | 78.74 | 37.20 | 120.29 | Common cause - no signficant change |
| Subject Access Requests - % Closed within 30 calendar days | Jan-26 | 100% | | | 100.0% | 100.0% | 95.0% | 79.9% | 110.0% | Special Cause - improving variation |
| Freedom of Information requests – Total Received | Feb-26 | | | | 52 | 61 | 50.74 | 17.18 | 84.31 | Common cause - no signficant change |
| Freedom of Information requests – % Closed within 20 working days | Jan-26 | 80% | | | 78.7% | 82.4% | 65.7% | 40.2% | 91.2% | Special Cause - improving variation |

# KSO4 EXECUTIVE SUMMARY

## Capital

| | In Month £'000 | | | Year to Date £'000 | | | Forecast Outturn £'000s | | |
|---|---|---|---|---|---|---|---|---|---|
| | Plan | Actual | Variance | Plan | Actual | Variance | Plan | Actual | Variance |
| IT | 0 | 212 | 212 | 131 | 453 | 322 | 131 | 659 | 528 |
| Medical Equipment | 83 | 24 | (59) | 249 | 30 | (219) | 1,000 | 563 | (437) |
| Estates Maintainance | 193 | 105 | (88) | 193 | 1359 | 1,166 | 1,907 | 1,346 | (561) |
| Estates Other | 0 | 0 | 0 | 750 | 0 | (750) | 750 | - | (750) |
| EPR | 248 | 966 | 718 | 744 | 2983 | 2,239 | 2,983 | 2,983 | 0 |
| CDC | 1,495 | 713 | (782) | 4485 | 2801 | (1,684) | 17,949 | 5,849 | (12,100) |
| Other Capital | 24 | 777 | 753 | 24 | 2511 | 2,487 | 1,640 | 6,810 | 5,170 |
| **Total** | 2,043 | 2,797 | 754 | 6576 | 10137 | 3,561 | 26,360 | 18,210 | (8,150) |

## 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 | 9,253 | 9,690 | 437 | 105,410 | 105,070 | (340) | 115,453 | 115,167 | (286) |
| Other Operating Income | 352 | 635 | 283 | 3,867 | 4,115 | 248 | 4,226 | 4,332 | 106 |
| **Total Income** | 9,605 | 10,325 | 720 | 109,277 | 109,185 | (92) | 119,679 | 119,499 | (180) |
| **Pay** | | | | | | | | | |
| Substantive | (5,857) | (6,188) | (331) | (64,797) | (66,808) | (2,011) | (70,672) | (72,499) | (1,827) |
| Bank | (342) | (321) | 21 | (3,907) | (3,001) | 906 | (4,228) | (3,247) | 981 |
| Agency | (134) | (62) | 72 | (1,474) | (690) | 784 | (1,599) | (753) | 846 |
| **Total Pay** | (6,333) | (6,571) | (238) | (70,178) | (70,499) | (321) | (76,499) | (76,499) | 0 |
| **Total Non-Pay** | (2,922) | (3,144) | (222) | (32,597) | (31,719) | 878 | (34,943) | (34,516) | 427 |
| **Total Non Operational Expenditure** | (709) | (769) | (60) | (7,243) | (7,375) | (132) | (8,511) | (8,630) | (119) |
| **Total Expenditure** | (9,964) | (10,484) | (520) | (110,018) | (109,593) | 425 | (119,953) | (119,645) | 308 |
| **Surplus/(Deficit)** | (359) | (159) | 200 | (741) | (408) | 333 | (274) | (146) | 128 |
| *Technical Adjustments* | 23 | 12 | (11) | 253 | 133 | (120) | 274 | 146 | (128) |
| **Adjusted Surplus / (Deficit)** | (336) | (147) | 189 | (488) | (275) | 213 | 0 | (0) | (0) |

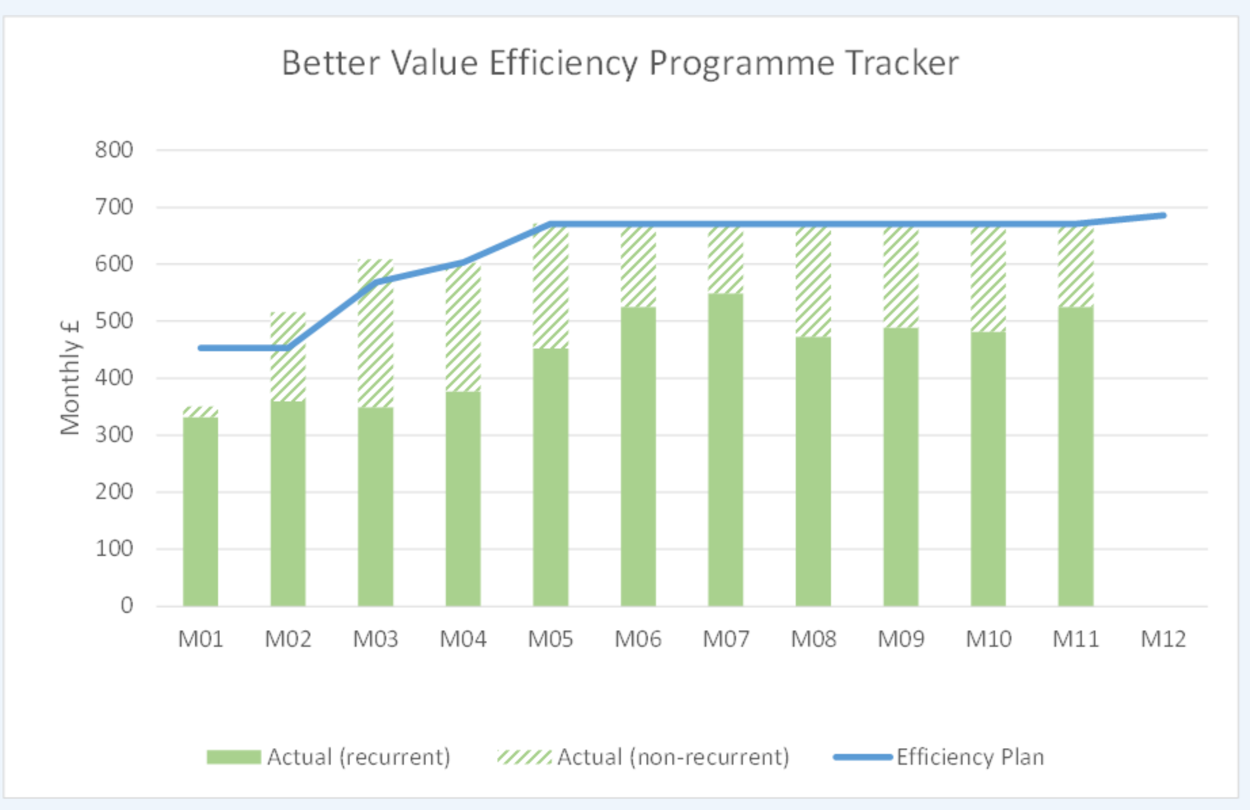
| | Annual Target | Forecast Outturn |
|---|---|---|
| Income & Expenditure | £0.0m | £0.0m |
| Cash at bank | £1.9m | £1.9m |
| Capital Spend | £26.4m | £25.6m |
| Efficiencies | £7.46m | £7.46m |
| BPPC (NHS & Non-NHS) | | |
| Volume | 95.0% | 91.9% |
| Value | 95.0% | 93.6% |

## Efficiency

| | In Month £'000 | | | Year to Date £'000 | | | Forecast Outturn £'000s | | |
|---|---|---|---|---|---|---|---|---|---|
| | Plan | Actual | Variance | Plan | Actual | Variance | Plan | Actual | Variance |
| Pay - Establishment Reviews | 83 | 258 | 175 | 833 | 2,027 | 1,194 | 922 | 2,154 | 1,232 |
| Pay - Corporate Service and Digital Transformation | 175 | 80 | (95) | 1,825 | 592 | (1,233) | 2,000 | 786 | (1,214) |
| Pay - Clincal Service Redesign | 134 | 56 | (78) | 1,177 | 616 | (561) | 1,310 | 672 | (638) |
| Pay - Agency | 39 | 21 | (18) | 429 | 459 | 30 | 463 | 493 | 30 |
| Non-Pay - Procurement | 58 | 14 | (44) | 578 | 363 | (216) | 641 | 422 | (220) |
| Non-Pay - Other | - | 117 | 117 | - | 1,376 | 1,376 | - | 1,407 | 1,407 |
| Non-Pay Corporate Service and Digital Transformation | 137 | 63 | (74) | 1,437 | 678 | (759) | 1,584 | 781 | (803) |
| Non-Pay Clinical Service Redesign | 13 | 56 | 43 | 143 | 616 | 473 | 153 | 672 | 519 |
| Income - Non-patient care | 31 | 6 | (25) | 341 | 48 | (293) | 376 | 73 | (303) |
| Income - Other | 1 | - | (1) | 11 | - | (11) | 11 | - | (11) |
| **Total** | 671 | 671 | 0 | 6,774 | 6,774 | 0 | 7,460 | 7,460 | (0) |

# Trust Best Value Efficiency Programme

| Financial Risk Rating | £000 | M11 YTD | Current Forecast | Variance |
|---|---|---|---|---|
| Blue | 2,413 | 2,037 | 2,437 | 24 |
| Green | 1,100 | 815 | 1,075 | (26) |
| Amber/Green | 1,982 | 1,309 | 1,435 | (547) |
| Amber | 832 | 276 | 300 | (532) |
| Amber/Red | 222 | 0 | 0 | (222) |
| Red | 994 | 0 | 0 | (994) |
| Mitigating items | | 2,337 | 2,342 | 2,342 |
| **Total** | **7,544** | **6,775** | **7,589** | **45** |



# KSO4 AREAS OF FOCUS

| Area | Summary, impact and actions |
|---|---|
| Breakeven YTD | In month position £0.2m ahead of planned £0.3m deficit for M12 and the Trust is £0.2m ahead of YTD plan (£0.5m deficit). Patient income is £0.3m off plan YTD, mainly due to underperformance in CDC (£0.7m), devices income (£0.1m) and depreciation funding (£0.2m), offset by pathway development funding. This is being offset by an underspend in non-pay. The Trust would be reporting a deficit of £1.6m without the inclusion of non-recurrent deficit support funding. |
| Cash at Bank YTD | Cash at M11 was £19.4m and cash levels remain supported by the slow spend in capital spending. |
| Capital Spend YTD | The Capital Plan for M11 included £16.5m for CDC and £0.8m for boiler lease (which was contracted in 2024/25).A further £12.1m for Bognor CDC was transferred back to the ICB leaving our revised capital plan at £18.2m for the year. The spend to M11 was £10.1m with another £8m to be spent in M12. We are working on delivering these plans and on contingencies and are confident that the Trust will spend the capital and stay within the allocation. |
| Efficiencies (Cost Improvement Plans) YTD | Delivery of £6.8m vs plan of £6.8m. Non-recurrent benefits, largely in the form of budgetary underspends are offsetting the schemes that have not delivered in-year. These underspends will be reviewed as part of Directorate budget setting and where possible, they will be removed and effectively become recurrent savings. |
| BPPC (NHS & Non-NHS) Volumes | Better Payment Practice Code (BPPC) is slightly below target at 92.4% slightly increased from previous month. |
| BPPC (NHS & Non-NHS) Values | BPPC is slightly below target at 90.4% 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 – there was an increased spend in M11 but this was mainly due to a catch up from prior months |
| Pay Spend | Pay is £0.2m adverse in month and £0.3m adverse for the YTD with slippage in better value schemes (£0.8m) offset by underspends mainly in CDC. Spend has increased in Q4 in part due to increased weekend working however there is specific funding offsetting this increase. Pay spend will need to be maintained at the current trend to support delivery of control total. |
| Non-Pay Spend | £0.9m underspent for the YTD mainly due to underspends in CDC and 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

## Sussex Pathology Network (SPN)

Exec Lead: CMO
Lead: PMO

Reporting Month: Feb-26

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. Until the LIMS/ICE replacement, which has been delayed until mid-2027, QVH will continue to depend on end-of-life systems which brings increased risk from cyber security threats, reduced levels of supplier support potentially impacting day to day clinical activity and increased operational costs.

**LIMS** – Conversations with Supplier continue - Funding from NHSE to support ongoing costs for 2026/27 FY has been applied for through the SPN on behalf of all organisations, a decision is expected in March 2026. LIMS technical testing is ongoing where possible but limited by connectivity issues (firewall permissions across SPN networks).

**Order Comms (ICE)** -Delivery of ICE will align with the revised timescales for WinPath Enterprise (LIMS). Development of the testing strategy is underway in collaboration with the LIMS project to ensure alignment and avoid duplication. There has been some slippage on the overall programme due to the complexity of the requirements but this is manageable within the LIMS Programme timescales.

**Digital Infrastructure** - Resourcing remains a risk across all digital projects but work is continuing and all Trusts are engaged.

**Digital Histopathology (DHP)** - Digital histopathology deployment remains a high priority for the department. The team continue to work through a number of technical issues relating to slide labelling and PAS/PACS connectivity. Team remain on target to commence activity in Q1 2026/27 subject to completion of patient data feed from QVH Trust Integration Engine (TIE) to Sectra.

**Managed Service Contract (MSC)** - Responses to clarification questions will be completed this month in preparation for bidder pre-submissions. Preparation for evaluation and moderation sessions is underway

**Network Formation and Laboratory Operating Model (LOM)** - The Network Formation and Laboratory Operating Model projects are continuing with drafting of the Outline Business Case. Review of outputs from site visits undertaken by Archus to support development of physical options for LOM being undertaken.

| Milestone | Start Date | Expected Completion | Comments |
|---|---|---|---|
| LIMS – Commercial negotiation and CCN to be finalised | Jan 2026 | Apr 2026 | DHP-LIMS integration relies on QVH Cerebro installation in March |
| Completion of Network Formation outline business case (OBC) for approval | Sept 2025 | June 2026 | FBC production to commence in May/June 26 |
| Managed Service Contract – bidder pre-submission deadline | Apr 2026 | May 2026 | CQs to be completed by end of March |
| Commencement of digital histopathology reporting | April 2025 | Q1 26/27 | Subject to completion of TIE/Sectra interfacing for patient data fields |

| 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. SPN to ensure that all funding is fully committed within current financial year. |
| 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

| Electronic Patient Record (EPR) | Exec Lead: CMO<br>Lead: EPR team | Reporting Month: March-25 | Overall Status: R / A / G<br>Amber |
|---|---|---|---|

The Archie EPR system continues to be optimised. As of 27 March 2026, over five months post go live:

- 71,851 digital clinical documents have been created
- 27,858 medicines prescribed and 65,932 administered
- 287,840 patient in context links out to other clinical systems in support of direct patient care
- Digitised documentation includes nearly 600,000 pieces of paper, which equates to 72 mature trees saved and avoidance of approximately 3 tonnes of $CO_2$. This directly supports the Trust's Green Plan and the NHS Net Zero commitments for 2040 and 2045
- 30% reduction in scanning

Optimisation continues with the programme team releasing additional functionality/modifications on a fortnightly basis. These include enhancements of existing documents, improvement of Critical Care Unit workflows and Theatres work to support improved staff experience and data capture. The programme team are also supporting a number of other key productivity projects for the Trust. These include provision of digital information into the NHS for patients, G2 digital transcription and Artificial Intelligence (AI) initiatives. The team are also exploring other efficiency opportunities including reduction in printing, reduction in scanning etc. The team is working in collaboration with the Trust Efficiency Steering Group to ensure any cost benefits are approved and realised. To date, approximately £210k worth of savings have been identified for 2026/27 and this is due for final validation on March 31st.

The PAS project has commenced with an expected go live of November 2026. However, this is at risk with challenges in a number of workstreams including Business Intelligence (BI)/Reporting, data migration and integration.

An NHSE Frontline Productivity Expressions of Interest bid was submitted to the Sussex Integrated Care Board (ICB) on 24th March for digital central funding for the next four years. We are expecting an outcome in June/July with funding available from October '26 if successful. This includes both capital and revenue funding for EPR optimisation including PAS and AI technologies, change management, digital medicines and cyber/hardware, The programme team have had their contracts approved by ELT with extensions until end December 2026.

| Milestone | Start Date | Expected Completion Date | Commentary |
|---|---|---|---|
| Archie Go Live. | 4th November 2025 | 21st November 2025 | Complete |
| PAS Go Live. | Q4 | Q4 2026 | Project planned for Q3/4 2026. Project at risk due to a number of challenging workstreams including data migration, integration and Business Intelligence, BI/reporting. |

| Date Raised | Risk Description | Mitigating Actions |
|---|---|---|
| Mar-26 | Number of PAS workstreams are challenging putting the November 26 go live at risk. These include data migration, integration and BI/reporting | Strategy documents have been received from suppliers for data migration and integration and are being reviewed collaboratively to see what mitigating steps can be enacted to keep go live on track. Options being reviewed with East Kent Hospitals and Kent and Medway DW team to support Trust BI team. |

# KSO5

## To collaborate with others

**Ambition**

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

**Board Assurance Framework**

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

**2025/26 Annual Objectives**

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

**2025/26 Annual goals**

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

# KSO5 EXECUTIVE SUMMARY

**Local Offer**

Job plans within Community Therapies have now been live for one month. Direct feedback was obtained from staff and used to prioritise refinements and three additional PAS users within Therapies have been trained to implement template changes. Overall productivity has increased by 7% in new patient consultations compared with Months 7–9. Performance against the referral-to-triage target has been fully achieved, with an average completion time of 8 working days (against a target of 10 working days). Correspondingly, waiting lists have improved, with the longest patient wait time reduced by three weeks.

Leadership teams attended, as planned, a workshop with Sussex Community Foundation Trust (SCFT) to explore collaboration opportunities, and where there are synergies to support patient pathway development. Work will continue to progress in this area following a number of key next steps agreed.

**Major Service Review**

Work continues to progress to develop the single point of access for elective services across Sussex. This will enable digital patient pathway development for a number specialities, including ENT.

**Community Diagnostic Centre (CDC) – East Grinstead and Bognor**

Steel installation has been completed and laying of concrete in progress 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

| **Community Diagnostics Centre (CDC)** | **Exec Lead: DCEO**<br>**Lead: PMO** | **Reporting Month: June-25** | **Overall Status: QVH – Green**<br>**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 installation of the steel framework and laying of concrete.
2. Continued engagement continues with University of Chichester regarding next steps for the Bognor site.
3. Activity against plan for East Grinstead was at 70% for February 2026 and income against plan (year to date) is 81%.
4. Redesign work planning continues for Bognor site. Long term operating model agreed in principle. More detailed work and formal agreements being undertaken.

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, and negotiation with University of Chichester on Heads of Terms for the Bognor project.

| Milestone | Start Date | Expected Completion Date | Commentary |
|---|---|---|---|
| Agreement on Heads of Terms. | 30/4/25 | 31/03/26 | Discussions with University of Chichester on new site for Bognor. Delays in obtaining a draft Heads of Terms from the University.. Deadline of March 2026. |
| Construction completion on East Grinstead site | 01/09/25 | 01/10/26 | Steel installation completed and laying of concrete commenced onsite. Delays on completion date becauise of bad weather. |
| Design of Bognor retro-fit | 01/09/25 | 31/03/26 | High level floor plan agreed December 2025 and detailed room planning has now commenced and due to be complete by end of March 2026 |

| | | |
|---|---|---|
| 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. | Confirmed that UHSX and ICB continuing 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

| Group | Metric | Value | Target | Variance to Target | Latest Month | Specialist Rank | Specialist Rank (out of) | England Rank | England Rank (out of) |
|---|---|---|---|---|---|---|---|---|---|
| **A&E / Minor Injury Unit** | All 4 Hour Waits Performance | 98.83% | 98.00% | 0.83% | Feb-26 | 2 | 3 | 9 | 140 |
| **Cancer Treatment** | 62 days Performance | 74.86% | 85.00% | -10.14% | Jan-26 | 9 | 13 | 46 | 135 |
| | FDS Performance | 82.44% | 75.00% | 7.44% | Jan-26 | 4 | 11 | 12 | 133 |
| **Diagnostics (DM01)** | Under 6 Weeks Performance | 88.79% | 95.00% | -6.21% | Jan-26 | 9 | 13 | 48 | 155 |
| **Referral To Treatment** | Within 18 Weeks Performance | 59.57% | 92.00% | -32.44% | Jan-26 | 11 | 13 | 97 | 150 |

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

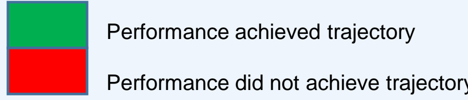
# Trajectories- Operational performance

| RTT | M1 | M2 | M3 | M4 | M5 | M6 | M7 | M8 | M9 | M10 | M11 | M12 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 65ww | | | | | | | 67 | 64 | 64** | 50** | 46 | 36 |
| 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 M9 and M10, the trust achieved the aggregate trajectory in terms of 65ww patient numbers, but was behind plan in having patients waiting over 65 weeks in specialties outside of breast.

Assurance

Variation/Performance

| Variation/Performance | Pass (P) | Hit and miss (?) | Fail (F) | No target |
|---|---|---|---|---|
| Improvement – high (H) | **Excellent** **Celebrate and Learn**<br>• This metric is improving<br>• Your aim is high numbers, and you have some<br>• You are consistently achieving the target because the current range of performance is above the target | **Good** **Celebrate and Learn**<br>• This metric is improving<br>• Your aim is high numbers, and you have some<br>• Your target lies within the process limits so we know that the target may or may not be achieved | **Concerning** **Celebrate but Take Action**<br>• This metric is improving<br>• Your aim is high numbers, and you have some<br>• 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**<br>• This metric is improving<br>• Your aim is high numbers, and you have some<br>• There is currently no target set for this metric |
| Improvement – low (L) | **Excellent** **Celebrate and Learn**<br>• This metric is improving<br>• Your aim is low numbers, and you have some<br>• You are consistently achieving the target because the current range of performance is below the target | **Good** **Celebrate and Learn**<br>• This metric is improving<br>• Your aim is low numbers, and you have some<br>• Your target lies within the process limits so we know that the target may or may not be achieved | **Concerning** **Celebrate but Take Action**<br>• This metric is improving<br>• Your aim is low numbers, and you have some<br>• 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**<br>• This metric is improving<br>• Your aim is low numbers, and you have some<br>• There is currently no target set for this metric |
| Common cause | **Good** **Celebrate and Understand**<br>• This metric is currently not changing significantly<br>• It shows the level of natural variation you can expect to see<br>• HOWEVER, you are consistently achieving the target because the current range of performance exceeds the target | **Average** **Investigate and Understand**<br>• This metric is currently not changing significantly<br>• It shows the level of natural variation you can expect to see<br>• Your target lies within the process limits so we know that the target may or may not be achieved | **Concerning** **Investigate and Take Action**<br>• This metric is deteriorating<br>• Your aim is low numbers, and you have some high numbers<br>• Your target lies below the current process limits so we know that the target will not be achieved without change | **Average** **Understand**<br>• This metric is currently not changing significantly<br>• It shows the level of natural variation you can expect to see<br>• There is currently no target set for this metric |
| Concern – high (H) | **Concerning** **Investigate and Understand**<br>• This metric is deteriorating<br>• Your aim is low numbers, and you have some high numbers<br>• HOWEVER, you are consistently achieving the target because the current range of performance is below the target | **Concerning** **Investigate and Take Action**<br>• This metric is deteriorating<br>• Your aim is low numbers, and you have some high numbers<br>• 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**<br>• This metric is deteriorating<br>• Your aim is low numbers, and you have some high numbers<br>• Your target lies below the current process limits so we know that the target will not be achieved without change | **Concerning** **Investigate**<br>• This metric is deteriorating<br>• Your aim is high numbers, and you have some low numbers<br>• There is currently no target set for this metric |
| Concern – low (L) | **Concerning** **Investigate and Understand**<br>• This metric is deteriorating<br>• Your aim is high numbers, and you have some low numbers<br>• HOWEVER, you are consistently achieving the target because the current range of performance is above the target | **Concerning** **Investigate and Take Action**<br>• This metric is deteriorating<br>• Your aim is high numbers, and you have some low numbers<br>• 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**<br>• This metric is deteriorating<br>• Your aim is high numbers, and you have some low numbers<br>• Your target lies above the current process limits so we know that the target will not be achieved without change | **Concerning** **Investigate**<br>• This metric is deteriorating<br>• Your aim is high numbers, and you have some low numbers<br>• There is currently no target set for this metric |

# GLOSSARY

| Abbreviation | Definition | Abbreviation | Definition | Abbreviation | Definition |
|---|---|---|---|---|---|
| AfC | Agenda for Change | ESR | Electronic Staff Record | OBC | Outline Business Case |
| AHP | Allied Health Professionals | F2SU | Freedom to Speak Up | OD&L | Organisational Development & Learning |
| BAF | Board Assurance Framework | FBC | Full Business Case | OH | Occupational Health |
| BLS | Basic Life Support | FDS | Faster Diagnosis Standard | OIP | Outline Implementation Plan |
| BPPC | Better Practice Payment Code | FFT | Friends and Family Test | OMFS | Oral and Maxillofacial surgery |
| BU | Business Unit | FPT | Full Patient Transfers | OPD | Outpatients Department |
| CD | Clinical Director | GA | General Anaesthetic | OPPROC | Outpatient Procedure |
| CDC | Community Diagnistic Centre | GIRFT | Getting It Right First Time | PAS | Patient Administration System |
| CDEL | Capital Departmental Expenditure Limit | GM | General Manager | PDC | Public Dividend Capital |
| CDI | Clostridium difficile infection | H&N | Head and Neck | PDSA | Plan, Do, Study, Act |
| CEO | Chief Excutive Officer | HoD | Head of Department | PID | Project Initiation Document |
| CFO | Chief Financial Officer | ICB | Integrated Care Board | PIFU | Patient Initiated Follow Up |
| CI | Continuous Improvement | ICE | Integrated Clinical Environment | PLACE | Patient-Led Assessments of the Care Environment |
| CMO | Chief Medical Officer | ICS | Integrated Care System | PROM | Patient Reported Outcome Measure |
| CNO | Chief Nursing Officer | IP | Inpatients | PSIRF | Patient Safety Incident Response Framework |
| COO | Chief Operating Officer | IPACT | Infection Prevention and Control Team | PTL | Patient Tracking List |
| COTD | Cancellations on the Day | IS | Independent Sector | QNET | Queen Victoria Hospital's intranet |
| CPO | Chief People Officer | KPI | Key Performance Indicator | QP | Quality Priority |
| CQC | Care Quality Commission | KSO | Key Strategic Objective | RTT | Referral to Treatment |
| CQUIN | Commissioning for Quality and Innovation | LAB | Local Academic Board | SDP | Shared Delivery Plan (NHS Sussex) |
| CRL | Capital resource Limit | LAU | Local Anaesthetic Unit | SLNB | Sentinel Lymph Node Biopsy |
| CSO | Chief Strategy Officer | LEEP | Leadership through Education for Excellent Patient Care | SPC | Statistical Process Control |
| DATIX | Reporting system for reporting clinical incidents | LFG | Local Faculty Group | SPN | Sussex Pathology Network |
| DM01 | Diagnostic waiting times and activity | LIMS | Laboratory Information Management System | SSCA | Surrey and Sussex Cancer Alliance |
| DNA | Did Not Attend | MAST | Mandatory and Statutory Training | TMJ | Temporomandibular Joint Dysfunction |
| DSU | Day Surgery Unit | MIU | Minor Injuries Unit | VPR | Violence Prevention Reduction |
| DTA | Decision to Admit | MRSA | Methicillin-resistant Staphylococcus Aureus | VWA | Value Weighted Activity |
| EDI | Equality, Diversity and Inclusion | MSC | Managed Service Contract | WRED | Workforce Disability Equality Standard |
| ENT | Ear Nose and Throat | MSK | Musculoskeletal | WRES | Workforce Race Equality Standard |
| EPR | Electronic Patient Record | MSSA | Meticillin Sensitive Staphylococcus Aureus | WTE | Whole Time Equivalent |
| ER | Employee Relations | NHSE | NHS England | | |
| ERF | Elective Recovery Fund | NICE | National Institute for Health and Care Excellence | | |

| Report cover-page | | | | | |
|---|---|---|---|---|---|
| **References** | | | | | |
| **Meeting title:** | Board of Directors | | | | |
| **Meeting date:** | 14/05/2026 | | **Agenda reference:** | **10-26** | |
| **Report title:** | 2026/27 Business Plan Summary | | | | |
| **Sponsor:** | Simon Marshall, Interim Chief Finance Officer | | | | |
| **Author:** | Jonathan Wharton, Deputy Chief Finance Officer | | | | |
| **Appendices:** | None | | | | |
| **Executive summary** | | | | | |
| **Purpose of report:** | To provide a summary of the final 2026/27 business plan | | | | |
| **Summary of key issues** | • The Trust submitted its final finance, activity and operating plan for 2026/27 on the 18 March 2026.<br>• The plan as submitted shows a breakeven position on income and expenditure, with a cost improvement programme of £7.5m and a capital programme of £7.8m. The submission was for a multi-year plan which broke even each year, met agreed performance targets and delivered workforce numbers that met NHSE guidance.<br>• The cost improvement programme (CIP) contained £0.8m of unidentified CIP that the Trust is working on identifying and coming up with non-recurrent measures to offset. The total CIP at £7.5m represents 6% of operating expenditure.<br>• The activity plan reflects the activity required to deliver the performance targets in 2026/27 and the following 2 years and therefore includes an increase in both activity and income to deliver these targets. The workforce plan includes staffing that will enable the Trust to deliver these activity levels.<br>• The Trust has agreed contract values with its commissioners and will be paid if we deliver the planned activity levels. Contracts will be signed during May.<br>• The workforce plan triangulates with the finance and activity plans and shows a net reduction of 49 WTE across the year. | | | | |
| **Recommendation:** | To note the report and ratify the plan submission. | | | | |
| **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:** | KSO1. KSO2, KSO3, KSO4, KSO5 | | | | |
| **Corporate risk register:** | none | | | | |
| **Regulation:** | none | | | | |
| **Legal:** | none | | | | |
| **Resources:** | none | | | | |
| **Assurance route** | | | | | |
| **Previously considered by:** | Executive Leadership Team, F&P Committee, Private Board | | | | |
| | Date: | March 26 | Decision: | Noted & approved. | |
| **Next steps:** | Sign off all directorate budgets; progress CIP development and delivery, complete Quality and Safety impact Assessments. | | | | |

| | |
|---|---|
| **Report to:** | Board of Directors |
| **Agenda item:** | 10-26 |
| **Date of meeting:** | 14 May 2026 |
| **Report from:** | Simon Marshall, Interim Chief Finance Officer |
| **Report author:** | Jonathan Wharton, Deputy Chief Finance Officer |
| **Date of report:** | May 2026 |
| **Appendices:** | None |

# QVH 2026/27 Business Plan Summary

This paper summarises the final business plan submitted by QVH for 2026/27.

## 1. Business Planning for 2026/27 Submission

For 2026/27 QVH submitted the final financial, activity and workforce plan to the ICB and then subsequently to NHSE on the 18th March 2026. The final plan that was submitted contained:

- An overall income and expenditure breakeven position
- A Cost Improvement Programme (CIP) of £7.5m or 6% of operating expenditure
- Capital programme of £7.8m, including estates safety funding
- Activity plans to deliver compliance with performance standards in year 1 and partial compliance in years 2 & 3
- Workforce plans showing a net reduction of 49 WTE
- A 5-year narrative plan.

The main change from the first submission was that the second and final submission was a multi-year plan with activity, finance, workforce and CIP covering 3 years and capital covering 5 years. The deficit support funding received in previous years has been withdrawn as per NHS guidance, with the maximum income reduction capped at 2.5%. The Trust's multi-year plan included the delivery of a breakeven position in all years. Please note the pay awards were not finalised when plan was submitted, and therefore these will be updated in year in line with NHSE guidance.

## 2. Financial Plan Summary

### Financial Position

The table below shows the financial submission that was made to NHSE on the 18th March. The Trust has agreed a breakeven plan for 2026/27 while recognising that there are risks to achieving this plan. The plan was phased across the year, to reflect savings and income profiles, which has led to some months of the year where the Trust is planning to make a deficit, offset by other months when it will generate a surplus. These combined will lead to a breakeven position by the year-end.

## Table 1

| | Out-turn 2025/26 Year Ending £'000 | Plan 2026/27 Month 1 £'000 | Plan 2026/27 Month 2 £'000 | Plan 2026/27 Month 3 £'000 | Plan 2026/27 Month 4 £'000 | Plan 2026/27 Month 5 £'000 | Plan 2026/27 Month 6 £'000 | Plan 2026/27 Month 7 £'000 | Plan 2026/27 Month 8 £'000 | Plan 2026/27 Month 9 £'000 | Plan 2026/27 Month 10 £'000 | Plan 2026/27 Month 11 £'000 | Plan 2026/27 Month 12 £'000 | Plan 2026/27 Year Ending £'000 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Operating income from patient care activities | 116,673 | 9,430 | 9,275 | 9,871 | 10,128 | 9,251 | 9,651 | 9,912 | 9,643 | 9,045 | 9,482 | 9,300 | 9,697 | **114,685** |
| Other operating income | 5,204 | 425 | 425 | 425 | 425 | 425 | 425 | 425 | 425 | 425 | 425 | 425 | 418 | **5,093** |
| Employee expenses | (77,468) | (6,411) | (6,369) | (6,341) | (6,338) | (6,270) | (6,270) | (6,270) | (6,270) | (6,296) | (6,270) | (6,270) | (6,302) | **(75,677)** |
| Operating expenses excluding employee expenses | (42,436) | (3,500) | (3,492) | (3,492) | (3,472) | (3,472) | (3,480) | (3,480) | (3,489) | (3,469) | (3,469) | (3,469) | (3,456) | **(41,740)** |
| **OPERATING SURPLUS/(DEFICIT)** | **1,973** | **(56)** | **(161)** | **463** | **743** | **(66)** | **326** | **587** | **309** | **(295)** | **168** | **(14)** | **357** | **2,361** |
| **FINANCE COSTS** | | | | | | | | | | | | | | |
| Finance income | 474 | 36 | 36 | 36 | 36 | 35 | 35 | 35 | 35 | 35 | 35 | 35 | 38 | **427** |
| Finance expense | (84) | (3) | (3) | (3) | (3) | (3) | (3) | (3) | (3) | (3) | (3) | (3) | (3) | **(36)** |
| PDC dividend expense | (2,631) | (239) | (239) | (239) | (239) | (239) | (239) | (239) | (239) | (239) | (239) | (239) | (240) | **(2,869)** |
| **NET FINANCE COSTS** | **(2,241)** | **(206)** | **(206)** | **(206)** | **(206)** | **(207)** | **(207)** | **(207)** | **(207)** | **(207)** | **(207)** | **(207)** | **(205)** | **(2,478)** |
| | | | | | | | | | | | | | | |
| **SURPLUS/(DEFICIT) FOR THE PERIOD/YEAR PER ACCOUNTS** | **(268)** | **(262)** | **(367)** | **257** | **537** | **(273)** | **119** | **380** | **102** | **(502)** | **(39)** | **(221)** | **152** | **(117)** |
| Remove capital donations/grants/peppercorn lease I&E impact | 279 | 10 | 10 | 10 | 10 | 10 | 10 | 10 | 10 | 10 | 10 | 10 | 8 | 118 |
| **Adjusted financial performance surplus/(deficit)** | **11** | **(252)** | **(357)** | **267** | **547** | **(263)** | **129** | **390** | **112** | **(492)** | **(29)** | **(211)** | **160** | **1** |

*Excluding additional DSF and national pension*

## Income and Activity

The Income plan has been phased to reflect expected activity levels required to meet performance targets, adjusted for seasonality, calendar days and working days. The total variable element in the plan is £53.0m and contains the growth in elective activity required to deliver the performance targets, contract values for 2026/27 have been agreed with all commissioners, and we will be paid according to the activity delivered. This additional activity and income is critical to both supporting the costs of delivering the performance targets and in supporting the CIP programme. There is a risk that the quarterly reconciliation process will push our full & final payments to later months of the year. However, in cash terms we have sufficient available balances to manage this risk. The tables below show the phasing of clinical income and other operating income across the year.

## Table 2

| **Income from patient care activities (by source)** | Plan 2026/27 Month 1 £'000 | Plan 2026/27 Month 2 £'000 | Plan 2026/27 Month 3 £'000 | Plan 2026/27 Month 4 £'000 | Plan 2026/27 Month 5 £'000 | Plan 2026/27 Month 6 £'000 | Plan 2026/27 Month 7 £'000 | Plan 2026/27 Month 8 £'000 | Plan 2026/27 Month 9 £'000 | Plan 2026/27 Month 10 £'000 | Plan 2026/27 Month 11 £'000 | Plan 2026/27 Month 12 £'000 | Plan 2026/27 Year Ending £'000 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| NHS England | 690 | 658 | 753 | 785 | 658 | 721 | 753 | 721 | 627 | 690 | 691 | 726 | 8,473 |
| Integrated Care Boards | 8,527 | 8,404 | 8,904 | 9,129 | 8,380 | 8,716 | 8,945 | 8,708 | 8,204 | 8,580 | 8,397 | 8,766 | 103,660 |
| NHS foundation trusts | 133 | 133 | 133 | 133 | 133 | 133 | 133 | 133 | 133 | 133 | 133 | 131 | 1,594 |
| NHS trusts | 13 | 13 | 13 | 13 | 13 | 13 | 13 | 13 | 13 | 13 | 13 | 17 | 160 |
| Non-NHS: private patients | 2 | 2 | 2 | 2 | 2 | 2 | 2 | 2 | 2 | 1 | 1 | 0 | 20 |
| Non-NHS: overseas patients (non-reciprocal, chargeable to patient) | 7 | 7 | 8 | 8 | 7 | 8 | 8 | 8 | 8 | 7 | 7 | 7 | 90 |
| Injury cost recovery scheme | 14 | 14 | 14 | 14 | 14 | 14 | 14 | 14 | 14 | 14 | 14 | 12 | 166 |
| Non-NHS: other | 44 | 44 | 44 | 44 | 44 | 44 | 44 | 44 | 44 | 44 | 44 | 38 | 522 |
| **Total income from patient care activities** | **9,430** | **9,275** | **9,871** | **10,128** | **9,251** | **9,651** | **9,912** | **9,643** | **9,045** | **9,482** | **9,300** | **9,697** | **114,685** |

**Table 3**

| Other operating income | Plan 2026/27 Month 1 £'000 | Plan 2026/27 Month 2 £'000 | Plan 2026/27 Month 3 £'000 | Plan 2026/27 Month 4 £'000 | Plan 2026/27 Month 5 £'000 | Plan 2026/27 Month 6 £'000 | Plan 2026/27 Month 7 £'000 | Plan 2026/27 Month 8 £'000 | Plan 2026/27 Month 9 £'000 | Plan 2026/27 Month 10 £'000 | Plan 2026/27 Month 11 £'000 | Plan 2026/27 Month 12 £'000 | Plan 2026/27 Year Ending £'000 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Research and development (both IFRS 15 and non-IFRS 15 income) | 26 | 26 | 26 | 26 | 26 | 26 | 26 | 26 | 26 | 26 | 26 | 24 | **310** |
| Education and training (excluding notional apprenticeship levy income) | 225 | 225 | 225 | 225 | 225 | 225 | 225 | 225 | 225 | 225 | 225 | 223 | **2,698** |
| Non-patient care services to other WGA bodies | 13 | 13 | 13 | 13 | 13 | 13 | 13 | 13 | 13 | 13 | 13 | 13 | **156** |
| Car parking income | 52 | 52 | 52 | 52 | 52 | 52 | 52 | 52 | 52 | 52 | 52 | 53 | **625** |
| Catering | 24 | 24 | 24 | 24 | 24 | 24 | 24 | 24 | 24 | 24 | 24 | 32 | **296** |
| Other income not covered | 11 | 11 | 11 | 11 | 11 | 11 | 11 | 11 | 11 | 11 | 11 | 5 | **126** |
| Other income generation schemes (recognised under IFRS 15) | 53 | 53 | 53 | 53 | 53 | 53 | 53 | 53 | 53 | 53 | 53 | 51 | **634** |
| Charitable and other contributions to expenditure | 21 | 21 | 21 | 21 | 21 | 21 | 21 | 21 | 21 | 21 | 21 | 17 | **248** |
| **Total other operating income** | **425** | **425** | **425** | **425** | **425** | **425** | **425** | **425** | **425** | **425** | **425** | **418** | **5,093** |

## Cost improvement plan (CIP)

The overall CIP target for 2026/27 is £7.5m or 6% of operating expenditure, which is the same level as that required in 2025/26. The CIP target represents a significant challenge for the organisation, as the CIP will need to be delivered through cost reductions with limited further opportunities to grow income due to the increase in activity and income required to deliver the performance targets already built in. Within the CIP plan is a target to reduce spend on corporate functions by £1.0m across the year in order to reduce the corporate overheads in line with national expectations. The programme also contains a target for clinical productivity of £1.8m, which is to improve the productivity of clinical services through cost reduction or delivering more activity at reduced cost. When the plan was submitted £0.8m was unidentified and this is being worked on by the Trust along with non-recurrent methods for covering this part of the CIP programme.

The CIP programme submitted in the plan has been phased with an increase throughout the year to represent the time it will take the Trust to implement the CIP programme. In order to avoid a back ended plan the CIP programme phasing needs to meet certain criteria including no less than 20% of CIP programmed in the first quarter and no more than 55% programmed in the second half of the year. The plans submitted met this with 21% in Q1 and the year split into 47% H1 and 53% H2. This does mean that the CIP programme needs to start quickly with many schemes coming on line near the start of the year. The table below shows the CIP programme and phasing as included in the submitted plan. (Smaller schemes under £100k have been grouped together)

**Table 4**

| CIP Narrative | | Plan 2026/27 Month 1 £'000 | Plan 2026/27 Month 2 £'000 | Plan 2026/27 Month 3 £'000 | Plan 2026/27 Month 4 £'000 | Plan 2026/27 Month 5 £'000 | Plan 2026/27 Month 6 £'000 | Plan 2026/27 Month 7 £'000 | Plan 2026/27 Month 8 £'000 | Plan 2026/27 Month 9 £'000 | Plan 2026/27 Month 10 £'000 | Plan 2026/27 Month 11 £'000 | Plan 2026/27 Month 12 £'000 | Plan 2026/27 Year Ending £'000 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Corporate saving | Pay | 51 | 56 | 56 | 67 | 67 | 67 | 67 | 67 | 57 | 67 | 67 | 61 | **750** |
| Partnership - efficiencies | Pay | 14 | 15 | 15 | 18 | 18 | 18 | 18 | 18 | 15 | 18 | 18 | 15 | **200** |
| Changes to LAU and theatre models | Pay | 40 | 50 | 61 | 50 | 75 | 75 | 75 | 75 | 75 | 75 | 75 | 74 | **800** |
| Improved bed utilisation | Pay | 17 | 21 | 25 | 21 | 31 | 31 | 31 | 31 | 31 | 31 | 31 | 34 | **335** |
| Productivity - Pay | Pay | 61 | 70 | 78 | 70 | 90 | 90 | 90 | 90 | 90 | 90 | 90 | 91 | **1,000** |
| Productivity - Non Pay | Non-Pay | 30 | 30 | 30 | 33 | 33 | 33 | 33 | 33 | 36 | 36 | 36 | 37 | **400** |
| Procurement Non-Pay Savings | Non-Pay | 22 | 22 | 22 | 25 | 25 | 25 | 25 | 25 | 27 | 27 | 27 | 28 | **300** |
| Digital Transformation | Non-Pay | 28 | 28 | 28 | 31 | 31 | 31 | 31 | 31 | 34 | 34 | 34 | 34 | **375** |
| Admin and Staff mix reviews | Pay | 34 | 37 | 37 | 44 | 44 | 44 | 44 | 44 | 38 | 44 | 44 | 46 | **500** |
| Temporary staffing Controls | Pay | 10 | 11 | 11 | 13 | 13 | 13 | 13 | 13 | 11 | 13 | 13 | 16 | **150** |
| Car parking price increase | Income | 13 | 13 | 13 | 13 | 13 | 13 | 13 | 13 | 13 | 13 | 13 | 7 | **150** |
| Critical Care/HDU | Pay | 5 | 6 | 8 | 6 | 9 | 9 | 9 | 9 | 9 | 9 | 9 | 12 | **100** |
| Partnership - subsidiary | Pay | 17 | 19 | 19 | 22 | 22 | 22 | 22 | 22 | 19 | 22 | 22 | 22 | **250** |
| Childrens day case model | Pay | 10 | 13 | 15 | 13 | 19 | 19 | 19 | 19 | 19 | 19 | 19 | 16 | **200** |
| Productivity - Planned Care | Non-Pay | 30 | 30 | 30 | 33 | 33 | 33 | 33 | 33 | 36 | 36 | 36 | 37 | **400** |
| Other income schemes under £100k | Income | 6 | 6 | 6 | 6 | 6 | 6 | 6 | 6 | 6 | 6 | 6 | 3 | **69** |
| Other Pay schemes under £100k | Pay | 2 | 4 | 4 | 4 | 4 | 4 | 4 | 4 | 4 | 4 | 4 | 7 | **49** |
| Other Non Pay schemes under £100k | Non-Pay | 55 | 55 | 55 | 56 | 56 | 56 | 56 | 56 | 65 | 65 | 65 | 65 | **705** |
| Trust 2026/27 non recurrent unidentified - Pay | Pay | 30 | 32 | 32 | 38 | 38 | 38 | 38 | 38 | 33 | 38 | 38 | 38 | **431** |
| Trust 2026/27 non recurrent unidentified - Non-Pay | Non-Pay | 24 | 24 | 24 | 27 | 27 | 27 | 27 | 27 | 30 | 30 | 30 | 31 | **328** |
| **Total** | | **499** | **542** | **569** | **590** | **654** | **654** | **654** | **654** | **648** | **677** | **677** | **674** | **7,492** |

## Underlying Deficit

The exit underlying deficit in 2025/26 was calculated during the planning process to be a £1.6m deficit, which is an improvement from the original plan of a £2.1m deficit. The Trust plan is to further reduce the underlying deficit by the end of 2026/27 to £0.8m. This number does not include the deficit support funding, which was removed in year (£1.5m) and was not part of the previous underlying deficit calculation – in effect, this element is therefore included within our in-year £7.5m CIP ask. The 3 year plan that was submitted sees the Trust move to an underlying breakeven by the end of 2027/28.

## Capital Programme

The Trust has been given its capital allocations for the next 5 years. It has also made some applications for additional funding. Allocation of these bids has not been confirmed with the exception of the estates safety funding for 2026/27 (although final confirmation is still to be received). The table below shows the capital funding the Trust has been allocated for the next 5 years. Please note the split of these programmes will need to be amended in year to take account of the final 2025/26 EG CDC slippage and the Bognor CDC Grant agreement / sale of assets.

**Table 5**

| Capial Programme | Plan 2026/27 Year Ending £'000 | Plan 2027/28 Year Ending £'000 | Plan 2028/29 Year Ending £'000 | Plan 2029/30 Year Ending £'000 | Plan 2030/31 Year Ending £'000 |
|---|---|---|---|---|---|
| IT Hardware | 300 | 750 | 1,500 | 1,500 | 1,500 |
| Medical Devices & Equipment Replacement Programme | 500 | 750 | 1,000 | 1,000 | 1,000 |
| Estates Programme | 762 | 2,484 | 2,523 | 2,608 | 3,563 |
| EPR | 1,000 | | | | |
| CDC | 1,000 | | | | |
| Sussex Pathology Network | 620 | | | | |
| Estates Safety Funding Programme | 3,603 | | | | |
| MIU refurbishment | | 500 | | | |
| **Total** | **7,785** | **4,484** | **5,023** | **5,108** | **6,063** |

The table below shows the phasing of the capital plan that was submitted and the indicative split between the capital programmes.

**Table 6**

| Capial Programme | Plan 2026/27 Month 1 £'000 | Plan 2026/27 Month 2 £'000 | Plan 2026/27 Month 3 £'000 | Plan 2026/27 Month 4 £'000 | Plan 2026/27 Month 5 £'000 | Plan 2026/27 Month 6 £'000 | Plan 2026/27 Month 7 £'000 | Plan 2026/27 Month 8 £'000 | Plan 2026/27 Month 9 £'000 | Plan 2026/27 Month 10 £'000 | Plan 2026/27 Month 11 £'000 | Plan 2026/27 Month 12 £'000 | Plan 2026/27 Year Ending £'000 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| IT Hardware | - | - | - | 33 | 33 | 33 | 33 | 33 | 33 | 33 | 33 | 36 | **300** |
| Medical Devices & Equipment Replacement Programme | - | - | 125 | - | - | 125 | - | - | 125 | - | - | 125 | **500** |
| Estates Programme | 63 | 64 | 63 | 64 | 63 | 64 | 63 | 64 | 63 | 64 | 63 | 64 | **762** |
| EPR | - | - | - | 111 | 111 | 111 | 111 | 111 | 111 | 111 | 111 | 112 | **1,000** |
| CDC | - | - | - | 1,000 | - | - | - | - | - | - | - | - | **1,000** |
| Sussex Pathology Network | 52 | 52 | 52 | 52 | 52 | 52 | 52 | 52 | 52 | 52 | 50 | 50 | **620** |
| Estates Safety Funding Programme | - | - | - | 400 | 400 | 400 | 400 | 400 | 400 | 400 | 400 | 403 | **3,603** |
| **Total** | **115** | **116** | **240** | **1,660** | **659** | **785** | **659** | **660** | **784** | **660** | **657** | **790** | **7,785** |

## 3. Activity plan summary

The Trust submitted an activity plan and trajectories that meet the national performance targets for 2026/27. The target is stretching and in later years' the targets are not all fully met. The Trust has had discussions with NHSE on these and agreed that the Trust would make considerable improvement in the RTT waiting lists (as per the plan) but would not meet the targets for year. The Trust also agreed that due to the increasing number of referrals the overall waiting list would see an increase instead of a decrease although the longest waiters would come down. The last measures that showed as not being met will be met by M12 in each year as per the guidance. The table below shows the activity and performance targets included in the plan.

**Table 7**

| Planning Metric | 2026/27 Specific Target/ Baseline | 2026/27 Plan | Variance to target/ basline | 2027/28 Specific Target/ Baseline | 2027/28 Plan | Variance to target/ basline | 2028/29 Specific Target/ Baseline | 2028/29 Plan | Variance to target/ basline | Notes |
|---|---|---|---|---|---|---|---|---|---|---|
| Percentage of RTT waiting list within 18 weeks | 69.4% | 69.40% | 0.04% | 80.70% | 75.40% | -5.30% | 92% | 81.40% | -10.60% | Improving trajectory |
| 28-day cancer Faster Diagnosis Standard | 80.0% | 81.07% | 1.07% | 80.00% | 81.15% | 1.15% | 80% | 81.44% | 1.44% | |
| Percentage of patients receiving a first definitive treatment for cancer within 62 days | 80.0% | 80.00% | 0.00% | 82.50% | 81.57% | -0.93% | 85% | 83.64% | -1.36% | Target met in M12 |
| Percentage of people treated beginning first or subsequent treatment of cancer within 31 days | 94.0% | 94.01% | 0.01% | 96.00% | 95.27% | -0.73% | 96% | 96.09% | 0.09% | Target met in M12 |
| Percentage of patients waiting for a diagnostic test or procedure for 6 weeks or over | | | | | | | 1% | 1.00% | 0.00% | |
| 4-hour A&E performance | 82.0% | - | - | 83.0% | - | - | 85% | - | - | |
| 12-hour breaches | - | 0 | - | 0 | 0 | 0.00% | 0 | 0 | -100.00% | |
| Total Waiting List | 21,792 | 21,181 | -2.80% | 21,181 | 22,582 | 6.61% | 22,582 | 23,861 | 5.66% | Increasing referrals |
| Average handover time (Total Handover time (ED and non ED)/No of handovers (ED and non-ED) | 00:11:53 | 00:11:47 | - 00:06 | 00:11:47 | 00:11:17 | - 00:29 | 00:11:17 | 00:11:16 | - 00:01 | |
| Percentage of Handovers over 45 Minutes | 0% | 0.00% | 0.00% | | | | | | | |
| Percentage of Handovers over 15 Minutes | | | | 0 | 0.00% | 0.00% | 0% | 0.00% | 0.00% | |

## 4. Workforce Plan Summary

For 2026/27, QVH has submitted a plan to reduce its overall establishment from 1,172 WTE to 1,123 WTE, a reduction of 49 WTE from the overall establishment.

NHSE set both bank and agency caps for each Trust. The plan that has been submitted comes in under these caps and follows the reduction in WTE of agency by 40% and bank by 10%. The workforce plan aligns with both the financial and activity plans. The changes to the Trust WTE reflects both the CIP programme reduction and the estimated staffing increases required to deliver the performance targets. The table below shows the breakdown of the workforce submission split by staff group.

**Table 8**

| | Staff in Post | | | | | | | | | | | | Establishment |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **Staff WTE by Staff Group** | **Plan 2026/27 Month 1 WTE** | **Plan 2026/27 Month 2 WTE** | **Plan 2026/27 Month 3 WTE** | **Plan 2026/27 Month 4 WTE** | **Plan 2026/27 Month 5 WTE** | **Plan 2026/27 Month 6 WTE** | **Plan 2026/27 Month 7 WTE** | **Plan 2026/27 Month 8 WTE** | **Plan 2026/27 Month 9 WTE** | **Plan 2026/27 Month 10 WTE** | **Plan 2026/27 Month 11 WTE** | **Plan 2026/27 Month 12 WTE** | **Plan 2026/27 Year Ending WTE** |
| **Non-medical - clinical staff** | | | | | | | | | | | | | |
| Registered nursing, midwifery and health visiting staff | **227.85** | **223.61** | **219.53** | **217.31** | **214.69** | **209.10** | **207.52** | **206.97** | **204.19** | **209.23** | **208.63** | **209.48** | **211.78** |
| *Allied health professionals (excluding paramedics)* | 81.71 | 80.63 | 80.39 | 81.69 | 80.82 | 81.97 | 80.31 | 78.00 | 77.58 | 78.07 | 77.98 | 78.75 | 78.75 |
| *Other scientific, therapeutic and technical staff* | 48.42 | 50.33 | 49.55 | 49.89 | 50.46 | 50.86 | 49.57 | 50.00 | 49.56 | 50.93 | 50.82 | 49.28 | 50.77 |
| *Healthcare scientists* | 44.30 | 45.13 | 47.03 | 47.27 | 47.16 | 47.48 | 48.49 | 48.65 | 49.41 | 50.27 | 51.22 | 49.77 | 52.56 |
| Healthcare scientists and scientific, therapeutic and technical staff | **174.43** | **176.09** | **176.96** | **178.85** | **178.43** | **180.31** | **178.37** | **176.66** | **176.55** | **179.26** | **180.02** | **177.80** | **182.08** |
| Qualified ambulance service staff | **3.55** | **3.55** | **3.54** | **3.55** | **3.29** | **3.27** | **3.27** | **3.27** | **3.26** | **3.29** | **3.29** | **2.48** | **2.48** |
| *Support to nursing staff* | 131.19 | 135.48 | 136.34 | 134.31 | 135.60 | 133.44 | 131.60 | 131.25 | 130.12 | 128.74 | 128.69 | 129.02 | 129.02 |
| *Support to allied health professionals* | 26.91 | 26.92 | 29.95 | 28.90 | 28.91 | 30.84 | 28.62 | 28.65 | 31.15 | 31.15 | 27.90 | 30.76 | 33.76 |
| *Support to other clinical staff* | 25.43 | 25.65 | 23.91 | 21.89 | 21.90 | 23.12 | 23.12 | 22.63 | 22.63 | 22.12 | 23.11 | 24.05 | 24.55 |
| Support to clinical staff | **183.53** | **188.05** | **190.20** | **185.11** | **186.41** | **187.41** | **183.34** | **182.52** | **183.89** | **182.01** | **179.70** | **183.83** | **187.33** |
| **Total non-medical - clinical staff** | **589.36** | **591.30** | **590.23** | **584.82** | **582.82** | **580.09** | **572.50** | **569.42** | **567.89** | **573.79** | **571.64** | **573.59** | **583.67** |
| **Medical and dental staff** | | | | | | | | | | | | | |
| Consultants | 90.64 | 93.20 | 95.76 | 95.05 | 97.36 | 98.98 | 100.59 | 100.90 | 102.37 | 101.55 | 102.62 | 102.49 | 103.99 |
| Career/staff grades | 22.92 | 23.66 | 22.55 | 24.65 | 24.46 | 25.31 | 25.33 | 25.49 | 24.99 | 26.11 | 26.07 | 25.11 | 25.61 |
| Resident grades | 67.36 | 67.33 | 67.07 | 67.30 | 69.30 | 69.93 | 68.97 | 69.36 | 69.37 | 70.38 | 71.95 | 70.16 | 70.16 |
| **Total medical and dental staff** | **180.91** | **184.19** | **185.38** | **187.00** | **191.12** | **194.22** | **194.89** | **195.74** | **196.74** | **198.04** | **200.63** | **197.76** | **199.76** |
| **Non medical - non-clinical staff** | | | | | | | | | | | | | |
| NHS infrastructure support | 367.79 | 362.93 | 358.68 | 354.96 | 345.29 | 343.48 | 335.88 | 331.83 | 330.10 | 333.06 | 332.11 | 333.12 | 333.12 |
| Any others | 8.00 | 8.00 | 8.00 | 8.00 | 8.00 | 7.00 | 7.00 | 7.00 | 7.00 | 7.00 | 7.00 | 7.00 | 7.00 |
| **Total non medical - non-clinical staff** | **375.79** | **370.93** | **366.68** | **362.96** | **353.29** | **350.48** | **342.88** | **338.83** | **337.10** | **340.06** | **339.11** | **340.12** | **340.12** |
| **Total Staff WTE** | **1146.06** | **1146.42** | **1142.29** | **1134.77** | **1127.23** | **1124.80** | **1110.27** | **1103.98** | **1101.73** | **1111.89** | **1111.38** | **1111.47** | **1123.55** |

## 5. Next Steps

The finance and directorate teams have been working on finalising the Trust internal budgets and signing these off. A number of budgets have been signed off with the final adjustments being made to others budgets following the allocations of funding to deliver the activity and performance plans. It is expected that sign off will be completed during May.

## 6. Conclusion and Recommendation

The Trust Board is asked to note the financial, activity and workforce plans that are summarised in this paper and that were previously submitted with the prior agreement of the Board, whilst recognising that there is substantial risk to delivery in the plan as submitted that will need to be managed and mitigated in year.

<table>
<tr><th colspan="6">Report cover-page</th></tr>
<tr><td colspan="6">References</td></tr>
<tr><td>Meeting title:</td><td colspan="5">Board of Directors</td></tr>
<tr><td>Meeting date:</td><td colspan="2">14/05/2026</td><td colspan="2">Agenda reference:</td><td>11-26</td></tr>
<tr><td>Report title:</td><td colspan="5">Quality & Safety committee assurance report</td></tr>
<tr><td>Sponsor:</td><td colspan="5">Russell Hobby, Non-executive director and committee member</td></tr>
<tr><td>Author:</td><td colspan="5">Jo Emmanuel, Non-executive director committee Chair<br>Katie Ally, Governance officer</td></tr>
<tr><td>Appendices:</td><td colspan="5">None</td></tr>
<tr><td colspan="6">Executive summary</td></tr>
<tr><td>Purpose of report:</td><td colspan="5">To alert, assure and advise the Board regarding matters considered at the last committee meeting.</td></tr>
<tr><td>Summary of key issues</td><td colspan="5">– IQPR month 11 report and the month 12 year end performance update, Referral to Treatment (RTT) standards were not fully achieved; however, there has been sustained progress in reducing long waits, including significant reductions in 52 and 65 week waits. The committee received assurance that all patients experiencing extended waits are subject to appropriate clinical oversight, with strengthened leadership arrangements and improved PTL management in place to mitigate safety risks, while recognising ongoing pressures related to capacity, industrial action and breast services.<br>– Cancer standards were delivered at year end, with all patients waiting over 62 days receiving regular clinical harm reviews and no harm identified. Assurance was provided that targeted improvement plans, particularly within skin cancer pathways, are being implemented and monitored through the Trust Cancer Board to support timely diagnosis and treatment.<br>– Patient safety continues to be prioritised across urgent, diagnostic and elective pathways, with Urgent Emergency Care performance meeting national standards, stable diagnostic performance, and active mitigations in place to manage known capacity constraints. The committee also noted ongoing improvements in theatre utilisation and data quality to support safer, more efficient care delivery.<br>– Patient-Led Assessments of the Care Environment (PLACE) inspection results, mixed performance across quality domains, with some areas at or above national average but declines in food, dementia and disability. Assurance was received that targeted improvement actions are in place and that delivery of the 2026 Action Plan will be monitored through established governance to improve patient experience and compliance.<br>– Quality Impact Assessment position for the 2025/26 Better Value Programme, majority of schemes were appropriately assessed and approved. Strengthened governance, live tracking and executive oversight are in place, and that learning from 2025/26 is informing earlier and more robust completion of QIAs and POAPs for 2026/27. Quarterly updates will be provided for continued assurance and any schemes reaching the agreed risk threshold will be escalated appropriately.</td></tr>
<tr><td>Recommendation:</td><td colspan="5">The Board is asked to note the contents of the report</td></tr>
<tr><td>Action required</td><td>Approval</td><td>Information</td><td>Discussion</td><td>Assurance</td><td>Review</td></tr>
<tr><td rowspan="2">Link to key strategic objectives (KSOs):</td><td>KSO1:</td><td>KSO2:</td><td>KSO3:</td><td>KSO4:</td><td>KSO5:</td></tr>
<tr><td>To deliver outstanding care</td><td>To innovate and improve</td><td>To be an excellent employer</td><td>To deliver sustainable services</td><td>To collaborate with others</td></tr>
<tr><td colspan="6">Implications</td></tr>
</table>

| 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:** 11-26
**Date of meeting:** 14 May 2026
**Report from:** Russell Hobby, Non-executive director and committee member
**Report author:** Jo Emmanuel, Non-executive director and committee Chair
Katie Ally, Governance officer
**Date of report:** 06 May 2026
**Appendices:** None

**Sub-committee assurance report**
**Quality & Safety committee – 5 May 2026**

**Key agenda items**

- **Executive committee for Quality & Risk (ECQR) – matters to raise with the committee**
- **Integrated Quality & Performance Report – month 11**
- **65 week wait**
- **Quality Priorities Quarter 4 2025/2026**
- **Quality Priorities 2026/2027**
- **Update on continuous improvement initiatives**
- **Electronic Patient Records (EPR) – review of clinical safety and lessons learnt relevant to quality**
- **Patient-Led Assessments of the Care Environment (PLACE) inspection**
- **Quality Impact Assessment**
- **Bi Annual assessment of addressing Health Inequalities (incl. lessons learnt) and Priorities for 2026/2027**
- **Guardian of Safe Working Hours Report**
- **Patient safety overview & update Quarters 3 & 4**

**Alert**

– The committee reviewed the month 11 report and the month 12 year end performance update, noting that RTT standards were not fully achieved; however, there has been sustained progress in reducing long waits, including significant reductions in 52 and 65 week waits. The committee received assurance that all patients experiencing extended waits are subject to appropriate clinical oversight, with strengthened leadership arrangements and improved PTL management in place to mitigate safety risks, while recognising ongoing pressures related to capacity, industrial action and breast services.

- The committee noted that cancer standards were delivered at year end, with all patients waiting over 62 days receiving regular clinical harm reviews with no harm identified. Assurance was provided that targeted improvement plans, particularly within skin cancer pathways, are being implemented and monitored through the Trust Cancer Board to support timely diagnosis and treatment.
- The committee received assurance that patient safety continues to be prioritised across urgent, diagnostic and elective pathways, with Urgent Emergency Care performance meeting national standards, stable diagnostic performance, and active mitigations in place to manage known capacity constraints. The committee also noted ongoing improvements in theatre utilisation and data quality to support safer, more efficient care delivery.
- The committee noted the PLACE inspection's mixed performance across quality domains, with some areas at or above national average but declines in food, dementia and disability. Assurance was received that targeted improvement actions are in place and that delivery of the 2026 Action Plan will be monitored through established governance to improve patient experience and compliance.
- The committee reviewed the Quality Impact Assessment (QIA) position for the 2025/26 Better Value Programme, noting that the majority of schemes were appropriately assessed and approved. The committee received assurance that strengthened governance, live tracking and executive oversight are in place, and that learning from 2025/26 is informing earlier and more robust completion of QIAs and POAPs for 2026/27. The committee agreed to receive quarterly updates and that any schemes reaching the agreed risk threshold will be escalated appropriately.

**Assure**

- The committee reviewed the risks associated with the use of personal devices for medical photography and received assurance that governance is being strengthened through an approved policy and a developing SOP. The committee noted current service and technical constraints and agreed that further work is required to support safe implementation without compromising patient care.
- The committee received a verbal update on the internal audit on incident management and was assured on the progress so far. Further quarterly updates will be provided.
- Key items escalated via the ECQR assurance report included 60% of risks require updating as end of year target date has passed, immediate action is underway. A significant backlog of historic incidents remains despite timely closure of new incidents; targeted work is in progress to review, theme and close with expected improvement within three months. RTT performance remains a key risk, with year-end delivery behind plan and ongoing impact on patient experience; cancer performance is improving overall, with specific risks in skin pathways being addressed through the Cancer Board.
- The committee noted good progress against the 2025/26 Quality Priorities, acknowledging the ambitious scope and delivery achieved. The need to strengthen evidence of learning and impact, particularly in preventing recurrence of issues, and received assurance that work is underway to embed real-time learning and improvement into 2026/27 priorities.
- The committee approved the 2026/27 Quality Priorities.
- The committee received an update on Continuous Improvement activity, noting progress in leadership ownership, staff engagement and embedding improvement into day-to-day practice. Highlighted the need to strengthen training coverage, clinical engagement and alignment across improvement approaches to evidence tangible impact on patient experience. Assurance was received that

executive ownership and clearer alignment with quality priorities are supporting sustainable improvement despite delivery within existing resources.
- The committee reviewed the clinical safety position for the Archie EPR programme, noting a robust safety approach, effective co-design with staff and a decline in EPR-related incidents since go-live. The committee acknowledged lessons learned, particularly around training and readiness, and received assurance that these are being addressed for future deployments. The committee also noted early consideration of clinical safety risks for the Archie PAS programme ahead of the planned November 2026 go-live.
- The committee noted the assurance contained in the Estate assurance update relating to Water, Fire, Ventilation, Asbestos and the lift in main outpatients. The lift is intermittently out of service with two patient falls reported as a result. Mitigations are in place to ensure safety of patients when the lift is out of use.
- The committee received the Guardian of Safe working (GOSW) report and noted improvements to the resident doctor exception reporting process, including system updates and reduced response times to within seven days. The committee received assurance that rota safety is being effectively managed with no current concerns, while recognising ongoing monitoring of working hours in specific services and further work required to enhance rest facilities.
- The committee reviewed the Patient Safety overview report for quarters three and four 2025/2026 and subsequent discussion in the meeting provided assurance on progress relating to shared learning, increased attendance at monthly Clinical Learning Forms and reintroduction of Safety Bulletins in quarter four circulated via Connect publication.

**Advise**
- Research governance is on track against strategy. Enhanced process to ensure timely opening of and recruitment to clinical trials has been put in place.

**Risks discussed and new risks identified**
The committee reviewed the Board assurance framework (BAF) risk relevant to its remit (quality), and received the organisational risk register (ORR).

The committee reviewed the BAF quality risk and ORR, noting the current risk score of nine against a target of six, and the need to clarify priorities and risk appetite before further reduction. The committee recognised the need to refresh the BAF to reflect current pressures and noted progress within the ORR, including improvements relating to mental capacity assessments. Assurance was received that risk management processes are strengthening, with a continued focus on visibility, prioritisation and alignment with operational risks

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

| Report cover-page | | | | | |
|---|---|---|---|---|---|
| **References** | | | | | |
| **Meeting title:** | Board of Directors | | | | |
| **Meeting date:** | 14/05/2026 | | **Agenda reference:** | **12-26** | |
| **Report title:** | Financial, workforce and operational performance assurance | | | | |
| **Sponsor:** | Peter O'Donnell, Non-executive director and committee Chair | | | | |
| **Author:** | Peter O'Donnell, Non-executive director and committee Chair<br>Katie Ally, Governance officer | | | | |
| **Appendices:** | None | | | | |
| **Executive summary** | | | | | |
| **Purpose of report:** | To alert, assure and advise the Board regarding matters considered at the last committee meeting. | | | | |
| **Summary of key issues** | – The Trust is reporting a year end position of a £1.6m surplus, benefitting from a late re-allocation of Deficit support funding. The underlying position is in line with the breakeven plan.<br>– Year end RTT targets were not fully achieved i.e. 52 and 65 weeks waits although there was continued improvement in long waits. Ongoing risks remain for recovery in early 2026/27 linked to late referrals and industrial action. Strengthened oversight is being put in place.<br>– Year-end cancer standards were delivered, with no clinical harm identified for patients waiting over 62 days. Improvement plans are in place to manage short-term risks to Faster Diagnostic Standards, with recovery expected later in Quarter 1 2026/27.<br>– Urgent Emergency Care performance remained strong and diagnostic waiting times were stable, with mitigations in place to manage capacity constraints.<br>– Theatre utilisation was below target and a plan is being put in pace to improve productivity.<br>– Challenges in time to hire and appraisal completion were noted, with executive actions and wellbeing initiatives in place.<br>– The 2026/27 Business Plan was assessed by NHS England as compliant subject to conditions, with the financial plan accepted and the performance plan subject to ongoing monitoring of RTT and waiting list standards.<br>– The year end capital outturn was delivered broadly in line with plan, with updated capital plans and reallocations in place to support key priorities moving forward, including completion of the East Grinstead Community Diagnostic Centre (CDC).<br>– The new East Grinstead CDC is projected to open in early October, The replacement of the Policy Administration system (PAS) is experiencing a number of challenges to meet its deadline of a November go live and delays will be difficult to manage. | | | | |
| **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:**<br>*To deliver outstanding care* | **KSO2:**<br>*To innovate and improve* | **KSO3:**<br>*To be an excellent employer* | **KSO4:**<br>*To deliver sustainable services* | **KSO5:**<br>*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:** 12-26
**Date of meeting:** 14 May 2026
**Report from:** Peter O'Donnell, Non-executive director and committee Chair
**Report author:** Peter O'Donnell, Non-executive director and committee Chair
Katie Ally, Governance officer
**Date of report:** 07 May 2026
**Appendices:** None

**Sub-committee assurance report**
**Finance & Performance committee – 5 May 2026**

**Key agenda items**

- **Integrated Quality and Performance Report Month 11 and month 12 forecast**
- **Cost Improvement Programme update**
- **Business Plan 2026/2027 update incl. Capital**
- **Capital Spend 2025/2026 update incl. M12**
- **Systems Financial Year end and forecast**
- **Community Diagnostic Centre – Bognor – Handover**
- **Community Diagnostic Centre – East Grinstead**
- **Digital Transformation incl. PAS**
- **Information Management & Technology (IM&T) assurance**
- **Estate assurance – critical infrastructure delivery**
- **Local Security management incl. milestones**

**Alert**

- The committee noted the month 11 Integrated Quality & Performance report and received a month 12 verbal update.
- The RTT year end targets were not fully achieved, although there was continued improvement in long-waiters, including a reduction in 52- and 65-week waits. The committee received assurance that strengthened waiting list oversight and leadership actions are being put in place, to meet targets in q1 next year while recognising ongoing risks in early 2026/27, linked late referrals and industrial action.
- The committee noted delivery of year end cancer standards, with no clinical harm identified for patients waiting over 62 days. The committee received assurance that improvement plans are in place to manage short-term risks to Faster Diagnostic Standards, with recovery expected later in Quarter 1 2026/27.

- The committee noted strong Urgent Emergency Care performance and stable diagnostic waiting time performance, with mitigations in place to manage capacity constraints.
- The committee noted income performance slightly below plan, driven by lower CDC activity, and received assurance that plans for 2026/27 are more realistic. The committee also noted theatre utilisation continues to be below target and were advised that further productivity actions are underway.
- The committee discussed the growth in the overall waiting list over the last few months and were informed this will require more radical pathway initiatives to address.
- The committee noted full delivery of the 2025/26 efficiency programme against the £7.46m target, including £2.5m of mitigating items, and requested further analysis over the details and sustainability of these mitigations.
- The committee was assured the 2026/27 Business Plan has been assessed as compliant subject to conditions. The financial plan was accepted without conditions, and the performance plan was accepted subject to ongoing review and monitoring of RTT18 and total waiting list size standards in Years 2 and 3, with further work continuing in these areas.
- The committee reviewed the year end capital outturn and the updated capital plans for 2025/26 and 2026/27, including required reallocations to support completion of the East Grinstead CDC. The committee received assurance that capital spend was delivered broadly in line with plan and that the 2026/27 capital programme has been updated to reflect additional funding and ensures sufficient resources are in place to deliver key priorities including East Grinstead CDC.
- The committee noted that the Trust delivered a year end £1.6m surplus position, including additional Deficit Support Funding. The position is subject to final verification and audit.
- The Patient Administration System project has a red status reflecting the complexity of the programme, tight timescales and supplier delivery delays. Delays would cause budget and timing issues which would not be easy to manage.

**Assure**

- The committee noted the successful transition of the Bognor CDC programme to the CIC from 1 April 2026, including transfer of funding, assets and responsibilities. The committee received assurance that appropriate arrangements are in place to support continuity and a smooth handover, with transitional support from QVH and key stakeholder engagement soon to be completed.
- The committee received assurance that East Grinstead CDC construction and programme delivery remain on track for an October opening.
- Reduced bank and agency usage in Month 11 however slight increase in Month 12 as planned. Stable sickness absence. Slight increases in time to hire and a small decline in appraisal completion were noted. Assurance received that focused executive action is in place. Ongoing inclusion and wellbeing initiatives continue to support workforce engagement.

**Advise**

- The committee noted good progress in delivery of the 2025/26 critical infrastructure programme, with key schemes improving estate safety, compliance and resilience, including fire alarm upgrades, electrical infrastructure replacement and asbestos removal. The committee received assurance that targeted actions are reducing backlog maintenance risks, although some residual risks remain

and will continue to be managed through the risk register. Further funding for 2026/27 remains subject to confirmation.

- The committee noted that effective and proportionate security arrangements were in place throughout 2025/26, with full delivery of the Local Security Management Specialist work programme and stable incident levels. The committee received assurance that security risks are being proactively managed in line with national requirements, including preparedness for Martyn's Law, and requested benchmark data in future reports to better evidence how good our position is compared to others.

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

The committee noted the current position of the Board Assurance Framework (BAF) and Organisational Risk Register, including that seven of the nine strategic risks remain outside risk appetite, with no changes to scores since March 2026. The committee acknowledged concerns regarding slippage, the number of outstanding actions and risks exceeding target dates, and emphasised the need for stronger pace, visibility and timeliness of risk management.

The committee received assurance that controls are in place and risks are being actively managed, with quality and sustainability risks rated green. It was noted that the highest scoring open risk remains risk 66 (delivery of the Pathology Network Programme), with a current score of 16, and that risk 208 has been opened to replace the previously closed partnership timeline risk. The committee requested that the BAF be kept more regularly updated to reflect current operational pressures, including RTT performance and emerging cyber risks, and was assured that further work is underway to strengthen oversight, assurance and accountability through clearer ownership and review.

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

| Report cover-page | | | | | |
|---|---|---|---|---|---|
| **References** | | | | | |
| **Meeting title:** | Board of Directors | | | | |
| **Meeting date:** | 14/05/2026 | | **Agenda reference:** | **13-26** | |
| **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<br>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** | • Review of the 2025 Staff Survey, highlighting reductions in engagement and morale, increased fatigue and workload pressures, and a decrease in staff recommending QVH as a place to work. The committee has emphasised the importance of leadership in driving staff engagement and further improving response rates and has requested future reporting on the results of the quarterly Pulse surveys.<br>• Good progress reported in the implementation and transition phase of the strategic partnership, with programme governance and programme arrangements in place, risks identified and managed. Further detail on the benefits realisation piece will be provided at the committee's next meeting.<br>• Good progress towards compliance with the Sexual Safety Charter (91%) and national Violence Prevention and Reduction (VPR) Standards (98%), with remaining actions identified and full compliance expected by May 2026.<br>• Assurance received on delivery of Year 1 of the QVH Strategy 2025–2030, including key achievements such as implementation of the Electronic Patient Record and development of the Health Inequalities Dashboard.<br>• Review of the Trust-wide Engagement Plan, noting its role in strengthening engagement and the patient voice, with a request for consideration of how effectiveness and outcomes will be measured.<br>• Review of Board Assurance Framework risks relating to long-term sustainability, leadership capacity, and workforce, with no change to current risk scores.<br>• Discussion of workforce equality and inclusion, including plans to develop EDI networks as part of the strategic partnership and a request for a deep dive into the experiences of ethnically diverse staff.<br>• The committee has reviewed the proposed the Key Strategic Objectives for 2026/27 and recommends these to the Board for approval. | | | | |
| **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:** 13-26
**Date of meeting:** 14 May 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:** 30 April 2026
**Appendices:** None

**Sub-committee assurance report**
**Strategy & culture committee – 29 April 2026**

**Key agenda items**

- **Partnership implementation & engagement update**
- **Trust-wide engagement plan**
- **QVH Strategy 2025-2030: 2025/26 year 1 delivery & 2026/27 year 2 planning**
- **Key Strategic Objectives 2026/27**
- **Staff survey 2025**
- **Sexual safety & violence prevention & reduction - update**
- **Board Assurance Framework (BAF) & organisational risks**
- **Committee work programme 2026/27**

**Alert**

- The committee reviewed the results of the 2025 Staff Survey, acknowledging the challenging national NHS context and the current uncertainty for staff as the Trust enters a strategic partnership. The committee noted the decline in engagement and morale, increased fatigue and workload pressures, and the reduction in staff recommending QVH as a place to work. These were identified as key areas of focus to ensure they do not develop into sustained downward trends. Managers are being supported to develop action plans with their teams. The committee encouraged a focus on areas of greatest variability, with more granular analysis of teams of particular concern. Although the survey achieved a response rate above the national average, comparable with other specialist trusts and higher than that of proposed potential partners, the committee emphasised the importance of leadership in driving staff engagement and further improving response rates. The committee has requested future reporting on the results of the quarterly Pulse surveys.

**Assure**

- Good progress is being made in the implementation and transition phase of the strategic partnership. Clear programme governance and leadership arrangements are now in place, with risks identified and actively managed. The

shared Partnership Working Group continues to meet weekly, operating as the primary delivery and coordination forum across all six workstreams and reporting to the Executive Leadership Team. Actions arising from the finance review are being progressed as part of the implementation plan, and work continues on developing the future governance structure for the group. Benefits realisation tracking is being developed, and the committee highlighted the importance of ensuring alignment with the aims and intended outcomes of the strategic partnership. Further detail on this will be provided at the committee's next meeting. The committee also requested that the organisational culture aspects of the partnership are reflected in future reporting. Members noted positive feedback from the Chief Medical Officer on discussions with counterparts at Royal Surrey NHS Foundation Trust and Ashford and St Peter's Hospitals NHS Foundation Trust. The Committee was assured on the progress made to date and commended the team for the work undertaken so far.

- QVH has made strong progress towards full compliance with the Sexual Safety Charter and is currently assessed as 91% compliant. The remaining requirements relate to Trust-wide communications, updates to the Managing Conduct policy, provision of specialist support for employee relations, and the completion of non-mandated sexual safety e-learning. Work on these actions is ongoing. The Trust is also 98% compliant with the national Violence Prevention and Reduction (VPR) Standards. This position is supported by established governance arrangements, risk assessments, reporting mechanisms, training, and assurance processes. Remaining actions focus on formalising post-incident support, withdrawal-of-care processes, and consistent approaches to managing staff-on-staff incidents. Full compliance is expected by May 2026. The committee will receive exception reporting on the delivery of the outstanding actions. There was discussion on how lessons learned from incidents inform the development of practice, and the committee noted that this occurs at both local level and through the Sussex VPR group.
- The committee received assurance on the delivery of the *QVH Strategy 2025-2030* during year one. Key achievements include delivery of the Electronic Patient Record, development of the Health Inequalities Dashboard and improved Ethnicity data recording and delivery of the Better Value Programme.
- The committee reviewed the Trust-wide Engagement Plan, which provides a framework for consistent, inclusive and transparent engagement and communications. The plan sets out the Trust's approach to engagement across key audiences and supports the strengthening of the patient voice. The committee welcomed the plan, which builds on existing engagement and communications activity. An implementation plan will be developed, and the Committee suggested that further consideration be given to how the effectiveness and outcomes of the plan will be measured.

**Advise**

- The committee has reviewed the proposed Key Strategic Objectives 2026/27 and recommends these to the Board for approval.

**Risks discussed and new risks identified**

The committee reviewed BAF risks which relate to the long term sustainability of the Trust, leadership capacity and workforce. The scores for all of these BAF risks remain the same.

The committee discussed the People BAF and the actions being taken to support staff, with particular reference to the development of Equality, Diversity and Inclusion (EDI) networks, which are not currently active at QVH. The committee noted that there are plans to develop these networks as part of the strategic partnership.

However, the committee requested that a deep dive into the experiences of ethnically diverse staff is undertaken and the findings reported back to the committee.

The People BAF will be updated to detail the direction of travel and actions in relation to areas of focus for the staff survey.

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

| Report cover-page | | | | | |
|---|---|---|---|---|---|
| **References** | | | | | |
| **Meeting title:** | Board of Directors | | | | |
| **Meeting date:** | 14/05/2026 | | **Agenda reference:** | **14-26** | |
| **Report title:** | Freedom to Speak Up - Annual Report | | | | |
| **Sponsor:** | Jackie Doherty, Freedom to Speak Up Guardian | | | | |
| **Author:** | Jackie Doherty, Freedom to Speak Up Guardian | | | | |
| **Appendices:** | None | | | | |
| **Executive summary** | | | | | |
| **Purpose of report:** | To provide Board with the Freedom to Speak Up annual report. | | | | |
| **Summary of key issues** | Independent Freedom to Speak Up (FTSU) Guardian in place since 1 May 2024, with strong Executive and senior leadership support. Key highlights of the report are as follows:<br>• 36 concerns raised between 1 April 2025 – 31 March 2026 which consistent with the previous year<br>• Reporting rate above national average, indicating strong visibility and staff willingness to speak up<br>• 61% of cases managed confidentially, reflecting the value of independent, impartial support<br><br>Main themes reported:<br>• Management issues – 39%<br>• Systems and processes – 22%<br>• Bullying and harassment – 17%<br>• Behaviours and relationships – 17%<br><br>There are increased requests for escalation, demonstrating growing staff confidence in the FTSU process. The report recommends to further strengthen speaking up culture and internal routes. | | | | |
| **Recommendation:** | The Board are asked to note the contents of the report and support the recommendations. | | | | |
| **Action required** | Approval | Information | Discussion | **Assurance** | Review |
| **Link to key strategic objectives (KSOs):** | KSO1: | 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:** | KSO1 | | | | |
| **Organisational risk register:** | None | | | | |
| **Regulation:** | CQC | | | | |
| **Legal:** | None | | | | |
| **Resources:** | None | | | | |
| **Assurance route** | | | | | |
| **Previously considered by:** | | | | | |
| | Date: | | Decision: | | |

| **Next steps:** | |
|---|---|

**Annual Report**
**01 April 2025 – 31 March 2026**

**Circulation:**

**Main point of contact**

**Liz Blackburn**

**Acting Chief Nursing Officer**

**Prepared by:**

**Jackie Doherty**

**Guardian**

**The Guardian Service Ltd.**

**Date: 29 April 2026**

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8. **Confidentiality** ....5
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## 1. Executive summary

The Guardian Service has been the independent provider for Freedom to Speak Up in Queen Victoria Hospital NHS Foundation Trust since 01 May 2024.

Since implementation the service has been well supported by the Executive team, senior leaders and managers within the Trust.

During the reporting period of 01 April 2025 to 31 March 2026, there have been a total of 36 cases raised to the FTSU Guardian. This is consistent with activity during the previous year where 33 cases were reported over an 11-month period.

According to the latest available National Guardian's Office (NGO) data report (April 2024–March 2025), the national average rate of concerns raised is approximately 8–10 per 1,000 staff. Based on a Trust headcount of approximately 1,200 staff, the 36 concerns raised equate to a rate of 30 concerns per 1,000 staff, which is above the national average.

Higher than average numbers can reflect greater trust in speaking up routes and stronger Guardian visibility. However, it may also indicate a perception that internal routes are ineffective, or staff feel apprehensive about speaking up internally due to a fear of reprisal or a sense of futility.

Confidentiality, i.e. where cases are not escalated by the Guardian to the Trust, at 61% is not necessarily a reflection of staff lacking trust in the organisation. This may reflect staff just needing an independent, impartial listener. Guardians may challenge staff thinking and encourage both reflection and consideration of a different perspective and so help them identify their own way forward with an issue.

The main themes for this year have been:

- Management issue -39%
- System and Process-22%
- Bullying and Harassment-17%
- Behaviour and Relationships-17%

Further examples of these can be found in section 11-assessment of cases.

There has been an increase in the number of staff who have requested the Guardian to escalate their case both sharing their details, or keeping these confidential, however it is important that all staff believe they will be listened to and appropriate action will be taken when they Speak Up.

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

## 2. Purpose of the paper

The main purpose of this report is to give an insight into the data arising from cases, themes and issues raised through the Freedom to Speak Up Guardian from 01 April 2025-31 March 2026. The report follows the guidance from the National Guardian Office (NGO) on the content FTSU Guardians should include when reporting to their Board which include Assessment of cases, Action taken to improve speaking-up culture and Recommendations.

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## 3. Background to Freedom to Speak Up

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

## 4. The Guardian Service

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

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

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

## 5. Access and Independence

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

## 6. Categorisation of Calls and Agreed Escalation Timescales

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

| Call Type | Description | Agreed Escalation Timescales |
|---|---|---|
| Red | Includes patient and staff safety, safeguarding, danger to an individual including self-harm. | Response required within 12 hours |
| Amber | Includes bullying, harassment, and staff safety. | Response required within 48 hours |
| Green | General grievances e.g. a change in work conditions. | Response required within 72 hours |

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

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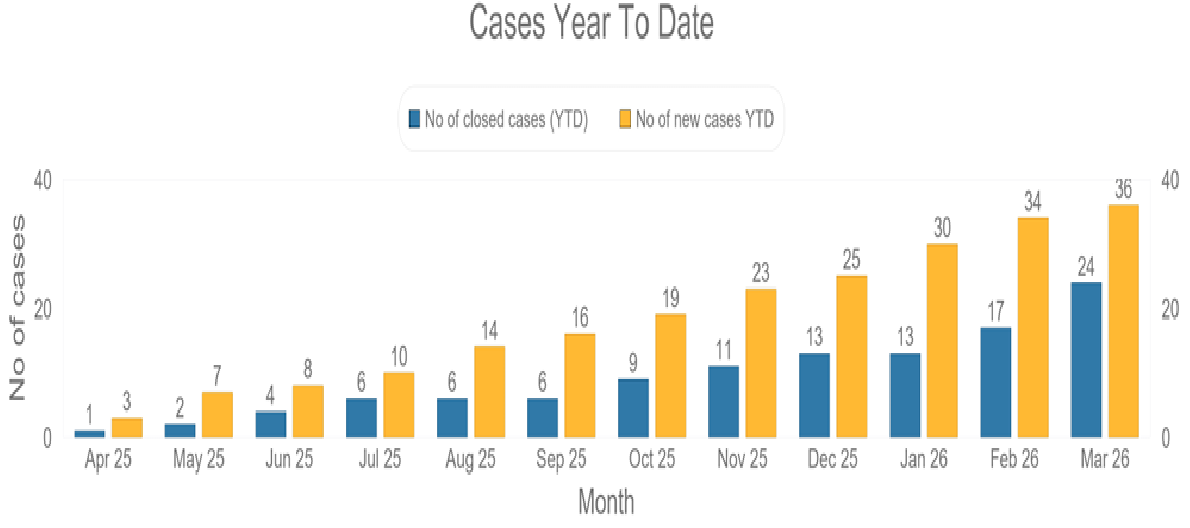
| White | No discernible risk to organisation. | No organisational response required |
|---|---|---|

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

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

## 7. Number of concerns raised.

There have been a steady number of concerns raised with a total of 36 in the period 01 April 2025 to 31 March 2026.

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## 8. Confidentiality

| Confidentiality | No. of concerns | Percentage |
|---|---|---|
| Keep it confidential within Guardian Service remit | 22 | 61% |
| Permission to escalate with name | 7 | 19.5% |
| Permission to escalate anonymously | 0 | 0% |
| Permission to escalate without name | 7 | 19.5% |
| **Total** | **36** | **100%** |

## 9. Themes

Concerns raised are broken down into the following categories.

| Theme | Total |
|---|---|
| A Patient and Service User Safety / Quality | 2 |
| B Management Issue | 14 |
| C System Process | 8 |
| D Bullying and Harassment | 5 |
| E Discrimination / Inequality | 0 |
| F Behavioural / Relationship | 6 |
| G Other (Describe) | 0 |
| H Worker Safety | 1 |
| I Sexual Misconduct | 0 |
| **Grand Total** | **36** |

## 10. Trends in Cases

| **Average Cases per month** | Apr | May | Jun | Jul | Aug | Sep | Oct | Nov | Dec | Jan | Feb | Mar | Average |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| April 24 to March 25 | N/A | 3 | 4 | 6 | 1 | 1 | 4 | 1 | 4 | 6 | 0 | 3 | 3 |
| April 25 to March 26 | 3 | 4 | 1 | 2 | 4 | 2 | 3 | 4 | 2 | 5 | 4 | 2 | 3 |

There has been a total of 36 cases raised with the Freedom to Speak Up Guardian in the period this report covers.

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This is an average of 3 cases per month which aligns with the previous 11 months since the Guardian Service commenced at QVH in May 2024.

## 11. Assessment of Cases

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

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

Management issue

This theme accounted for 39% of cases raised and some examples of this are:

- Believing there are inappropriate/unprofessional behaviours in the team, and these are not being dealt with by managers.
- Feeling pressure due to extra workload and responsibilities and this not being acknowledged by managers.
- Not feeling listened to and heard by managers.

System and Process

The theme of system and process accounted for 22% and examples of this are:

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

Bullying and Harassment

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

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

Behaviour/Relationship

This theme made up 17% of cases and examples of this are:

- Staff members feeling team members are behaving inappropriately.
- Staff members feeling isolated within the team.
- Feeling threatened by other staff members

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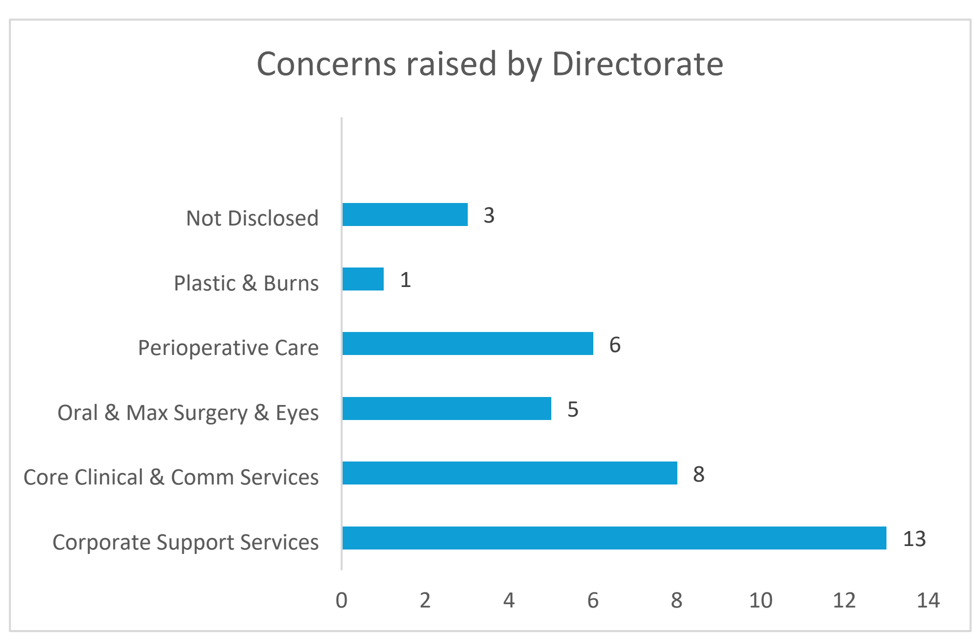
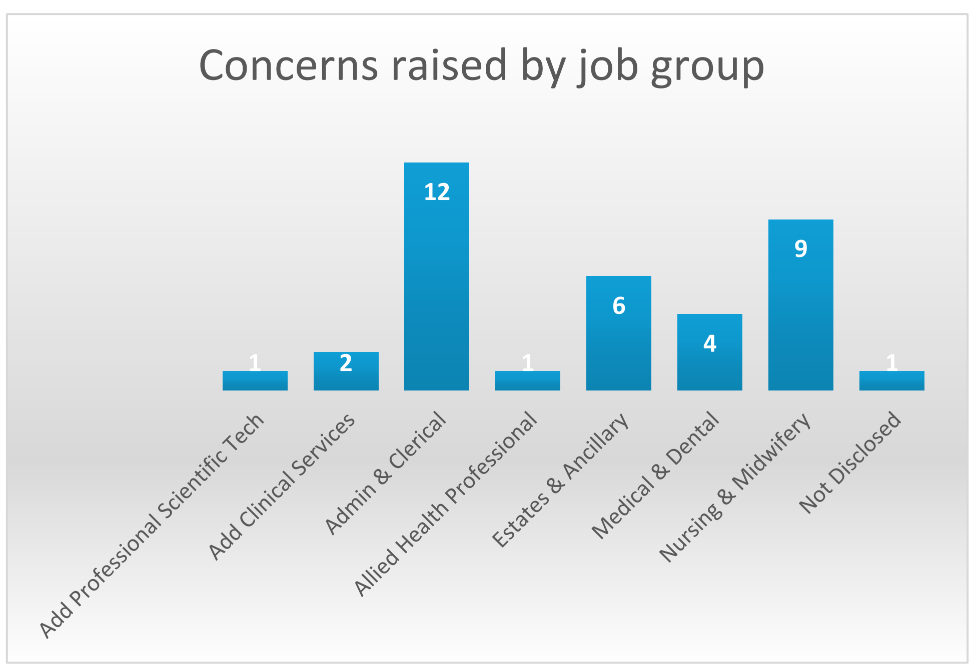
## 12. Statistical Graphs

### Concerns raised by Directorate




### Concerns raised by Job Group

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## 13. Why do staff use The Guardian Service?

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

| Reason for using Guardian Service | Number | Percentage |
|---|---|---|
| Impartial Support | 18 | 50% |
| Have raised concern before but not been listened to | 13 | 36% |
| Believe they will not be listened to | 2 | 6% |
| Fear of reprisal | 3 | 8% |
| Total | 36 | 100% |

## 14. Detriment

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

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

- Online booking system available from January 2026 to make the service more accessible to staff.
- Regular promotions from FTSUG including drop-in sessions, walkarounds, staff handovers and team meetings.
- Monthly meeting with Chief Nursing Officer to discuss activity report which includes themes and outcomes of cases-no identifying details are shared, therefore maintaining staff members' confidentiality.
- Quarterly meeting held with Non-Executive Director to discuss activity, and any emerging themes and support required.
- Monthly meetings being held with the Chief Executive Officer to share any themes or concerns, particularly while Trust is undergoing restructuring due to cost savings and the transition towards a strategic partnership.
- Regular attendance on Team Talk by FTSUG to promote the service.
- Visibility of Executive team across all areas of the Trust promoting FTSU to encourage staff confidence in Speaking Up.

## 16. Learning and Improvements

- The FTSUG takes a coaching approach and supports staff to address their concerns, as much as possible, independently. Staff are encouraged, where appropriate, to raise their concerns initially

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with their line manager or another leader in their division. Exploring ideas on using existing tools, like team meetings and supervision, can also help an individual bring about a resolution. The FTSUG is an empathetic listener and often just providing a listening ear is all that is required to help staff address their concerns.

- Retraining and observation put in place for a staff member as extra support after a concern raised.

## 17. Comments & Recommendations

- Due to a number of concerns citing colleagues and managers unprofessional behaviours as a reason for them coming to the Guardian Service, the Trust may like to consider reminding staff about the Behaviour Framework that are already in place across the Trust.
- A number of staff in QVH report they use the Guardian Service because they have already raised a concern but not been listened to. Quite often this is as a result of staff expectations not being managed with regard to outcomes they can expect, timescales, and levels of information that will be shared with them. Support for those dealing with the concern around this would be helpful.
- Staff involved in the Trust's formal processes have expressed concerns about the negative impact on their mental health and well-being, both during and after the process.
- It is important to continually assess individual's well-being and make them aware of available support options. Additionally, aftercare should be considered, including regular check-ins with staff following the outcomes of formal processes, to ensure effective coping strategies are in place for all parties involved.
- Leaders at every level need to role-model the speaking-up principles. It helps workers feel safe, valued, and confident to speak up and workers are likely to emulate the values and behaviours they see in their more senior colleagues.
- It is important that the Trust is able to ensure that managers, primarily mid-level managers, receive the support they need to handle speaking-up concerns. This could include mandating The National Guardians Office Speaking Up, Listening Up, Follow Up training, soft skills training on listening, emotional intelligence, improving empathy and self-awareness which are all behaviours that are crucial in the effective handling of concerns

## 18. Staff Feedback

Some positive feedback received from staff members who have used the Guardian service:

- The Guardian was brilliant, both sympathetic but realistic and spoke of options available with the utmost respect to me.
- The Guardian was friendly and compassionate and responded effectively to my concerns**.**
- I would thoroughly recommend the guardian service not only as a safe way of communicating concerns but effectively communicating to senior managers.

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<table>
<tr><th colspan="6">Report cover-page</th></tr>
<tr><td colspan="6">References</td></tr>
<tr><td>Meeting title:</td><td colspan="5">Board of Directors</td></tr>
<tr><td>Meeting date:</td><td colspan="2">14/05/2026</td><td>Agenda reference:</td><td colspan="2">15-26</td></tr>
<tr><td>Report title:</td><td colspan="5">Guardian of safe working (GoSW) hours report</td></tr>
<tr><td>Sponsor:</td><td colspan="5">Jennifer O'Neill, Guardian of Safe working hours</td></tr>
<tr><td>Author:</td><td colspan="5">Jennifer O'Neill, Guardian of Safe working hours</td></tr>
<tr><td>Appendices:</td><td colspan="5">Appendix one: Quarter 3 GoSW report for 2025/26<br>Appendix two: Quarter 4 GoSW report for 2025/26</td></tr>
<tr><td colspan="6">Executive summary</td></tr>
<tr><td>Purpose of report:</td><td colspan="5">To provide the Board with assurance on safe working arrangements for resident doctors.</td></tr>
<tr><td>Summary of key issues</td><td colspan="5">The exception reporting process for resident doctors has been updated in line with national requirements, and the Trust is now using the official updated software (Allocate) – since the start of February 2026.<br><br>The removal of the educational supervisors from the exception reporting process, the automatic approval of ERs under 2 hours and the software upgrade have meant that our response time to ERs since February has been less than 7 days.<br><br>Long oncology cases within Maxillofacial Surgery can, at times, lead to breaches in contracted working hours for residents. This is being monitored, and work is ongoing to identify the most appropriate adjustments to work schedules to prevent breaches.<br><br>The Trust's 10-Point Plan will address the working conditions that have been maintained and further developed. Resident representatives have made progress in securing lockers in a suitable location; however, further improvement is still required in relation to resident rest facilities.</td></tr>
<tr><td>Recommendation:</td><td colspan="5">The Board is asked to note the above and be assured that there have been no immediate recent rota safety concerns and that the situation continues to be monitored.</td></tr>
<tr><td>Action required</td><td>Approval</td><td>Information</td><td>Discussion</td><td>Assurance</td><td>Review</td></tr>
<tr><td rowspan="2">Link to key strategic objectives (KSOs):</td><td>KSO1:</td><td>KSO2:</td><td>KSO3:</td><td>KSO4:</td><td>KSO5:</td></tr>
<tr><td>To deliver outstanding care</td><td>To innovate and improve</td><td>To be an excellent employer</td><td>To deliver sustainable services</td><td>To collaborate with others</td></tr>
<tr><td colspan="6">Implications</td></tr>
<tr><td colspan="2">Board assurance framework:</td><td colspan="4">None</td></tr>
<tr><td colspan="2">Organisational risk register:</td><td colspan="4">None</td></tr>
<tr><td colspan="2">Regulation:</td><td colspan="4">None</td></tr>
<tr><td colspan="2">Legal:</td><td colspan="4">None</td></tr>
<tr><td colspan="2">Resources:</td><td colspan="4">HR/ recruitment for staffing levels and Estates and switchboard for on call room</td></tr>
<tr><td colspan="6">Assurance route</td></tr>
<tr><td colspan="2">Previously considered by:</td><td colspan="4">Quality and safety committee</td></tr>
<tr><td colspan="2"></td><td>Date:</td><td>05/05/26</td><td>Decision:</td><td></td></tr>
</table>

| | |
|---|---|
| **Report to:** | Board Directors |
| **Agenda item:** | 15-26 |
| **Date of meeting:** | 14 May 2026 |
| **Report from:** | Jennifer O'Neill, Guardian of Safe working |
| **Report author:** | Jennifer O'Neill, Guardian of Safe working |
| **Date of report:** | 29 April 2026 |
| **Appendices:** | Appendix one: Quarter 3 GoSW report for 2025/26<br>Appendix two: Quarter 4 GoSW report for 2025/26 |

# Guardian of Safe working hours report

## Situation

The Guardian of Safe Working Hours continues to provide oversight of resident working hours, rota arrangements and exception reporting to ensure compliance with national standards and to support safe patient care. During the reporting period, changes to national guidance and local processes have necessitated updates to the Trust's exception reporting systems and governance arrangements. These changes are now embedded, with ongoing monitoring to ensure their effectiveness and sustainability.

## Background

The Guardian of Safe Working Hours role is a statutory requirement under national junior doctor contractual arrangements and provides independent assurance to the Trust on the safe working of residents. This includes oversight of work schedules, rota gaps, locum use and exception reporting, and the identification and escalation of any risks to resident wellbeing or patient safety.

The Guardian reports support assurance that appropriate systems are in place and that emerging risks are identified and managed in a timely manner.

## Assessment

During this reporting period, the Trust has strengthened its exception reporting processes in line with national requirements. These changes have improved the timeliness and efficiency of exception report handling and have supported clearer accountability within the process.

Ongoing monitoring has identified that certain service pressures, including the duration of complex oncology cases within Maxillofacial Surgery, may occasionally result in residents exceeding contracted working hours. This has been recognised as an area for continued oversight, with work underway to explore adjustments to work schedules where appropriate.

Progress continues to be made against the Trust's 10-Point Plan for improving resident working conditions. Engagement with resident representatives remains active, with improvements achieved in some areas and further developments planned in others, including rest facilities.

Overall, no immediate or unresolved rota safety risks have been identified during the reporting period. The Guardian will continue to monitor trends, review exception data and escalate concerns as required.

**Recommendation**
The Board is asked to note the above and be assured that there have been no immediate recent rota safety concerns and that the situation continues to be monitored.

# QUARTERLY REPORT ON SAFE WORKING HOURS: DOCTORS AND DENTISTS IN TRAINING

## Quarter 3 – 1 October to 31 December 2025

**Executive summary**

**Introduction**

This report is made jointly by the Guardian of Safe Working (GOSW) Miss Jennifer O'Neill and the specialist work force data provided by Lydia Rome Medical Workforce Administrator
**High level data for QVH**

| | |
|---|---|
| Number of doctors / dentists in training (total): | 65 (49 HEE 16 Trust) |
| Number of doctors / dentists in training on 2016 contract (total): | 65 (49 HEE 16 Trust) |
| Amount of time available in job plan for guardian to do the role: | 0.75 PAs / 3 hours per week |
| Admin support provided to the guardian (if any): | Ad hoc |
| Amount of job-planned time for educational supervisors: | 0.25 PAs per trainee |

*excludes Radiology HEE trainees, lead employer UHSx facilitates the exception reporting.

**a) Exception reports (all were regarding working hours breached and none for missed educational opportunities or breaks)**

| Exception reports by department | | | | |
|---|---|---|---|---|
| Specialty | No. exceptions carried over from last report | No. exceptions raised | No. exceptions closed | No. exceptions outstanding |
| Anaesthetics | 0 | 0 | 0 | 0 |
| Maxillofacial | 0 | 31 | 31 | 0 |
| Orthodontic | 0 | 0 | 0 | 0 |
| Plastics | 0 | 8 | 8 | 0 |
| **Total** | 0 | 39 | 39 | 0 |

| Exception reports by grade | | | | |
|---|---|---|---|---|
| Specialty | No. exceptions carried over from last report | No. exceptions raised | No. exceptions closed | No. exceptions outstanding |
| ST3 + | 0 | 26 | 26 | 0 |
| CT1-2 / ST1-2 | 0 | 13 | 13 | 0 |
| **Total** | 0 | 39 | 39 | 0 |

| Exception reports (response time) | | | | | |
|---|---|---|---|---|---|
| | Addressed within 48 hours | Addressed within 7 days | Addressed 8 to 30 days | Addressed over 30 days | Still open |
| All grades | 9 | 6 | 24 | 0 | 0 |

Response time to exception reports needs focused improvement work as there is a mandate to respond within 10 days from 4th February 2026, which changes to within 7 days from August 2026. If more time is needed to investigate the claim, there is a facility for an extension/pause.

## b) Work schedule reviews

We have had a work schedule review for Maxillofacial Surgery DCT's, at the request of the GOSW – due to a high number of exception reports raised. This showed no work schedule deviations but poor rostering practices which arose due to changing working patterns by using existing staff to fill rota gaps. Both the rostering practices and the rota gaps have now been addressed and simultaneously solved.

## c) Locum bookings

Extra shifts that have been covered have been covered by bank and not agency. There were less vacancies and extra workload requirements in this quarter compared to the previous quarterly report. However, perhaps because of increased sickness in these winter months, the overall bank hours worked increased from 1156.5 in the previous quarter (June to September 2025) to 2277.34 (October to December 2025 inclusive). Ongoing use of bank workforce is being closely monitored through the Temporary Staffing Oversight Group.

### i) Bank

| Locum bookings (bank) by department | | | | | |
|---|---|---|---|---|---|
| Specialty | Number of shifts requested | Number of shifts worked | Number of shifts given to agency | Number of hours requested | Number of hours worked |
| Anaesthetics | 50 | 42 | 0 | 501.92 | 421.92 |
| Maxillofacial | 115 | 106 | 0 | 812.22 | 779.92 |
| Orthodontics | 0 | 0 | 0 | 0.00 | 0.00 |
| Plastics | 106 | 96 | 0 | 957.50 | 875.50 |
| Total | 271 | 244 | 0 | 2271.64 | 2077.34 |

| Locum bookings (bank) by grade | | | | | |
|---|---|---|---|---|---|
| Specialty | Number of shifts requested | Number of shifts worked | Number of shifts given to agency | Number of hours requested | Number of hours worked |
| CT1-2* | 44 | 27 | 0 | 332.72 | 240.42 |
| ST3 +* | 227 | 217 | 0 | 1,938.92 | 1836.92 |
| Total | 271 | 244 | 0 | 2271.64 | 2077.34 |

*Includes Trust Grade doctors – Health Roster is not configured to identify HEE/Trust separately

| Locum bookings (bank) by reason* | | | | | |
|---|---|---|---|---|---|
| Specialty | Number of shifts requested | Number of shifts worked | Number of shifts given to agency | Number of hours requested | Number of hours worked |
| Vacancy | 18 | 16 | 0 | 128.30 | 118 |
| Sickness | 43 | 33 | 0 | 429.70 | 383 |
| Increase in workload* | 54 | 45 | 0 | 501.92 | 414.92 |
| Other** | 156 | 150 | 0 | 1211.72 | 1161.42 |
| Total | 271 | 244 | 0 | 2271.64 | 2077.34 |

** Increase in workload includes: Additional Clinics/Lists, WLI*

*** Other includes: Annual Leave, On Call, Special Leave, Study leave, Maternity*

| Locum bookings (bank) by department and reason | | | | | |
|---|---|---|---|---|---|
| Specialty | Vacancy | Sickness | Increased Workload* | Other ** | Number of shifts |
| Anaesthetics | 0 | 0 | 11 | 39 | 50 |
| Maxillofacial | 3 | 31 | 0 | 81 | 115 |
| Orthodontics | 0 | 0 | 0 | 0 | 0 |
| Plastics | 15 | 12 | 43 | 36 | 106 |
| Total | 18 | 43 | 54 | 156 | 271 |

** Increase in workload includes: Additional Clinics/Lists, WLI*

*** Other includes: Annual Leave, On Call, Special Leave, Study leave, Maternity*

### ii) Agency

| Locum bookings (agency) by department | | | | |
|---|---|---|---|---|
| Specialty | Number of shifts requested | Number of shifts worked | Number of hours requested | Number of hours worked |
| Anaesthetics | 0.0 | 0.0 | 0.0 | 0.0 |
| Maxillofacial | 0.0 | 0.0 | 0.0 | 0.0 |
| Orthodontic | 0.0 | 0.0 | 0.0 | 0.0 |
| Plastics | 0.0 | 0.0 | 0.0 | 0.0 |
| Radiology | 0.0 | 0.0 | 0.0 | 0.0 |
| Total | 0.0 | 0.0 | 0.0 | 0 |

| Locum bookings (agency) by grade | | | | |
|---|---|---|---|---|
| Specialty | Number of shifts requested | Number of shifts worked | Number of hours requested | Number of hours worked |
| CT1-2 | 0.0 | 0.0 | 0.0 | 0.0 |
| ST3-8 | 0.0 | 0.0 | 0.0 | 0.0 |
| Total | 0.0 | 0.0 | 0.0 | 0.0 |

| Locum bookings (agency) by reason | | | | |
|---|---|---|---|---|
| Specialty | Number of shifts requested | Number of shifts worked | Number of hours requested | Number of hours worked |
| Vacancy | 0.0 | 0.0 | 0.0 | 0.0 |
| Sickness | 0.0 | 0.0 | 0.0 | 0.0 |
| Total | 0.0 | 0.0 | 0.0 | 0.0 |

**Locum work carried out by trainees**

### d) Vacancies

| Vacancies by month | | | | | | |
|---|---|---|---|---|---|---|
| Specialty | Grade | Month 1 | Month 2 | Month 3 | Total gaps (average) | Number of shifts uncovered* |
| Anaesthetics | ST3+ | 11 | 10 | 17 | 12.6 | 2 |
| Maxillofacial Core | CT1-2 | 0 | 5 | 0 | 1.6 | 9 |
| Maxillofacial higher | ST3+ | 32 | 35 | 34 | 33.6 | 0 |
| Plastic surgery core | CT1-2 | 4 | 5 | 9 | 6 | 2 |
| Plastic surgery higher | ST3+ | 24 | 28 | 26 | 26 | 8 |

| | | | | | | |
|---|---|---|---|---|---|---|
| Orthodontics | ST3+ | 0 | 0 | 0 | 0.00 | 0 |
| Total | | 71 | 83 | 86 | 79.8 | 21 |

**Currently non reportable*

## e) Fines

| Fines by department | | |
|---|---|---|
| Department | Number of fines levied | Value of fines levied |
| Total | 0 | £0 |

| Fines (cumulative) | | | |
|---|---|---|---|
| Total fines levied, as of end of last quarter - since 4/2/21 | Fines this quarter | Total disbursements, including this quarter | Fine balance at the end of this quarter |
| £12946.05 | £0 | £12526.44 | £419.61 |

**Notes from GOSW:**

One safety concern was reported regarding delays and overruns caused by the Archie EPR system in a fully booked clinic; the issue was resolved with team support and payment for extra hours, and the report was closed.

An educational exception report was filed due to service commitment preventing a resident from attending a teaching day.

There has been a general increase in exception reporting this quarter, with most reports coming from Maxillofacial residents and linked to long head and neck oncology cases, suggesting a need for a work schedule review.

No fines were issued this quarter; locally employed doctors can report exceptions and claim extra hours but lack payment or fine protection in their contracts.

The option for TOIL (Time Off In Lieu) will be embedded in the Allocate Software, and discussions with the JLNC are planned to negotiate an agreed process for handling leave hours and maintaining confidentiality.

# QUARTERLY REPORT ON SAFE WORKING HOURS: DOCTORS AND DENTISTS IN TRAINING

## Quarter 4 – 1 January to 31 March 2026

**Executive summary**

**Introduction**

This report is made jointly by the Guardian of Safe Working (GOSW) Miss Jennifer O'Neill and the specialist work force data provided by Lydia Rome Medical Workforce Administrator
**High level data for QVH**

| | |
|---|---|
| Number of doctors / dentists in training (total): | 69 (47 HEE 22 Trust) |
| Number of doctors / dentists in training on 2016 contract (total): | 69 (47 HEE 22 Trust) |
| Amount of time available in job plan for guardian to do the role: | 0.75 PAs / 3 hours per week |
| Admin support provided to the guardian (if any): | Ad hoc |
| Amount of job-planned time for educational supervisors: | 0.25 PAs per trainee |

*excludes Radiology HEE trainees, lead employer UHSx facilitates the exception reporting.

**a) Exception reports (27 were regarding working hours breached and 7 for missed educational opportunities or breaks)**

| Exception reports by department | | | | |
|---|---|---|---|---|
| Specialty | No. exceptions carried over from last report | No. exceptions raised | No. exceptions closed | No. exceptions outstanding |
| Anaesthetics | 0 | 0 | 0 | 0 |
| Maxillofacial | 0 | 12 | 12 | 0 |
| Orthodontic | 0 | 0 | 0 | 0 |
| Plastics | 0 | 20 | 20 | 0 |
| **Total** | 0 | 34 | 34 | 0 |

| Exception reports by grade | | | | |
|---|---|---|---|---|
| Specialty | No. exceptions carried over from last report | No. exceptions raised | No. exceptions closed | No. exceptions outstanding |
| ST3 + | 0 | 32 | 32 | 0 |
| CT1-2 / ST1-2 | 0 | 2 | 2 | 0 |
| **Total** | 0 | 34 | 34 | 0 |

| Exception reports (response time) | | | | | |
|---|---|---|---|---|---|
| | Addressed within 48 hours | Addressed within 7 days | Addressed 8 to 30 days | Addressed over 30 days | Still open |
| All grades | 0 | 27 | 5 | 2 | 0 |

**b) Work schedule reviews**

**c) Locum bookings**

**i) Bank**

| Locum bookings (bank) by department | | | | | |
|---|---|---|---|---|---|
| Specialty | Number of shifts requested | Number of shifts worked | Number of shifts given to agency | Number of hours requested | Number of hours worked |
| Anaesthetics | 84 | 68 | 16 | 853 | 710.5 |
| Maxillofacial | 163 | 156 | 0 | 1199.5 | 1123 |
| Orthodontics | 0 | 0 | 0 | 0.00 | 0.00 |
| Plastics | 68 | 61 | 0 | 616 | 539.50 |
| Total | 315 | 285 | 16 | 2668.5 | 2373 |

| Locum bookings (bank) by grade | | | | | |
|---|---|---|---|---|---|
| Specialty | Number of shifts requested | Number of shifts worked | Number of shifts given to agency | Number of hours requested | Number of hours worked |
| CT1-2* | 20 | 14 | 0 | 157.5 | 99.5 |

| ST3 +* | 295 | 271 | 16 | 2511 | 2273.5 |
|---|---|---|---|---|---|
| Total | 315 | 285 | 16 | 2668.5 | 2373 |

*Includes Trust Grade doctors – Health Roster is not configured to identify HEE/Trust separately

| Locum bookings (bank) by reason* | | | | | |
|---|---|---|---|---|---|
| Specialty | Number of shifts requested | Number of shifts worked | Number of shifts given to agency | Number of hours requested | Number of hours worked |
| Vacancy | 15 | 13 | 0 | 143 | 114 |
| Sickness | 23 | 21 | 0 | 143.75 | 139.75 |
| Increase in workload* | 58 | 43 | 2 | 534.5 | 390.5 |
| Other** | 219 | 208 | 14 | 1847.25 | 1728.75 |
| Total | 315 | 285 | 16 | 2668.5 | 2373 |

** Increase in workload includes: Additional Clinics/Lists, WLI, Theatre Overruns*

*** Other includes: Annual Leave, On Call, Special Leave, Study leave, Maternity*

| Locum bookings (bank) by department and reason | | | | | |
|---|---|---|---|---|---|
| Specialty | Vacancy | Sickness | Increased Workload* | Other ** | Number of shifts |
| Anaesthetics | 0 | 2 | 24 | 58 | 84 |
| Maxillofacial | 3 | 16 | 5 | 139 | 163 |
| Orthodontics | 0 | 0 | 0 | 0 | 0 |
| Plastics | 12 | 5 | 29 | 22 | 68 |
| Total | 15 | 23 | 58 | 219 | 315 |

** Increase in workload includes: Additional Clinics/Lists, WLI*

*** Other includes: Annual Leave, On Call, Special Leave, Study leave, Maternity*

### ii) Agency

| Locum bookings (agency) by department | | | | |
|---|---|---|---|---|
| Specialty | Number of shifts requested | Number of shifts worked | Number of hours requested | Number of hours worked |
| Anaesthetics | 16 | 16 | 192.5 | 192.5 |
| Maxillofacial | 0.0 | 0.0 | 0.0 | 0.0 |
| Orthodontic | 0.0 | 0.0 | 0.0 | 0.0 |
| Plastics | 0.0 | 0.0 | 0.0 | 0.0 |
| Radiology | 0.0 | 0.0 | 0.0 | 0.0 |
| Total | 0.0 | 0.0 | 192.5 | 192.5 |

| Locum bookings (agency) by grade | | | | |
|---|---|---|---|---|
| Specialty | Number of shifts requested | Number of shifts worked | Number of hours requested | Number of hours worked |
| CT1-2 | 0.0 | 0.0 | 0.0 | 0.0 |
| ST3-8 | 16 | 16 | 192.5 | 192.5 |
| Total | 16 | 16 | 192.5 | 192.5 |

| Locum bookings (agency) by reason | | | | |
|---|---|---|---|---|
| Specialty | Number of shifts requested | Number of shifts worked | Number of hours requested | Number of hours worked |
| Vacancy | 0.0 | 0.0 | 0.0 | 0.0 |
| Sickness | 0.0 | 0.0 | 0.0 | 0.0 |
| Increased Workload | 2 | 2 | 17 | 17 |
| Other** | 14 | 14 | 175.5 | 175.5 |
| Total | 16 | 16 | 192.5 | 192.5 |

**Locum work carried out by trainees**

### d) Vacancies

| Vacancies by month | | | | | | |
|---|---|---|---|---|---|---|
| Specialty | Grade | Month 1 | Month 2 | Month 3 | Total gaps (average) | Number of shifts uncovered* |
| Anaesthetics | ST3+ | 19 | 27 | 38 | 28 | 16 |

| | | | | | | |
|---|---|---|---|---|---|---|
| Maxillofacial Core | CT1-2 | 0 | 3 | 0 | 1 | 3 |
| Maxillofacial higher | ST3+ | 44 | 62 | 54 | 53.3 | 4 |
| Plastic surgery core | CT1-2 | 8 | 9 | 0 | 5.6 | 3 |
| Plastic surgery higher | ST3+ | 18 | 17 | 16 | 17 | 4 |
| Orthodontics | ST3+ | 0 | 0 | 0 | 0.00 | 0 |
| Total | | 89 | 115 | 108 | 104.9 | 30 |

**Currently non reportable*

**e) Fines**

| Fines by department | | |
|---|---|---|
| Department | Number of fines levied | Value of fines levied |
| Total | 0 | £0 |

| Fines (cumulative) | | | |
|---|---|---|---|
| Total fines levied, as of end of last quarter - since 4/2/21 | Fines this quarter | Total disbursements, including this quarter | Fine balance at the end of this quarter |
| £12946.05 | £0 | £12910.44 | £35.61 |

**Notes from GOSW:**

Exception reports have remained steady with all reports closed and none were outstanding at the end of the quarter.

A key area of progress was timeliness of response to submitted exception reports since the introduction of the new software, and removal of educational supervisors from the process in line with the national exertion reporting reforms.

All ERs since the introduction of the new software at the end of January 2026 received responses within 7 days. The mandate is that we need to respond within 10 days (from Feb 2026) and from August 2026 the trust may get fined if the response time is over 7 days.

No safety concerns were formally reported during the quarter.

Exception reporting in Maxillofacial Surgery decreased, but the long oncology cases sometimes cause breaches in the contracted working hours, and ways to prevent this are being examined at a departmental level.

Workforce pressures remain evident, with increased vacancy levels and higher bank locum usage, but these pressures appear to have been managed without transferring risk to trainees. Agency locum use remained minimal (there was a temporary need for use of a locum in anesthetics).

No guardian fines were levied during the quarter.

| Report cover-page | | | | | |
|---|---|---|---|---|---|
| **References** | | | | | |
| **Meeting title:** | Board of Directors | | | | |
| **Meeting date:** | 14/05/2026 | | **Agenda reference:** | **16-26** | |
| **Report title:** | *QVH Strategy 2025-2030*: 2025/26 year 1 delivery & Key Strategic Objectives 2026/27 | | | | |
| **Sponsor:** | Kathy Brasier, Acting Chief Strategy Officer | | | | |
| **Author:** | Kathy Brasier, Acting Chief Strategy Officer<br>Ellie Winter, Strategy Programme Manager | | | | |
| **Appendices:** | Appendix one: Key Strategic Objectives 2026/27 | | | | |
| **Executive summary** | | | | | |
| **Purpose of report:** | To provide the Strategy and Culture Committee with assurance on delivery of the *QVH Strategy 2025–2030* during Year 1 and the emerging strategic priorities for Year 2. | | | | |
| **Summary of key issues** | Significant national and system change has shaped delivery during 2025/26, with the Strategy providing a stable framework for prioritisation and partnership development<br><br>Delivery in 2025/26 focused on establishing strong foundations across all five Key Strategic Objectives, with sustained performance against core standards and material progress in access, sustainability and partnership readiness.<br>Priorities for 2026/27 intentionally build on learning from 2025/26 and align to the partnership and collaboration direction of the NHS 10 Year Health Plan and Sussex Strategy, strengthening organisational foundations in readiness for partnership delivery. | | | | |
| **Recommendation:** | The Board is asked to **note** progress against the key strategic objectives during 2025/2, and **approve** the Key Strategic Objective priorities for 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:** | BAF 5 | | | | |
| **Organisational risk register:** | | | | | |
| **Regulation:** | NHSE, ICB | | | | |
| **Legal:** | None | | | | |
| **Resources:** | None | | | | |
| **Assurance route** | | | | | |
| **Previously considered by:** | Executive Leadership Team and Strategy and Culture Committee | | | | |
| | Date: | 14/04/2025 and 20/04/2025 | Decision: | For approval at Trust Board 14/05/2026 | |

| | |
|---|---|
| **Report to:** | Board of Directors |
| **Agenda item:** | 16-26 |
| **Date of meeting:** | 14 May 2026 |
| **Report from:** | Kathy Brasier, Acting Chief Strategy Officer |
| **Report author:** | Kathy Brasier, Acting Chief Strategy Officer<br>Ellie Winter, Strategy Programme Manager |
| **Date of report:** | 10 April 2026 |
| **Appendices:** | Appendix one: Key Strategic Objectives 2026/27 |

**QVH Strategy 2025-2030: 2025/26 Year 1 delivery & 2026/27 Year 2 planning**

**Introduction**

This paper provides the Strategy and Culture Committee with an update on delivery of the Queen Victoria Hospital NHS Foundation Trust *QVH Strategy 2025–2030*, focusing on progress during the first year of implementation and approval of the 2026/27 priorities for Year 2.

**Purpose**

The Strategy sets out a five-year framework across three strategic themes, Centre of Excellence, Holistic Needs and Service Integration, underpinned by five Key Strategic Objectives (KSOs). The KSOs provide the primary mechanism for delivery, monitoring and assurance. This paper sets out the operating context for delivery of the Strategy, provides an assessment of progress during Year 1 (2025/26) against the KSOs, and proposes the priorities for Year 2 (2026/27), to support assurance and oversight by the Committee for onward approval at the Trust Board meeting in May 2026.

**Operating context**

Delivery of the first year of the Strategy has taken place during a period of significant national and system change. NHS England is operating within a reduced and more devolved model, with consolidation of Integrated Care Boards (ICBs) and expectations that providers take greater responsibility for transformation, partnership working and financial sustainability. In Sussex, this has driven increased emphasis on place-based working, neighbourhood models of care, and provider leadership. In this context, the QVH Strategy has provided a stable framework for prioritisation, supporting the Trust to balance ambition with delivery capacity and financial constraint, while remaining aligned to national and system direction.

**Strategic Delivery Year 1: 2025/26**

Delivery during Year 1 has been steered through the five KSOs, which translate the three strategic themes into practical organisational priorities. Progress across the year reflects a period of foundation building, capability development and targeted delivery, rather than large-scale reconfiguration.

- **KSO 1: To deliver outstanding care**

Under KSO 1, the Trust focused on delivering against national access standards, progressing priority clinical reviews and strengthening quality and equity of access. Patients waiting over 52 weeks reduced from 2.2% to 1.2% of the total waiting list, urgent and emergency care 4-hour performance remained high at 99.83%, and 82% of patients were told whether they had cancer or not within 28 days, exceeding the national standard. Clinically led service improvement continued in priority areas. The Trust responded to the national Burns Review and continues to work with clinical teams and system partners to optimise the Burns care model, and to improve pathways for children and young.

Alongside this, significant work progressed in embedding the tackling of health inequalities. Ethnicity data completeness improved from a 2024/25 average of 79.8% to 83.9% in 2025/26,

strengthening the Trust's ability to understand variation in access and experience. Cancer staging completeness remained consistently strong, with data shared with primary care partners to support earlier identification of patients at risk of late presentation. For the first time at QVH, analysis of elective access by age, gender, ethnicity and deprivation was established through the Health Inequalities Dashboard. This showed no consistent variation in long waits by age, gender or ethnicity, but identified a clear deprivation gradient, with patients from more deprived communities more likely to experience longer waits and higher DNA rates. This provides a robust baseline for targeted improvement in 2026/27.

- **KSO 2: To innovate and improve**

Delivery under KSO 2 focused on strengthening research, innovation and continuous improvement (CI) capability. The Trust maintained an active research portfolio, with 11 live research studies underway, and continued use of audit to support evidence-based practice. Progress in developing the foundations for a Research, Innovation and Education Hub, supported by a charity bid is underway. As a part of the CI Programme, 18 CI huddle areas were established, 54 staff completed Yellow or Green Belt training, 23 staff completed NHS Impact Operational Improvement training, and three Trust-wide celebration events were held.

- **KSO 3: To be an excellent employer**

Under KSO 3, the Trust focused on culture, leadership and staff experience. Eight Behavioural Framework workshops were delivered, engaging 58 staff and supporting embedding of Trust values across the organisation. Leadership development continued through the commencement of the new Managers Essentials Programme, resilience workshops, coaching and change management support. EDI activity progressed through the work of EDI champions across the organisation, contributing to improved patient and staff experience. Workforce indicators showed positive movement, with vacancy rates reducing and reliance on temporary significantly staffing decreasing over the year.

- **KSO 4: To deliver sustainable services**

KSO 4 focused on financial sustainability, digital transformation, estates resilience and best-value delivery. The Trust delivered its £7.5m cost improvement requirement, including £2.1m of corporate cost reductions, strengthening the underlying financial position, despite a proportion of non-recurrent savings. A major milestone was achieved with the go-live of the Electronic Patient Record, Archie, in November, with optimisation ongoing. Progress was also made in estates resilience and infrastructure, including fire safety works, boiler and window replacements, asbestos removal, expanded car parking and investment in new clinical equipment such as a Dual-Energy X-ray Absorptiometry (DEXA) scanner. Elective capacity was enhanced through expansion of the Local Anaesthetic Unit, and work continues with the Sussex pathology network to modernise services, including digital histopathology.

- **KSO 5: To collaborate with others**

Delivery under KSO 5 focused on moving partnership working into delivery. During the year, QVH completed a full strategic partnership appraisal with Royal Surrey NHS Foundation Trust and Ashford and St Peter's Hospitals NHS Foundation Trust (RSFT/ASPH) group, supported by structured evaluation and extensive engagement. A total of 947 staff and stakeholder feedback submissions informed the final recommendation presented to the Board in December 2025. Following the Board decision, the Trust has moved into a formal transition phase for the partnership implementation. Work has now commenced across the six agreed workstreams, focusing on detailed planning, governance, engagement and early implementation activity. Alongside this, Community Diagnostic Centre building works progressed, with completion expected in Autumn 2026. The Trust also contributed to the Sussex Major Services Review, including the Integrated Frailty and Complex Needs Delivery Group and the Single Point of Access workstream for Sussex services.

**Summary**
A summary 25/26 delivery status rating each priority as Red, Amber, Green, or blue for complete, at year end, can be found below in Figure 1. Learning points from 2025/26 will be reported through the Strategy and Culture Committee.

| | INITIATIVE | DELIVERY RAG |
|---|---|---|
| KSO1 | Access Targets (RTT, DMO1, Cancer, UEC) | Partial achievement |
| | *Health Inequalities (QP)* | Partial achievement |
| | Development of Childrens model (phase1) | On track |
| | Burns review outcomes business case (recommendations from NHSE) | On track |
| KSO2 | Research & Innovation (governance, collaboration, and research centre) | Complete |
| | *Evidence through measurable outcome measures (QP)* | On track |
| | Embed Continuous Improvement (CI) | On track |
| KSO3 | Embed Values/ Behavioural Framework | On track |
| | Deliver Equality, Diversity and Inclusion Priorities | Partial achievement |
| KSO4 | Deliver trust costs by £7.5m (6%) including £2.1m in corporate costs | Complete |
| | Electronic Patient Record (EPR) (MP) | Complete |
| | Phase 2 reconfiguration of estates/ critical infrastructure | On track |
| | Pathology and Imaging Networks (MP) | On track |
| KSO5 | Development of strategic partnerships to deliver corporate sustainability | Complete |
| | QVH Local – Community Diagnostic Centres (MP) | Planned opening October 2026 |
| | Contribution to Sussex Major Services Review (MSR) | Complete |

*Figure 1: RAG status of 25/26 priorities at year end*

**Year 2: Emerging Strategic Priorities 26/27**
The priorities for Year 2 have been shaped by learning from Year 1, alongside the external policy context set out in the NHS 10 Year Health Plan and the Sussex Integrated Care Strategy. Each element of delivery for 2026/27 has been intentionally aligned to the national and system direction on collaboration and partnership working, while strengthening the Trust's organisational foundations in readiness for partnership delivery. Across all KSOs, the emphasis is on embedding delivery, translating insight into measurable improvement, and ensuring the Trust is operationally, financially and culturally prepared to deliver effectively within an increasingly collaborative system landscape (See Appendix one).

- **KSO 1: To deliver outstanding care**

In 2026/27, the Trust will continue to place quality and access at the centre of care for patients, families and the communities we serve. The focus will be on delivering national access standards across elective, cancer and urgent care pathways, alongside sustained reduction in long waits. Priority clinical service reviews for burns, prosthetics and breast services will be completed with commissioners, ensuring clear outcomes and next steps. Quality priorities will focus on reducing inequalities in access and DNAs, improving patient understanding and experience, and strengthening outcome and effectiveness measures, while maintaining strong patient survey and PLACE performance.

- **KSO 2: To innovate and improve**

The Trust will continue to position research, innovation and continuous improvement as core enablers of service quality and sustainability. Delivery will focus on progressing Year 2 of the Research and Innovation strategic plan, including development of the Research, Innovation and Education Hub and strengthening academic and commercial partnerships. The QVH Way will underpin all improvement and transformation activity, providing a consistent approach to change. Continuous improvement capability will be developed through delivery of the in-house CI training programme for all new starters.

- **KSO 3: To be an excellent employer**

In 2026/27, the Trust will focus on developing its workforce and leadership capability to support high-quality care and effective partnership working. Priorities include strengthening an inclusive and collaborative culture through continued delivery of the behaviours framework and speaking-up arrangements, alongside development of trust-wide and directorate leadership capability. Organisational culture and staff experience will be monitored through the Staff Survey, People Pulse Survey, the Workforce Race Equality Standard (WRES) and the Workforce Disability Equality Standard and (WDES), and an updated Cultural Diagnostic Assessment. The Trust will maintain strong performance against core workforce metrics, including appraisal completion and resident doctor standards.

- **KSO 4: To deliver sustainable services**

Delivery under KSO 4 will prioritise best value, financial sustainability and estates resilience to support safe and sustainable services. Focus areas include delivering a breakeven position and the £7.5m Better Value Programme, alongside continued reduction of corporate costs. Key estates and infrastructure projects will be delivered, including the Community Diagnostic Centre, MRI and Research, Innovation and Education developments, with measurable reductions in estates backlog maintenance. Diagnostic pathways will continue to be transformed through the CDC model, and digital transformation will support Trust and system priorities, including successful installation of the Altera Patient Administration System (PAS).

- **KSO 5: To collaborate with others**

Delivery under KSO 5 will focus on progressing the transition and early implementation of the strategic partnership, alongside continued engagement with staff, governors and stakeholders. Priorities include delivery of key partnership transition milestones and implementation of the Trust's internal and external engagement plans. Additionally, the Trust will continue to support system transformation through active participation in provider collaboratives and delivery of agreed Sussex and Surrey priorities, including development of Single Point of Access (SPOA).

**Recommendation**

The Board is asked to **note** progress against the Key Strategic Objectives during 2025/26, and **approve** the Key Strategic Objective priorities for 2026/27.

Appendix one: Key Strategic Objectives 2026/27

# KEY STRATEGIC OBJECTIVES (KSOs) 2026/27

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

| | KSO 1<br>To deliver outstanding care | KSO 2<br>To innovate and improve | KSO 3<br>To be an excellent employer | KSO 4<br>To deliver sustainable services | KSO 5<br>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 objectives** | ➤ Delivery of Access Targets (RTT, Cancer, UEC, DMO1) including the National Cancer Plan (COO) (Finance and Performance Committee)<br>➤ Strategic service reviews for burns, prosthetics and breast in liaison with commissioners (CNO/CSO/COO) (Strategy and Culture Committee - where required Quality and Safety Committee/Finance and Performance Committee)<br>➤ *QP:* Health Inequality DNA and Access, Patient Schools, Outcomes and Effectiveness measures (CNO/CMO) (Quality and Safety Committee) | ➤ Research, Innovation and Education Hub and strengthen academic and commercial partners (CMO) (Quality and Safety Committee)<br>➤ Ensure the QVH Way underpins all improvement and transformation programmes (CMO) (Quality and Safety Committee) | ➤ Enhance inclusive collaborative culture including behaviours framework and speaking up (EDI) (CPO) (Strategy and Culture Committee)<br>➤ Develop Trust and Directorate leadership capability (CPO) (Strategy and Culture Committee) | ➤ Maintain financial sustainability, reduction of corporate costs and delivery of £7.5m Better Value Programme (CFO) (Finance and Performance Committee)<br>➤ Delivery of key estates infrastructure projects and improving estates resilience and backlog maintenance (MRI, R&I, CDC) (CPO/COO/DEF) (Finance and Performance Committee) **MP**<br>➤ Digital transformation to support Trust and system priority objectives, including Patient Administration System (PAS) (CMO) (Finance and Performance Committee) **MP**<br>➤ Transform diagnostic pathways using Community Diagnostic Centre (CDC) for neighbourhood care (COO/DCOO) (Finance and Performance Committee) **MP** | ➤ Strategic partnership transition and implementation (CEO/CSO) (Strategy and Culture Committee) **MP**<br>➤ Delivery of external and internal Engagement Plan (CEO/CSO) (Strategy and Culture Committee)<br>➤ Support system transformation through Provider Collaborative (CSO) (Strategy and Culture Committee) |
| **Annual goals** | ➤ RTT 69%, Cancer FDS 80%, 31 Day 94%, 62 Day 80%, UEC 98%, DMO1 92% (COO)<br>➤ Sustained reduction in patients waiting over 52 weeks by 1% (COO)<br>➤ Completion of service reviews and outcomes (CNO/CSO/COO)<br>  ➤ Burns – September 2026<br>  ➤ Prosthetics October 2026<br>  ➤ Breast – March 2027<br>➤ Maintain leading national positions for patient surveys (CNO)<br>➤ Achievement of above national average in 8 domains of the Patient Led Assessments of Care Environment (PLACE) (CNO) | ➤ Development of Research and Innovation:<br>  ➤ Establish the Research, Innovation and Education Hub to connect staff and navigate them to development opportunities including improvement, transformation and innovation<br>  ➤ Acceleration of commercial research opportunities in partnership with the NIHR Commercial Research Delivery Centre Sussex and the Research Delivery Network (CMO)<br>➤ Delivery of CI in-house targeted training programme (CMO) | ➤ Maintain or improve performance against workforce metrics, including 90% completion of staff appraisal (CPO)<br>➤ >95% compliance with Resident Doctor 10-point plan (CMO)<br>➤ People Pulse Survey (CPO)<br>➤ Annual measurement of:<br>  ➤ Staff Survey<br>  ➤ WRES/WDES<br>  ➤ Update Cultural Diagnostic Assessment (CPO) | ➤ Successful installation of Altera PAS – November 2026 (CMO)<br>➤ Delivery of 2026/27 break even position (CFO)<br>➤ Delivery of key infrastructure projects (CFO/CPO/DEF)<br>  ➤ CDC – September 2026<br>  ➤ MRI – March 2027<br>  ➤ RI&E – March 2027<br>➤ Successful delivery of Sussex Pathology Network Programme (SPN) (CMO) | ➤ Delivery of key partnership transition milestones (CSO)<br>➤ Implementation of Trust Engagement Plan (CSO)<br>➤ To support the delivery of Sussex and Surrey Provider Collaborative priority plans including Single Point of Access (SPOA) (CEO) |

DRAFT

| Report cover-page | | | | | |
|---|---|---|---|---|---|
| **References** | | | | | |
| **Meeting title:** | Board of Directors | | | | |
| **Meeting date:** | 14/05/2026 | | **Agenda reference:** | **17-26** | |
| **Report title:** | Board Assurance Framework (BAF) | | | | |
| **Sponsor:** | Jamie O'Callaghan, interim Company secretary<br>Executive risk leads | | | | |
| **Author:** | Jamie O'Callaghan, interim Company secretary | | | | |
| **Appendices:** | Appendix one- BAF summary<br>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.<br><br>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.<br><br>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.<br><br>There have been no changes to risk scores since the Board review on 12 March 2026. | | | | |
| **Recommendation:** | To **review** the BAF and:<br>- 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<br>- 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:** | **KS oval O2:** | **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:** | 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: | March, April, May 2026 | Decision: |  |
|---|---|---|---|---|
| **Next steps:** |  |  |  |  |

**Report to:** Board of Directors
**Agenda item:** 17-26
**Date of meeting:** 14 May 2026
**Report from:** Jamie O'Callaghan, interim Company secretary
Executive risk leads
**Report author:** Jamie O'Callaghan, interim Company secretary
**Date of report:** May 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 March, April and May 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**<br>**Finance**<br>**Leadership capacity** | |
| **Possible** | | | **Workforce**<br>**Quality** | **Digital**<br>**Access**<br>**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 March 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**<br>There is a risk that the Trust will not deliver against its operational plan and national access standards<br><br>Caused by rise in waiting lists; increased demand; national changes; support to the wider Sussex system<br><br>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<br>• The strategic review of breast reconstruction has been delayed to September 2026<br>• Actions completed health inequalities date and action plan development for 65 week and 62 day waits<br>• Non RTT oversight and reporting in place from Q4 of 2025/26<br>• As at April 2026 there are 39 patients on a skin pathway awaiting a clinical harm review, and 14 on a head and neck pathway awaiting a clinical review |
| 2 | **Digital**<br>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<br><br>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<br><br>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<br>• Board cyber training completed<br>• All actions in DSPT and CAF remediation plan are completed<br>• The funding request for the EPR programme team from December 2025 was successful (action)<br>• EPR 'Go Live' was a success with no negative patient impact caused<br>• Cyber to be separated as separate risk in next iteration of BAF as supported by the Board |
| 3 | **Estate**<br>There is a risk that the Trust's estate deteriorates further to the point where it is no longer safe<br><br>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<br><br>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<br>• The Director of estates and facilities post is now filled<br>• An updated 6 facet survey will be completed by 31 July 2026. This will provide key assurance<br>• £2.8m additional estates safety funding received<br>• 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 |

| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| | | | | | | | | • Good progress made for year end capital estates spend- action closed |
| 4 | **Finance**<br>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<br><br>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<br><br>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<br>• The Trust is on track to meet breakeven for 2025/26 subject to audit<br>• The medium term financial plan has been submitted but more work is required<br>• The business plan for 2026/27 has been submitted and accepted as compliant<br>• Assurance is required that further recurrent savings can be made |
| 5 | **Leadership capacity**<br>There is a risk that there will not be leadership capacity to deliver the strategic partnership, key strategic objectives and key projects<br><br>Caused by three interim executive roles including Chief executive officer; turnover in Board level roles and organisational memory loss; three NEDs finishing terms in June 2026<br><br>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<br>• Three NEDs are coming to end of terms at the end of June 2026- the recruitment process is underway<br>• On track for shared Chair and CEO roles in September 2026<br>• Chief strategy officer role has been filled on an interim basis<br>• Chief finance officer cover to be confirmed from June 2026 |
| 6 | **Workforce**<br>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<br><br>Caused by significant organisational change; uncertainty; the Trust's significant cost improvement target; requirement for corporate service cost reduction; leadership capacity and managers capability<br><br>Resulting in staff turnover; single points of challenge and lack of resilience; challenges with recruitment | 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<br>• 2025 staff survey results published and shared with the Board at its meeting in May 2026<br>• MAST compliance in February is stable<br>• The Trust does not have EDI networks- opportunity to link into partner organisations networks<br>• Managers training programme is in place and has received positive feedback |

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|---|---|---|---|---|---|---|---|---|
| | 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 | | | | | | | • Further assurance is required regarding the embedding of the behaviours framework<br>• There is a decline in mood and motivation and increase in staff long term sickness |
| 7 | **Quality**<br>There is a risk that the Trust may not consistently deliver high quality, safe and effective care<br><br>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<br><br>Resulting in poor patient experience and outcomes; potential harm; reputational damage | 20 | 9 | 6 | ↔ | Green (indicates that there are no serious issues and the controls are effective) | This risk is currently outside of risk appetite, with a higher score. The risk appetite for this area is minimal (1-3) | • The score remains the same as at last review<br>• The risk has passed its target date but not met its target score<br>• Nursing staffing levels have been reduced in line with efficiencies<br>• The PSIRF policy and resource action is off track<br>• Quality governance structure is embedded<br>• Clinical lead for quality has been appointed<br>• There has been an improvement in up to date clinical policies |
| 8 | **Regulation**<br>There is a risk that the Trust may not be able to meet its regulatory requirements<br><br>Caused by scale; cost improvement plans; corporate savings; turnover at Board level; additional licence conditions; non-compliance; leadership capacity; national changes to requirements<br><br>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<br>• There has been an improvement in policy compliance<br>• The draft Head of Internal Audit Opinion for 2025/26 is that there is an adequate framework of risk management, governance and control<br>• The Trust's additional licence conditions have been lifted<br>• The Trust received a rating of Green Amber for its Provider Capability Assessment<br>• The first draft of the Governance handbook has been completed |
| 9 | **Sustainability**<br>There is a risk that the Trust will not secure long term sustainability<br><br>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 | 20 | 15 | 10 | ↔ | Green (indicates that there are no serious issues and the controls are effective) | 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. The score will be reviewed after mutual planning and decision making related to the partnership is complete<br>• The assurance rating is now green due to a detailed implementation plan being in place as well as mutual of understanding of risks and mitigations |

| | | | | | | | | |
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| | the commissioning of services; changes to service specifications; staff morale; time constraints; differing views of key stakeholders on options<br><br>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 | | | | | | | • A communication and engagement plan has been agreed between partners as well as shared lines<br>• Decision making to be undertaken by partner Boards in early summer following mutual planning<br>• Financial reviews undertaken of QVH have had positive outcomes with no significant concerns |

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

| BAF | Risk description |
|---|---|
| | **Risk description**<br>Risk:<br>There is a risk that the Trust will not deliver against its operational plan and national access standards<br>Caused by:<br>Rise in waiting lists; increased demand; national changes;<br>Resulting in:<br>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 |

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|---|---|---|---|---|---|
| **Responsible committee** | Finance and performance committee | **Date Risk Added:** | 13 November 2025 | | |
| **Principal Exec – Risk Owner** | Chief operating officer | **Date Risk last reviewed:** | 7 April 2026 | | |
| **Risk Handler(s)** | Deputy Chief operating officer | **Date Risk last formally discussed:** | 12 March | **Group** | Trust Board |

| Inherent Score | Current Score | Target Score |
|---|---|---|
| 16 (Likelihood 4 × Consequence 4) | 12 (Likelihood 3 × Consequence 4) | 8 (Likelihood 2 × Consequence 4) |
| | **Direction of travel since last review**: ↔ | **Target date**: 31 March 2027<br>**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:<br>Review of cancer action plan by Cancer Board monthly. In Q4, QVH has been working with the Surrey and Sussex Cancer Alliance to map the skin cancer pathway. A revised action plan incorporating QVH and SSCA actions will be presented to Cancer Board in April. FDS and 62 day cancer performance has shown improvement in M10 and M11. Green/ Amber<br><br>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, late tertiary referrals, annual leave and industrial action. The Trust requires NHSE strategic | Non-RTT waits oversight and reporting – this is being reported on from M11 2025/26 and will continue in 2026/27.<br><br>NHSE strategic review of breast reconstruction- the Trust has indicated wanting to be a key player within this. |

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|---|---|---|
| | review of breast reconstruction in order to reduce 65 week waits, September 2025, Red (see action 2).<br><br>2nd line:<br>Monthly reporting and monitoring through the IQPR demonstrates challenges with 65 week waits, 52 week waits and 18 week wait performance. For cancer, 31 day performance remains static and challenged in meeting the 31 day standard. Amber/ Red (see action 2 and 8)<br><br>3rd line:<br>Internal audit on faster diagnosis standards demonstrates reasonable assurance with a good control framework in place, September 2025, Green<br><br>Internal audit of skin cancer waiting lists due to be undertaken in Q1 2026/27.<br><br>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)<br><br>National Oversight Framework rating by NHSE. The Trust was rated 29 out of 134 trusts for performance overall for Q3 2025/26, March 2026 (improved by 1 place) Green | |
| **Governance and oversight** incl. twice weekly tracking list meeting, weekly operational performance meeting, system capacity meeting, monthly access and responsiveness meeting | 2nd line:<br>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:<br>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)<br><br>Process established within cancer care pathways for harm from delays to be clinically evaluated resulting in targeted action and shared learning reported to Cancer Board. Reporting through Quality Committee to ECQR and by exception to Quality & Safety Committee demonstrates targeted action and shared learning, Amber (see action 4) | Clinical Lead for Cancer has responsibility and oversight of progress in this metric. As at April 2026 there are 39 patients on a skin pathway awaiting a clinical harm review, and 14 on a head and neck pathway awaiting a clinical review. |
| **Health inequalities priorities** improving data collection around ethnicity and processes for patients under the mental capacity act | 1st line:<br>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.<br><br>Impact on health inequalities work for patients. |

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| | Paper on health inequalities discussed at quality and Safety Committee in Q4 2025/26 with progress on developing a HI dashboard. | |
| **Access policy, booking policy, training manual for appointments staff, EPRR policies** in place | 2nd line:<br>Internal review of policies demonstrates the majority of operational policies are in date and have been reviewed against most recent guidance, with one operational policy outstanding to be reviewed in April. Green<br><br>EPRR annual assurance to Board demonstrates Substantial compliance November 2025, Green<br><br>3rd line:<br>Internal audit on faster diagnosis standards demonstrates reasonable assurance with a good control framework in place, September 2025, Green | |

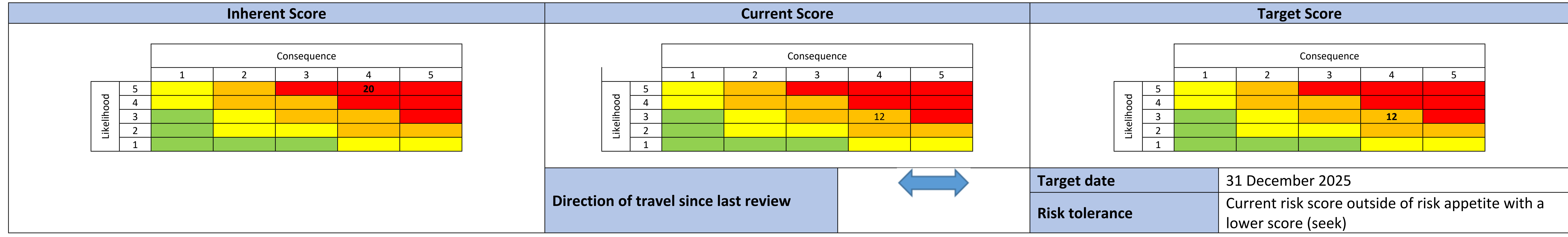
| **Actions** | **Timescale** | **Lead** | **Status** (complete, on track, off track, not yet started) |
|---|---|---|---|
| 1. Improvements to teledermatology pathway to improve capacity within skin. QVH part of Sussex dermatology transformation work to look at single point of access from 2027. | April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

| **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 | Q1- 2026/27 | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| ✓ | ✓ | | ✓ | ✓ | | | | | | | |

| BAF | **Risk description**<br>Risk:<br>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<br>Caused by:<br>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;<br>Resulting in:<br>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** | Tamara Everington, Chief medical officer | **Date Risk last reviewed:** | 5 April 2026 | | |
| **Risk Handler(s)** | Bill Gordon, Chief digital information officer | **Date Risk last formally discussed:** | 12 March 2026 | **Group** | Trust Board |




| 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:<br>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<br><br>Development of the data strategy working with System partners |
| **Digital policies and procedures** | 1st line:<br>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)<br><br>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 |

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|---|---|---|
| | 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)<br><br>3rd line:<br>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:<br>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)<br><br>2nd line:<br>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)<br><br>Monitoring in place for key infrastructure by third party contractor and NHSE CSOC monitoring of cyber alerts, Amber<br><br>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<br><br>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<br><br>3rd line:<br>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<br><br>Actions to be completed in CAF DSPT improvement plan. Completed February 2026<br><br>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:<br>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)<br><br>3rd line:<br>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.<br><br>Significant inflationary increase in resource cost anticipated in relation to digital resources which is not budgeted for. |

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|---|---|---|
| | 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:<br>Contractors to support specific functions to support programme such EPR monitored through programme Board until December 2025. Funding received to March 2026. Green<br><br>2nd line:<br>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 | Q1 2026/27 | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| ✓ | | | ✓ | | | Amber | Amber | Amber | | | |

| BAF | **Risk description**<br>Risk:<br>There is a risk that the Trust's estate deteriorates to the point where it is no longer safe<br>Caused by:<br>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<br>Resulting in:<br>Harm to individuals; Potential impact on service delivery; services no longer being delivered from the QVH site; financial loss; reputational damage. |
|---|---|

| **Responsible committee** | Finance and Performance committee | **Date Risk Added:** | 10 November 2025 | | |
|---|---|---|---|---|---|
| **Principal Exec – Risk Owner** | Chief People officer | **Date Risk last reviewed:** | 10 April 2026 | | |
| **Risk Handler(s)** | Interim Director of Estates and Facilities | **Date Risk last formally discussed:** | 12 March 2026 | **Group** | Trust Board |

**Inherent Score**

| Likelihood \ Consequence | 1 | 2 | 3 | 4 | 5 |
|---|---|---|---|---|---|
| 5 | | | | 20 | |
| 4 | | | | | |
| 3 | | | | | |
| 2 | | | | | |
| 1 | | | | | |

**Current Score**

| Likelihood \ Consequence | 1 | 2 | 3 | 4 | 5 |
|---|---|---|---|---|---|
| 5 | | | | | |
| 4 | | | | 16 | |
| 3 | | | | | |
| 2 | | | | | |
| 1 | | | | | |

**Target Score**

| Likelihood \ Consequence | 1 | 2 | 3 | 4 | 5 |
|---|---|---|---|---|---|
| 5 | | | | | |
| 4 | | | | | |
| 3 | | | | 12 | |
| 2 | | | | | |
| 1 | | | | | |

| **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:<br>Regular reporting on the Trust's estate to the Finance and Performance committee demonstrates that works are completed are in line with statutory requirements, March 2026, Green<br><br>2nd line:<br>Regular report regarding out of date policies to the ECQR. Following the E&FSC meeting on 26th March, only 2 estate policies will be out of date. 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.<br><br>The last six facet survey was completed in 2023- an updated detailed six facet survey is required by 31.7.26<br><br>Authorised engineer (AE) for electrical appointed and review on electrical compliance to be completed<br><br>Authorised engineer (AE) for medical gases appointed and review on medical gas compliance to be completed |

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|---|---|---|
| | Policy log demonstrates that key estates policies are in place to support compliance with statutory requirements, March 2026, Amber (see action 7)<br><br>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, New digital collection system is in the process of being launched March 2026, Amber (see action 2)<br><br>3rd line:<br>Authorised engineer (AE) review on water compliance was completed in September 2025 and the report is being actioned<br><br>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<br><br>Histology water action plan to be completed |
| **Estates capital funding plan** to ensure prioritisation of works in line with risks | 1st line:<br>Regular reporting on the Trust's estate to the Finance and Performance committee demonstrates limited funding available to appropriately address critical infrastructure risks, March 2026, Amber (see action 2). Receipt of the additional £2.8m of estates safety funding in 2025/26 and £3.6m in 2026/27 will go a long way to address this.<br><br>2nd line:<br>Review of estates budget by management accountant demonstrates that the directorate is overspent on its allocated budget at this stage of the year due to unplanned and unforeseen issues, March 2026, Amber (see action 2)<br><br>Regular reporting on financial performance through the IQPR demonstrates that the estates capital budget fully spent at March 2026, Green (see action 8)<br><br>3rd line:<br>£2.8m of estates safety funding received in November 2025, Green (see action 2) | QVH does not meet the NHS new hospital programme criteria so there is no assurance regarding a future rebuild, however the current site is uneconomic to keep repairing.<br><br>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:<br>EPRR annual assurance to Board demonstrates full compliance, Green | Lack of EPRR lead<br><br>There is a need to review estates specific business continuity plans<br><br>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<br><br>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<br><br>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)<br><br>3rd line:<br>The Management Plan is reviewed annually by an external specialist contractor. The next review of due in November 2025. Green<br><br>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:<br>Review of team demonstrates that key roles are in place including Associate Director of Estates and Facilities, Project managers and Compliance Manager, however there are gaps in expertise relation to electrical and mechanical, March 2026, Red (see actions 4 and 5) | Lack of qualified persons in roles incl authorised persons such as electrical and mechanical.<br><br>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 | Successful candidate starts May 2026 |
| 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 July 2026 | DEF | On going |
| 4. Appointment of authorised engineer (AE) to be completed | 31 March 2026 | DEF | Ongoing |
| 5. Review of estates specific business continuity plans | 31 March 2026 | ADEF | Ongoing |
| 6. All estates policies to be updated in line with requirements | 31 March 2026 | ADEF | 2 policies to be completed. |
| 7. Continued oversight of estates capital spend to support year end position | 31 March 2026 | CFO | Completed |

| **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) |
|---|---|

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

| BAF | **Risk description**<br>Risk:<br>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.<br>Caused by:<br>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.<br>Resulting in:<br>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:** | 10 April 2026 | | |
| **Risk Handler(s)** | Deputy Chief Finance Officer | **Date Risk last formally discussed:** | 12 March 2026 | **Group** | Trust Board |

**Inherent Score**

| Likelihood | Consequence 1 | 2 | 3 | 4 | 5 |
|---|---|---|---|---|---|
| 5 | | | | 20 | |
| 4 | | | | | |
| 3 | | | | | |
| 2 | | | | | |
| 1 | | | | | |

**Current Score**

| Likelihood | Consequence 1 | 2 | 3 | 4 | 5 |
|---|---|---|---|---|---|
| 5 | | | | | |
| 4 | | | | 16 | |
| 3 | | | | | |
| 2 | | | | | |
| 1 | | | | | |

**Target Score**

| Likelihood | Consequence 1 | 2 | 3 | 4 | 5 |
|---|---|---|---|---|---|
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| **Direction of travel since last review** | ⟺ |
|---|---|

| **Target date** | 31 March 2027 |
|---|---|
| **Risk tolerance** | Current risk score outside of risk appetite (higher) (minimal) |

| **Controls (what are we doing about risk)** | **Assurances and RAG rating (how do we know if it's working)** | **Gaps in assurance (what additional assurance is needed)** |
|---|---|---|
| **Efficiency Steering Group** (ESG) is charged with overseeing the Better Value Programme, including the identification of productivity and efficiency opportunities, ensuring that approved schemes are developed through to implementation including the completion of QIAs where necessary. The ESG is also responsible for the tracking and reporting of delivery of schemes and any remedial actions where needed. | 1st line:<br>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, March 2026, Amber (see action 1)<br><br>2nd line<br>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. |

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| | being delivered non-recurrently than planned, March 2026, Amber (see action 1) | |
| **Regular oversight of overall financial position** incl. regular reporting to the Resources and Financial Control Groups | 1st line:<br>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<br><br>2nd line:<br>Regular reporting on divisional financial performance, through the IQPR demonstrates that to date, the Trust remains on track for its breakeven target, March 2026, Green | |
| **Financial policies** including Standing Financial Instructions, Scheme of Delegation, Contract policy and Procurement policy | 1st line:<br>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, March 2026, Green<br><br>2nd line:<br>Regular report regarding out of date policies to the ECQR demonstrates no finance policies being out of date, March 2026, Green<br><br>3rd line:<br>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.<br><br>Assurance that the compliance position has materially improved long term. Quarterly reviews demonstrate compliance to date. |
| **Medium term financial plan** in development to support a forward view | The Trust has submitted its 5 year MTFP but significant amounts of internal and system work are still to be undertaken, Amber (see action 3) | |
| **Annual business planning process** incl. budget setting | 1st line:<br>Business plan for 2026/27 to the Finance Performance committee and Board demonstrates planned breakeven position, however this is not without risk, March 2026, Amber (see action 1)<br><br>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<br><br>2nd line:<br>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, March 2026, Amber | |

| | 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 | First draft Complete |
| 3. Medium term financial plan to be developed as part of the 2026/27 business planning process | Q4 25/26 | CFO | Plan submitted and accepted, 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 | Q1- 2026/27 | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| ✓ | ✓ | ✓ | ✓ | ✓ | | Amber | Amber | Amber | | | |

| BAF | **Risk description**<br>Risk:<br>There is a risk that there will not be leadership capacity to deliver the strategic partnership, key strategic objectives and key projects<br>Caused by:<br>Four interim executive roles including Chief executive officer; turnover in Board level roles and organisational memory loss; three Non-executive directors coming to end of terms in June 2026<br>Resulting in:<br>Closure of services/ site; regulatory intervention; reputational damage; non-delivery of recurrent annual financial, productivity and efficiency savings |
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| **Responsible committee** | Strategy and culture committee | **Date Risk Added:** | 13 November 2025 | | |
|---|---|---|---|---|---|
| **Principal Exec – Risk Owner** | Chief executive officer | **Date Risk last reviewed:** | 17 April 2026 | | |
| **Risk Handler(s)** | Chief executive officer | **Date Risk last formally discussed:** | 12 March 2026 | **Group** | Board |

| Inherent Score | Current Score | Target Score |
|---|---|---|
| Consequence × Likelihood matrix: 20 (Likelihood 5, Consequence 4) | Consequence × Likelihood matrix: 16 (Likelihood 4, Consequence 4) | Consequence × Likelihood matrix: 8 (Likelihood 2, Consequence 4) |

| **Direction of travel since last review** | ↔ |
|---|---|

| **Target date** | July 2026 |
|---|---|
| **Risk tolerance** | Current risk score outside of risk appetite (higher) (minimal) |

| Controls (what are we doing about risk) | Assurances and RAG rating (how do we know if it's working) | Gaps in assurance (what additional assurance is needed) |
|---|---|---|
| **Key Board level roles being filled** incl. executive portfolios covering all areas of operational business | 1st line:<br>Review of Board roles demonstrates all roles currently filled with some executive roles being filled by interims to ensure the required level of experience required. An interim Chair is now in post until September 2026, Amber<br><br>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)<br>Chief strategy officer role has been filled on an interim basis, April 2026, Green<br><br>3rd line: | Three Non-executive directors (NEDs) are coming to the end of their terms in June 2026- the Trust is currently out to recruitment for NEDs<br><br>Interim Chief finance officer coming to the end of contract in May 2026<br><br>Board skills and maturity matrix to be reviewed in June 2026 |

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| | Discussions with partners demonstrate commitment for shared Chair and CEO being in post by September 2025, April 2026, Amber | |
| **Programme of work to deliver strategic partnership** incl. timeline | 1st line:<br>Reporting to the Strategy and Culture committee outlining the timeline demonstrates that the Trust is meeting milestones, however the timeline remains challenging with external factors being a risk, February 2026, Amber<br><br>Transition and implementation plan was shared with Strategy and culture committee in February 2026, demonstrates commencement of workstreams and finance and governance reviews, Amber<br><br>3rd line:<br>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:<br>Update to Board to confirm the EPR Go Live has been a success with no patient cancellations, November 2025, Green<br><br>2nd line:<br>Reporting on major projects to the Finance and performance committee through the PMO and IQPR demonstrates the EG CDC being rated as Green/ Amber, the Bognor CDC being rated as Amber/ red March 2026, Amber (see action 4) | |
| **Key strategic objectives and priorities** | 1st line:<br>Reporting to the Board demonstrates good progress against the key strategic objectives and priorities for 2025/26, March 2026, Green<br><br>Key strategic objectives for 2026/27 due to be approved by the Board in May 2026. KSOs are aligned to national and QVH specific strategic priorities, May 2026, Green | |

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

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

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

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| **BAF** | **Risk:**<br>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<br>**Caused by:**<br>Significant organisational change; uncertainty; the Trust's significant cost improvement target; requirement for corporate service cost reduction; leadership capacity and managers capability<br>**Resulting in:**<br>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 |

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| **Responsible committee** | Strategy and culture committee | **Date Risk Added:** | 13 November 2025 | | |
| **Principal Exec – Risk Owner** | Chief people officer | **Date Risk last reviewed:** | 5 April 2026 | | |
| **Risk Handler(s)** | Deputy Chief people officer | **Date Risk last formally discussed:** | 12 March 2026 | **Group** | Board |

| Inherent Score | Current Score | Target Score |
|---|---|---|
| 15 (Likelihood 5, Consequence 3) | 9 (Likelihood 3, Consequence 3) | 6 (Likelihood 2, Consequence 3) |

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|---|---|
| **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:<br>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 February 2026 Amber (see actions 1 and 4)<br><br>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, March 2026 Amber (see actions 1 and 4)<br><br>2nd line:<br>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.<br><br>Responses to CTSG survey will determine focus of group. January 2026, DCPO meeting with ACEO to review CTSG focus.<br>March 2026 – CTSG to focus on speaking up<br><br>2025 staff survey closed 28 November. Data due for publication in March 2026.<br>March 2026 – staff survey results published. Areas of focus shared with triumvirate leadership team to support departmental managers with their prioritisation. Execs to lead with trust wide areas for improvement. |

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| | staff do not always feel confident action will be taken if they speak up. 2025 staff survey published in March 2026 Amber (see actions 1 and 4)<br>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:<br>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 April 2026 Green (see action 2)<br><br>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, March 2026 Green<br><br>2nd line:<br>Mandatory and statutory training compliance reported monthly through IQPR, demonstrates 92% compliance overall with improvement required in some specific areas such as Resus, October 2025. MAST compliance stable from November 2025 with to February 2026 Green | |
| **Managers training** programme, prioritising bands 6-8a- two day programme including policies and softer skills such as supporting staff to speak up and holding difficult conversations | 1st line: 2 cohorts underway with feedback / evaluation undertaken after each training day. Positive feedback received from participants, December 2026. Cohorts booked throughout 2026/27, March 2026 Green | Managers training programme commenced October 2025. Assurance will be in manager and staff feedback, ER cases, FTSU increases. March 2026 – feedback from cohorts demonstrating growth in confidence. Cohorts continue through Q4 of 2025/26. Evaluation feedback will continue to be reviewed. |
| **Behaviour framework and implementation** including embedding into 1:1's, appraisals, team charters, interview processes | 1st line: Data related to number of appraisals completed is reported monthly in the IQPR, demonstrates the average compliance rate is 81% against the 90% target, February 2026. Completion rates continue to be monitored through IQPRs with focus on those over 3 months out of date Amber<br><br>Employee relations team weekly review of employee relations cases, demonstrates focus points for specific support and interventions required, October 2025. March 2026 – weekly review meetings continue, with thematics from cases triangulated with other data Green (see action 1)<br><br>2nd line: Organisational cultural assessment undertaken to be presented to the Board in November 2025, demonstrates that there are micro cultures and ongoing focus required to embed behavioural framework. Presented to Board in November, with ongoing work to support culture development (December 2025). Update on areas of consideration and next steps presented to Strategy and Culture Committee in March 2026 Green | |

| **Mechanisms in place for staff to provide feedback** incl. Staff Survey, Quarterly People Pulse Surveys, Freedom to Speak Up Service, 'Tell Liz', 'Ask Abigail' | 2nd line: 2024 Staff survey results published in March 2025 with a 57% response rate, demonstrate disabled staff have a less positive experience than non-disabled staff and staff do not always feel confident action will be taken if they speak up. 2025 staff survey results published in March 2026, with small decline in some areas for speaking up, and increase in some areas, with focussed work underway to prioritise areas of decline Amber (see actions 1 and 4)<br><br>People Pulse Survey for Q2 was responded to by 14% of staff which demonstrated a decline in mood and motivation. People Pulse Survey for 2025/26 (up to January 2026) was responded to by 474 staff. In Q4 139 (10.7%) staff completed the People Pulse Survey. The Q4 results demonstrated an improvement in mood and motivation. Pulse survey is currently live for completion during April 2026. Amber (see actions 1 and 4)<br><br>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<br>March 2026 – staff survey results published with reports sent to departments. Workshops in place for supporting managers to understand results and work with their teams on areas of focus. |
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| **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 presented to Strategy and Culture Committee in March 2026.<br>Updated culture report will be presented to the Strategy and Culture Committee and Board at the end of Q2 when all the updated data is available. |

| **Links to Organisational Risk Register** | 133 (hard to recruit to roles) |
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| KSO1 | KSO2 | KSO3 | KSO4 | KSO5 | Overall Assurance Rating (RAG) | Q3- 2025/26 | Q4- 2025/26 | Q1- 2026/27 | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| ✓ | ✓ | | ✓ | | | Green | Green | Green | | | |

| **BAF** | Risk:<br>There is a risk that the Trust may not consistently deliver high quality, safe and effective care<br>Caused by:<br>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<br>Resulting in:<br>Poor patient experience and outcomes; potential harm; reputational damage |
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| **Responsible committee** | Quality and safety committee | **Date Risk Added:** | 13 November 2025 | | |
|---|---|---|---|---|---|
| **Principal Exec – Risk Owner** | Chief medical officer / Chief nursing officer | **Date Risk last reviewed:** | 16 April 2026 | | |
| **Risk Handler(s)** | Deputy Chief nursing officer | **Date Risk last formally discussed:** | 12 March 2026 | **Group** | Board |

| **Inherent Score** | **Current Score** | **Target Score** |
|---|---|---|
| 20 (Likelihood 4 × Consequence 5) | 9 (Likelihood 3 × Consequence 3) | 6 (Likelihood 2 × Consequence 3) |

| **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:<br>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<br><br>2nd line:<br>Quality and safety sub-committee of Board and executive sub-committee for quality in place with oversight of quality and safety matters. Green<br><br>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.<br><br>QIAs have not systematically been completed for productivity initiatives (theatre productivity QIA complete).<br><br>The co-dependence of initiatives has not been assessed through a QIA process. |

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| | Analysis of theatre productivity work stream presented to QSC did not show impact on quality and safety, April 2025. Green<br><br>3rd line:<br>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:<br>Summary incident reports collated and actively managed through directorates and groups reporting into Quality Committee Green<br><br>Exec/ Board level time spent in clinical areas observing and listening to patients / team members, ongoing, Green<br><br>2nd line:<br>Quality and safety sub-committee of Board and executive sub-committee for quality in place with oversight of quality and safety matters Green<br>Monthly review of incident evaluation at ECQR demonstrates effectiveness of primary processes, Green<br><br>IPC Surveillance to understand impact of environment on patient safety and outcomes, quarterly IPC meetings, no clinical concerns in December 2025 Green<br><br>Demonstration of learning through morbidity & mortality meetings, governance meetings, IQPR and the Clinical Learning Forum, Green<br><br>3rd line:<br>Biannual quality review by the ICB raised no quality concerns, Q3 in 2025/26, Green<br><br>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:<br>Summary complaint reports collated and actively managed through directorates and groups reporting into Quality Committee, Green<br><br>2nd line:<br>Quality and safety sub-committee of Board and executive sub-committee for quality in place with oversight of quality and safety matters Green<br><br>Responsiveness to patient complaints is embedded within assurance on 2025/26 quality priorities, Green<br><br>Patient stories to Board, November 2025, Green<br><br>Annual Complaints Report, July 2025, Green<br><br>3rd line: | Assurance on achievement of timely response to complaints (reduced from 40 to 30 days).<br><br>Dependency of process on a single individual. |

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| | 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<br>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<br><br>2nd line:<br>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).<br><br>3rd line:<br>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.<br><br>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:<br>Quality and Compliance Team regularly monitoring against audit and effectiveness standards. Green<br><br>Preparedness for regulatory body review is embedded in Ward to Board business as usual plans and scrutiny. Amber<br><br>2nd line:<br>Quality and safety sub-committee of Board and executive sub-committee for quality in place with oversight of quality and safety matters Green<br><br>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<br><br>3rd line:<br>Audit embedded in 2025/26 quality priorities and therefore reporting into Quality Account, Green (see action 5) | Engagement with directorates to address limited progress with audit completion.<br><br>Constraints in IT resources limiting optimal data collection through digital systems need to be addressed.<br><br>Shared plan for regulatory preparedness needs to be collated and shared. |
| **Safe staffing** procedures in place to ensure staffing fill rate does not fall below 98%. | 1st line:<br>Daily monitoring of staffing levels by HoNs demonstrates safe staffing levels. Staffing fill rate does not fall below 98%, October 2025, Green<br><br>2nd Line<br>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<br><br>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 | Reconfiguration of nursing staff and review of the impact on quality once in place, March 2026. |

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| | (see action 6)<br><br><u>3rd line:</u><br>NHSE Oversight of safer staffing processes and compliance, Green | |
| **Archie EPR implementation** included extensive clinical engagement | <u>1st line:</u><br>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)<br><u>2nd line:</u><br>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 | <u>1st line:</u><br>Dedicated clinical governance staff time to ensure consistent recognition and evaluation of quality and safety metrics, Green (see action 8)<br><br><u>2nd line:</u><br>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<br><br>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. | <u>1st line:</u><br>Line manager oversight of training compliance through ESR, Green<br><br><u>2nd line:</u><br>MAST training compliance monitored and acted upon through Quality committee, Green<br><br><u>3rd line:</u><br>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. | <u>1st line:</u><br>Inphase risk management system in place to manage risk, Green<br><br><u>2nd line:</u><br>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<br>IQPR, ECQR and local clinical governance meetings where risk evaluation takes place, Green<br><br><u>3rd line:</u><br>External auditing of risk management pending | Lack of robust process for risks to be escalated and approved to the risk register.<br><br>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 and evidenced in regular reports | 31 March 2027 | CPO, CNO, CMO | In progress / ongoing |

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| 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 July 2026 | CNO, COO, CMO, CIP Leads | In progress |
| 3. Review PSIRF policy and ensure resources in place to enable delivery | 31 October 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. Reduce overdue projects in directorates (eg. Completed, closed etc.) | 31 March 2026 | CMO, Head of Quality and Compliance | In progress / ongoing |
| 6. Reconfiguration of nursing staff and review of the impact on quality once in place to include care of patients in outpatient environment | 31 August 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 August 2026 | CIO, CMO | In progress / ongoing |
| 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 | Complete |
| 10. Embedded risk management process and adherence to policy. | 31 March 2026 | Trust Secretary | Complete |
| 11. Exploration of quality management systems to enable triangulation of intelligence. | 31 August 2026 | CMO, Head of Quality and Compliance, Company Secretary | In Progress |

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| **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 | Q1- 2025/26 | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| ✓ | ✓ | ✓ | ✓ | ✓ | | Amber | Amber | Amber | | | |

| BAF | |
|---|---|
| | **Risk description**<br>Risk:<br>There is a risk that the Trust may not be able to meet its regulatory requirements<br>Caused by:<br>Scale; cost improvement plans; corporate savings; turnover at Board level; non-compliance; leadership capacity; national changes to requirements<br>Resulting in:<br>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:** | 17 April 2026 | | |
| **Risk Handler(s)** | Company secretary | **Date Risk last formally discussed:** | 12 March | **Group** | Trust Board |

| **Inherent Score** | **Current Score** | **Target Score** |
|---|---|---|
| 20 (Likelihood 5 × Consequence 4) | 12 (Likelihood 3 × Consequence 4) | 8 (Likelihood 2 × Consequence 4) |

| **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:<br>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)<br><br>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<br><br>2nd line: | Assurance that the 'policy for policies' has been embedded and driving improvements in policy management<br><br>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, 36 are out of date which is an decrease since the last review. No key corporate policies are out of date, March 2026, Amber/ Green (see action 2)<br><br>3rd line:<br>Reporting on progress of internal audit plan to Audit and risk committee demonstrates actions are being completed in a timely manner, March 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:<br>Reporting to the Audit and risk committee regarding compliance demonstrates no known breaches since Q4 2024/25, January 2026, Green<br><br>2nd line:<br>Draft Annual Governance Statement conclusion for 2025/26 demonstrates no significant control issues. This is alligned to the draft Head of Internal Audit opinion, March 2026, Green<br><br>3rd line:<br>Draft Head of Internal Audit Opinion for 2025/26 is that there is an adequate framework for risk management, governance and internal control, March 2026, Green<br><br>Internal audit on compliance with governing documents and policies concluded reasonable assurance with considerable progress and strengthening of controls, September 2025, Green<br><br>The Trust received confirmation in March 2026 that its additional licence conditions have been removed due to the Trust's work on its strategy and strategic partnership and the strong relationship between the Board and Council of Governors, March 2026, Green | |
| **Annual Provider Capability Assessment** demonstrating Board awareness of gaps against key lines of enquiry from the Insightful Provider Board guidance | 1st line:<br>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)<br><br>3rd line:<br>Review of Provider capability assessment undertaken by NHSE and QVH received a rating of Amber/Green which is alligned to the Trust's own assessment, March 2026, Green | Review of progress against actions to address gaps- scheduled for June 2026 |
| **Code of Governance for NHS Provider trusts** | 2nd line:<br>Annual review of compliance against the Code of Governance for NHS provider trusts to Board demonstrates one area of non-compliance during 2025/26, related to NED pay. This is compared to multiple areas of compliance being reported in previous years. March 2026, Green | |

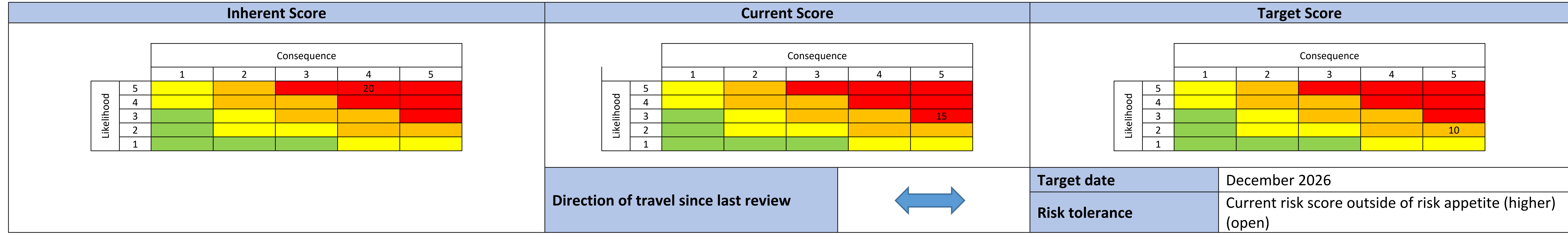
| **Actions** | **Timescale** | **Lead** | **Status** (complete, on track, off track, not yet started) |
|---|---|---|---|
| 1. Review of effectiveness of 'policy for policies' | July 2026 | CS, executive team | On track |
| 2. Continued oversight of management of out of date policies incl. priority areas | Ongoing | Policy owners | Ontrack |
| 3. Develop Governance handbook to support staff across organisation | March 2026 | CS | First draft complete |

| | | | |
|---|---|---|---|
| 4. Assurance to Audit and risk committee about compliance with governing documents | March 2026 | CS, CFO | Completed |
| 5. Review of progress against actions to address gaps within Provider capability assessment | June 2026 | CEO, CS | On track- scheduled for Audit and risk committee review |
| **Links to Organisational Risk Register** | | | |

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

| BAF | **Risk description**<br>Risk:<br>There is a risk that the Trust will not secure long term sustainability<br>Caused by:<br>Inability to progress the strategic partnership; Potential delays in progressing the partnership; Challenges with progression of partnership implementation and associated decision making; a potential breakdown in relationship between the Board and the Council of Governors; leadership capacity and resilience challenges; changes to the commissioning of services; changes to service specifications; staff morale; time constraints<br>Resulting in:<br>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** | Acting Chief Strategy Officer | **Date Risk last reviewed:** | 7 April 2026 | | |
| **Risk Handler(s)** | Acting Chief Strategy Officer | **Date Risk last formally discussed:** | 12 March 2026 | **Group** | Board of Directors |



| Inherent Score | Current Score | | Target Score | |
|---|---|---|---|---|
| 20 (Likelihood 5, Consequence 4) | 15 (Likelihood 3, Consequence 5) | | 10 (Likelihood 2, Consequence 5) | |
| | **Direction of travel since last review** | ⟷ | **Target date** | December 2026 |
| | | | **Risk tolerance** | Current risk score outside of risk appetite (higher) (open) |

| Controls (what are we doing about risk) | Assurances and RAG rating (how do we know if it's working) | Gaps in assurance (what additional assurance is needed) |
|---|---|---|
| **Engagement with strategic partners-** regarding partnership arrangements and implementation | 1st line:<br>Partnership steering group (internal established and considers engagement with partners, March 2026, Green<br><br>Reporting on engagement with partners to Strategy and culture committee demonstrates that engagement is effective and that progress is being made against the plan, February 2026, Green<br><br>3rd line:<br>Weekly partnership working group established between partners, January 2026, Green<br>Regular meetings established between Chairs and CEOs, March 2026, Green | Joint Transformation committee across partners |

| | | |
|---|---|---|
| **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:<br>Reporting to the Strategy and Culture committee demonstrates wide ranging engagement undertaken internally and externally, September 2025, Green<br><br>Communication and engagement plan for next phase has been agreed between partners, April 2026, Green<br><br>Shared lines of communication have been agreed between partners, April 2026, Green<br><br>3rd line:<br>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 | Stakeholder analysis across all partners to be completed |
| **Timeline -** Agreed timeline in place to keep track of key milestones incl. Chair and CEO in place by September 2026 and key decision-making points | 1st line:<br>Reporting to the Strategy and Culture committee outlining the timeline demonstrates that the Trust is meeting milestones, however the timeline remains challenging with external factors being a risk, February 2026, Amber (see action 1)<br><br>Transition and implementation plan was shared with Strategy and culture committee in February 2026, demonstrates commencement of workstreams and finance and governance reviews, Amber<br><br>3rd line:<br>Review of NHSE timeline demonstrates alignment with QVH timeline, October 2025, Green | Decision making by partner Boards in early summer following the period of shared planning, analysis and assurance<br><br>Outcome of QVH well led leadership and governance review<br><br>Contingency planning in the event of a delay in implementing the partnership |
| **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:<br>Strategic Assurance Group made of up internal key stakeholders in place to ensure critical decision making is appropriate and transparent, September 2025, Green<br><br>3rd line:<br>Partnership working group between QVH and RSFT/ASPH in place and meeting weekly. March 2026, Green | |
| **Partnership implementation plan-** incl. six key workstreams: Programme management, Corporate governance, Communication and engagement, Leadership and culture, Financial and planning alignment 2026/27, Clinical and corporate alignment | 1st line:<br>Reporting to Strategy and culture committee demonstrates that implementation plan is in place and progressing, February 2026, Green<br><br>2nd line:<br>Six key workstreams have assigned executive senior responsible officers and risks have been identified with mitigations, March 2026, Green<br><br>3rd line: | Benefits realisation for partnership to be further developed |

| | | |
|---|---|---|
| | Financial governance review of QVH undertaken by NHSE demonstrates no concerns. Recommendations will be monitored by the Partnership steering group, March 2026, Green<br><br>Review of financial documents undertaken by partners Chief finance officer demonstrates no significant concerns, March 2026, Green | |

| **Actions** | **Timescale** | **Lead** | **Status** (complete, on track, off track, not yet started) |
|---|---|---|---|
| 1. Continued engagement including internal and external stakeholders | Ongoing until implementation | DCSO | On track |
| 2. Governance arrangements in place to support December decision making – including Board to Board meetings | November 2025 | AJ/ LM | Complete |
| 3. Development of FAQ document for staff and key stakeholders | December 2026 | DCSO | Complete with ongoing updates as they arise |
| 4. Development of transition and implementation (incl. Governance) plan for partnership | March 2026 | CEO, DCSO, CS | Complete with ongoing updates as they arise |
| 5. Timeline for transition planning needs to be agreed between partners | March 2026 | Chair, CEO | Complete- agreed to work in parallel |
| 6. Communication and engagement plan needs to be agreed between partners | March 2026 | DCSO | Complete with ongoing updates as they arise |
| 7. Stakeholder an analysis across all partners to be completed | July 2026 | Acting CSO | On track |
| 8. Arrangements to be made for QVH to join partners Transformation committee | July 2026 | Acting CSO | On track |
| 9. QVH well led review of leadership and governance | June 2026 | CS | On track |
| 10. Benefits realisation for partnership | May 2026 | Acting CSO | On track |
| 11. Contingency planning in the event of a delay in implementing the partnership | June 2026 | Board | On track |

| **Links to Organisational Risk Register** | 132 (delivery of QVH Strategy 2025-2030), 189 (long term sustainability of key services), 190 (partnership criteria not meeting ICB and NHSE expectations), 191 (timeline not being delivered) |
|---|---|

<table>
<tr><th colspan="6">Report cover-page</th></tr>
<tr><td colspan="6">References</td></tr>
<tr><td>Meeting title:</td><td colspan="5">Board of Directors</td></tr>
<tr><td>Meeting date:</td><td colspan="2">14/05/2026</td><td colspan="2">Agenda reference:</td><td>18-26</td></tr>
<tr><td>Report title:</td><td colspan="5">Company Secretary’s report</td></tr>
<tr><td>Sponsor:</td><td colspan="5">Jamie O’Callaghan, interim Company secretary</td></tr>
<tr><td>Author:</td><td colspan="5">Jamie O’Callaghan, interim Company secretary</td></tr>
<tr><td>Appendices:</td><td colspan="5">Appendix one: Audit and risk committee terms of reference<br>Appendix two: Finance and performance committee terms of reference<br>Appendix three: Quality and safety committee terms of reference<br>Appendix four: Strategy and culture committee terms of reference<br>Appendix five: Modern slavery statement</td></tr>
<tr><td colspan="6">Executive summary</td></tr>
<tr><td>Purpose of report:</td><td colspan="5">This report confirms compliance with the Trust’s standard and additional licence conditions for 2025/26, provides an update on compliance with the Code of Governance for NHS Provider Trusts, provides an update on the development of the Trust’s Annual Governance Statement for 2025/26, and seeks approval of changes to the Board sub-committee terms of reference and the Annual Modern Slavery Statement.</td></tr>
<tr><td>Summary of key issues</td><td colspan="5">- The Trust has complied with its standard NHS provider licence conditions for 2025/26, and NHS England has confirmed national agreement to lift the Trust’s additional licence conditions, pending formal written confirmation<br>- Compliance with the Code of Governance for NHS Provider Trusts has continued to improve, with one area of non-compliance to be disclosed in the Annual Report and Accounts 2025/26<br>- Issues identified during 2024/25 relating to non-compliance with the Trust’s Scheme of Delegation and Standing Financial Instructions have been addressed, and ongoing review has provided assurance that there have been no breaches since quarter four of 2024/25 and during 2025/26<br>- A draft Annual Governance Statement for 2025/26 has been presented to the Audit and Risk Committee and the Trust’s external auditors. The draft statement concludes that:<br>o “No significant internal control issues have been identified during 2025/26. Significant internal control issues identified in 2024/25 related 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.”<br>o One internal audit concluded partial assurance during 2025/26, relating to job planning, with other reviews providing reasonable assurance and evidence of strengthened controls</td></tr>
<tr><td>Recommendation:</td><td colspan="5">The Board is asked to:<br>- Note that the Trust has complied with its standard NHS provider licence conditions for 2025/26<br>- Note the area of non-compliance with the Code of Governance for NHS Provider Trusts<br>- Note the update related to the Annual Governance Statement 2025/26<br>- Approve the committee terms of reference as appended<br>- Approve the Modern Slavery Statement for 2025/26 as appended</td></tr>
<tr><td>Action required</td><td>Approval</td><td>Information</td><td>Discussion</td><td>Assurance</td><td>Review</td></tr>
<tr><td></td><td>KSO1:</td><td>KSO2:</td><td>KSO3:</td><td>KSO4:</td><td>KSO5:</td></tr>
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<tr><td>Link to key strategic objectives (KSOs):</td><td>To deliver outstanding care</td><td>To innovate and improve</td><td>To be an excellent employer</td><td>To deliver sustainable services</td><td>To collaborate with others</td></tr>
<tr><td colspan="6">Implications</td></tr>
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<tr><td colspan="2">Regulation:</td><td colspan="4">Code of governance<br>Licence conditions<br>Annual reporting manual</td></tr>
<tr><td colspan="2">Legal:</td><td colspan="4">None</td></tr>
<tr><td colspan="2">Resources:</td><td colspan="4">None</td></tr>
<tr><td colspan="6">Assurance route</td></tr>
<tr><td colspan="2">Previously considered by:</td><td colspan="4">ELT, Audit and risk committee</td></tr>
<tr><td colspan="2"></td><td>Date:</td><td></td><td>Decision:</td><td></td></tr>
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**Report to:** Board Directors
**Agenda item:** 18-26
**Date of meeting:** 14 May 2026
**Report from:** Jamie O'Callaghan, interim Company secretary
**Report author:** Jamie O'Callaghan, interim Company secretary
**Date of report:** 06 May 2026
**Appendices:** Appendix one: Audit and risk committee terms of reference
Appendix two: Finance and performance committee terms of reference
Appendix three: Quality and safety committee terms of reference
Appendix four: Strategy and culture committee terms of reference
Appendix five: Modern slavery statement

## Company secretary's report

### Introduction

This report confirms compliance with the Trust's standard and additional licence conditions for 2025/26, provides an update on compliance with the Code of Governance for NHS Provider Trusts, provides an update on the development of the Trust's Annual Governance Statement for 2025/26, and seeks approval of changes to the Board sub-committee terms of reference and the Annual Modern Slavery Statement.

### Annual review of compliance with Licence conditions

The Audit and Risk Committee reviewed evidence and received assurance that the Trust has complied with its standard NHS provider licence conditions for 2025/26 at its meeting on 02 March 2026. Compliance with the licence conditions is reported throughout the Annual Report and Accounts, with principal risks to compliance and mitigating actions described in the Annual Governance Statement.

On 20 October 2021, following a referral made by the Trust, Queen Victoria Hospital NHS Foundation Trust received a notice of imposition of additional licence conditions from NHS Improvement under section 111 of the Health and Social Care Act 2012. These related to arrangements for effective working between the Council of Governors and the Board, and the need to ensure sufficient and effective Board leadership, capacity and capability. The additional licence conditions reflected risks of non-compliance with conditions CoS3, FT4.3, FT4.5(a), (d), (f) and (g), and FT4.6(a).

In January 2026, NHS England confirmed that agreement has been reached nationally to lift the additional licence conditions. The Trust is awaiting formal written confirmation that the conditions have been removed. The Committee noted the evidence demonstrating sustained improvement and compliance, including strengthened Board leadership, successful recruitment to key roles, and completion of all recommendations arising from the independent review into the Trust's handling of challenges associated with the merger proposal, including implementation of the Governor Code of Conduct.

Foundation trusts designated as providing commissioner requested services are required to make a declaration regarding the sufficiency of resources for the

forthcoming financial year. As the Trust has no commissioner requested services, this declaration is not required.

**Annual review of compliance with Code of governance for NHS provider trusts**
The Audit and Risk Committee received a report regarding compliance with the Code of Governance for NHS Provider Trusts at its meeting on 02 March 2026.

The Code of Governance sets out a common overarching framework for the corporate governance of NHS providers (being NHS trusts and NHS foundation trusts), reflecting developments in UK corporate governance and the development of integrated care systems. The Trust must comply with each of the provisions of the Code or, where appropriate, explain in each case why it has departed from the Code in its Annual Report and Accounts.

Work completed to ensure compliance with the Code includes:

- The development of a clear strategy, vision and values for the Trust
- A clear statement detailing the roles and responsibilities of the Council of Governors and a description of how disagreements between the Board and Council will be resolved, which has been added to the Scheme of Delegation
- The development of a succession plan, taking into account future challenges, risks and opportunities facing the Trust, and the skills and expertise required to meet them
- The Council of Governors completing an assessment of its effectiveness annually
- The development of a Council of Governors Code of Conduct

The Company Secretary has undertaken a detailed analysis of each provision of the Code against the Trust's governance framework. Areas in which the Trust has departed from the Code during 2025/26 and will therefore report non-compliance in its Annual Report and Accounts 2025/26 are set out below:

| Code provision | Non-compliance |
|---|---|
| E.2.2<br>Levels of remuneration for the Chair and other Non-Executive Directors should reflect the ***Chair and Non-Executive Director remuneration structure*** (published by NHS England Dec 2019). | The CoG appointments committee is responsible for setting the Chair and Non-Executive Directors' remuneration. All Non-Executive Directors receive the same remuneration – QVH NED and Chair remuneration at QVH is slightly above NHS England's recommended remuneration. The Trust will explain why the governor led Appointments committee has agreed that the Chair and NEDs at QVH are paid more than currently recommended within the national document within its Annual report and accounts 2025/26 |

**Annual governance statement 2025/26**

All NHS foundation trusts are required to prepare an Annual Governance Statement for inclusion within their Annual Report and Accounts. The Chief Executive Officer is required to state either that no significant internal control issues have been identified or to make specific reference to those significant internal control issues which have been identified.

A draft Annual Governance Statement for 2025/26 has been presented to the Audit and Risk Committee and the Trust's external auditors. The draft statement concludes that:

> *"No significant internal control issues have been identified during 2025/26. Significant internal control issues identified in 2024/25 related 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 Trust continues to operate with an underlying deficit position; however, plans are now in place to support the sustainability of the Trust's services for the future through strategic partnership."*

Key issues reported within the draft statement include:

- One internal audit concluded partial assurance during 2025/26, relating to job planning

The Audit and Risk Committee noted that issues identified during 2024/25 relating to non-compliance with the Trust's Standing Orders, Standing Financial Instructions and Scheme of Delegation and Reservation of Powers, together with weaknesses in budgetary control, business planning and contract management, have been addressed. Ongoing review has provided assurance that there have been no breaches of the Trust's governing documents since quarter four of 2024/25 and during 2025/26.

The draft statement outlines actions taken to address the previously identified internal control issues as follows:

- Strengthening governance and compliance arrangements.
- Actions implemented during 2024/25 to address non-compliance with governing documents have been embedded and are operating effectively.
- Continued oversight by the Audit and Risk Committee has provided assurance of sustained compliance during 2025/26.
- An internal audit completed during 2025/26 in this area concluded reasonable assurance, with internal auditors noting considerable progress and strengthening of controls compared to previous reviews.

**Annual review of committee terms of reference**

Audit and risk committee

At its meeting on 02 March 2026, the Audit and risk committee completed the annual review of its terms of reference and agreed to recommend them to the Board for approval with the following amendments:

- Clarity regarding how the committee reviews the effectiveness of the sub-committees (through regular assurance reporting and annual reports)
- Tweaks to wording under financial reporting to make clear Re the audit activity being external
- Secretariat section updated to allow Company secretary's nominee to be the secretary to the committee

These terms of reference are included as appendix one to this report for approval.

Finance and performance committee

At its meeting on 02 March 2026, the Finance and performance committee completed the annual review of its terms of reference and agreed to recommend them to the Board for approval with the following amendments:

- Minor amendments have been proposed to the terms of reference to ensure clarity regarding oversight of key strategic objectives which sits with the Strategy and culture committee.

These terms of reference are included as appendix two to this report for approval.

Quality and safety committee
At its meeting on 2 February 2026, the Quality and safety committee completed the annual review of its terms of reference and agreed to recommend them to the Board for approval with the following amendments:

- Removal of CQUIN's from the committee's remit as the CQUIN scheme is no longer a mandatory requirement
- The addition of cultural issues to be reported to the Strategy and culture committee
- Updates to job titles and roles

These terms of reference are included as appendix three to this report for approval.

Strategy and culture committee
At its meeting on 25 February 2026, the Strategy and culture committee completed the annual review of its terms of reference and agreed to recommend them to the Board for approval with the following amendments:

- The addition of oversight of the BAF risks within the committee's remit
- Acting Chief Strategy Officer added as a member of the committee

These terms of reference are included as appendix three to this report for approval.

**Modern slavery statement**

The Modern Slavery Act requires the annual reporting of actions taken to identify, prevent and mitigate modern slavery in the supply chain. It requires organisations to publish an annual modern slavery statement outlining actions taken to prevent modern slavery.

The Trust's draft statement for 2025/26 is included as appendix four to this report for approval. The statement meets the requirements set out within the Government modern slavery guidance and will need to be published on the Trust's website no later than two months after the year end.

**Recommendation**
The Board is asked to**:**

- **Note** that the Trust has complied with its standard NHS provider licence conditions for 2025/26
- **Note** the area of non-compliance with the Code of Governance for NHS Provider Trusts
- **Note** the update related to the Annual Governance Statement 2025/26
- **Approve** the committee terms of reference as appended
- **Approve** the Modern Slavery Statement for 2025/26 as appended

## Terms of reference

### Name of governance body

Audit and Risk committee

### Constitution

The Audit and Risk Committee (“the committee”) is a statutory, non-executive committee of the Board of Directors.

### Accountability

The Committee is accountable to the Board of Directors for its performance and effectiveness in accordance with these terms of reference.

### Authority

The Committee is authorised by the Board of Directors to:

- investigate any activity within its terms of reference, and commission appropriate independent reviews and studies
- seek relevant information from within the Trust and from any employee (all departments and employees are required to co-operate with requests from the committee).
- obtain relevant legal or other independent advice and to invite professionals with relevant experience and expertise to attend meetings of the committee. For legal advice, the Company secretary shall be consulted prior to procurement of external advice

### Purpose

The purpose of the Committee is the scrutiny of the organisation and maintenance of an effective system of governance, risk management and internal control. This should include financial, clinical, operational and compliance controls and risk management systems. The Committee is also responsible for maintaining an appropriate relationship with the Trust’s internal and external auditors.

### Duties and responsibilities

On behalf of the Board of Directors, the Committee will be responsible for the oversight and scrutiny of the Trust’s:

- **Integrated governance, risk management and internal control**

The Committee shall review the establishment and maintenance of an effective system of integrated governance, risk management and internal control, across the whole of the organisation’s activities (clinical and non-clinical), that supports the achievement of the organisation’s objectives.

In particular, the Committee will review the adequacy and effectiveness of:

- All risk and control related disclosure statements (in particular the annual governance statement), together with any accompanying head of internal audit opinion, external audit opinion or other appropriate independent assurances, prior to submission to the board of directors.
- The underlying assurance processes, including the board assurance framework, that indicate the degree of achievement of the Trust’s objectives, the effectiveness of the management of principal risks and the appropriateness



Reviewed by Audit & risk committee in March 2026
Approved by the Board of Directors at its meeting in 14 May 2026

of the above disclosure statements (this may be carried out in conjunction with other board committees which scrutinise and oversee the management of relevant strategic risks).
- The Board of Directors sub-committees through regular assurance reporting from sub-committees and annual reports from the Finance and performance committee and Quality and safety committee.
- The effectiveness of assurance arrangements over the Trust's role within the Integrated Care Board (ICB) and other partnership arrangements.
- The policies for ensuring compliance with relevant regulatory, legal and code of conduct requirements and any related reporting and self-certifications, including Code of governance for NHS provider trusts and NHS Provider licence.
- The policies and procedures for all work related to counter fraud, bribery and corruption and security as required by the NHS Counter Fraud Authority.

In carrying out this work, the Committee will primarily utilise the work of internal audit, external audit and other assurance functions, but will not be limited to these sources. It will also seek reports and assurances from directors and managers as appropriate, concentrating on the over-arching systems of integrated governance, risk management and internal control, together with indicators of their effectiveness. This will be evidenced through the Committee's use of an effective assurance framework to guide its work and the audit and assurance functions that report to it.

As part of its integrated approach, the Committee will have effective relationships with other key governance bodies of the Trust (for example, the Quality and Safety Committee) to support the committee's oversight role relating to the effectiveness of clinical systems of internal control. However, these other committees must not usurp the committee's role.

- **Financial reporting**

The Committee shall monitor the integrity of the financial statements of the organisation and any formal announcements relating to its financial performance.

The Committee should ensure that the systems for financial reporting to the Board of Directors including those of budgetary control are subject to review as to the completeness and accuracy of the information provided.

The Committee shall review the annual report and financial statements before submissions to the Board of Directors focusing particularly on:
- Reviewing the annual governancestatement and other disclosures relevant to the terms of reference of the Committee.
- Changes in, and compliance with, accounting policies, practices and estimation techniques
- Unadjusted mis-statements in the financial statements
- Significant judgements in preparation of the financial statements
- Significant adjustments resulting from the external audit
- Adequacy of management response to issues identified by external audit activity
- Letters of representation
- Explanations for significant variances

The committee should review schedules of losses and compensations, making recommendations to the Board of Directors.

The Committee should review the Trust's standing financial instructions, standing orders and the scheme of delegation on an annual basis and make recommendations for change to the Board of Directors.

The committee will receive assurance on compliance with the Trust's standing orders and standing financial instructions.

The committee will review the waiver register.

**Internal audit**

The Committee shall ensure that there is an effective internal audit function that meets the Public Sector Internal Audit Standards 2017 and provides appropriate independent assurance to the Committee, Chief Executive Officer (as accounting officer) and Board of Directors. This will be achieved by:

- Considering the provision of the internal audit service and the costs involved, making recommendations to the Board of Directors regarding the appointment of the internal auditors.
- Reviewing and approving the annual internal audit plan and more detailed programme of work, ensuring that this is consistent with the audit needs of the organisation as identified in the assurance framework.
- Considering the major findings of internal audit work (and management's response), and ensuring co-ordination between the internal and external auditors to optimise the use of audit resources.
- Ensuring that the internal audit function is adequately resourced and has appropriate standing within the organisation.
- Monitoring the effectiveness of internal audit and carrying out an annual review.
- Meeting with the Head of Internal Audit at least once a year, without management being present, to discuss their remit and any issues arising from the internal audits carried out.

**External audit**

The Committee shall review and monitor the external auditors' independence and objectivity and the effectiveness of the audit process. In particular, the Committee will review the work and findings of the external auditors and consider the implications and management's responses to their work. This will be achieved by:

- Considering the appointment and performance of the external auditors, as far as the rules governing the appointment allow (and making recommendations to the council of governors when appropriate).
- Ensuring that the work of the external auditor meets the requirements of the regulator and other regulatory bodies.
- Discussing and agreeing with the external auditors, before the audit commences, the nature and scope of the audit as set out in the annual audit plan.
- Discussing with the external auditors their evaluation of audit risks and assessment of the organisation and the impact on the audit fee.
- Reviewing all external audit reports including the report to those charged with governance (before its submission to the Board) and any work undertaken

outside the annual audit plan, together with the appropriateness of management responses.

- Ensuring that there is in place a clear policy for the engagement of external auditor's to supply non-audit services

**System for raising concerns**
The Committee shall review the effectiveness of the arrangements in place for allowing staff and contractors to raise (in confidence) concerns about possible improprieties in any areas of the organisation (financial, clinical, safety or workforce) matters and ensure that any such concerns raised were investigated proportionately and independently, and in line with the relevant policies.

**Counter fraud**
The Committee shall satisfy itself that the organisation has adequate arrangements in place for counter fraud and security that meet the NHS Counter Fraud Authority's requirements and shall review the outcomes of work in these areas.

With regards to the local counter fraud specialist it will review, approve and monitor counter fraud work plans, receiving regular updates on counter fraud activity, monitor the implementation of action plans and discuss NHSCFA quality assessment reports.

**Management**
The Committee shall request and review reports, evidence and assurances from directors and managers on the overall arrangements for governance, risk management and internal control.

The Committee may also request specific reports from individual functions within the organisation (for example, clinical audit).

**Governance and regulatory compliance**
The committee shall review the organisation's reporting on compliance with the NHS Provider Licence, Code of governance for NHS provider trusts and the fit and proper persons test.

The committee shall satisfy itself that the organisation's policy, systems and processes for the management of conflicts (including gifts and hospitality and bribery) are effective including receiving reports relating to non-compliance with the policy and procedures relating to conflicts of interest.

**Other assurance functions**
The Committee shall review the findings of other significant assurance functions, both internal and external to the organisation, and consider the implications for the governance of the organisation.

These will include, but will not be limited to, any reviews by Department of Health arm's length bodies or regulators/inspectors (for example, the Care Quality Commission and the NHS Resolution) and professional bodies with responsibility for the performance of staff or functions (for example, Royal Colleges and accreditation bodies).

In addition, the Committee will review the work of other Committees within the organisation whose work can provide relevant assurance to the Committee's own areas of responsibility. In particular, this will include any financial and operational performance, clinical governance, risk management or quality committees that are established.

In reviewing the work of the Quality and Safety Committee, and issues around clinical risk management, the Committee will wish to receive assurance relating to the effectiveness of systems and processes of clinical governance including the clinical audit function.

## Meetings

Meetings of the Committee shall be formal, minuted and compliant with relevant statutory and good practice guidance as well as the Trust's codes of conduct.

The Committee will meet at least four (4) times a year. The timing of Committee meetings should be planned to coincide with the important events in the year, thereby ensuring that the Committee is able to exercise its power to influence events.

At least once a year, the Committee should meet privately with representatives of the external and internal auditors.

The Chair of the Committee may cancel, postpone or convene additional meetings as necessary for the Committee to fulfil its purpose and discharge its duties.

Any member of the Committee can ask for a meeting to be convened in person, by video- conference or by telephone, or for a matter to be considered in correspondence.

The Board of Directors, Chief Executive Officer (as accounting officer), representative of the external auditor and head of internal audit may request additional meetings if they consider it necessary.

Notice of each meeting confirming the venue, time and date together with an Agenda shall be circulated by the Secretary to each member of the Committee at least 5 clear days prior to the date of the meeting.

## Conflicts of Interest

All members and attendees of the Committee must declare any relevant potential interests at the commencement of any meeting. The Chair of the Committee will determine if there is a conflict of interest such that the member and/or attendee will be required not to participate in a discussion.

Where the Committee considers an item of its business may give rise to a potential conflict by meeting in common, the Committee may refer that business to the Board.

## Chairing

The Committee shall be chaired by a non-executive director, appointed by the Trust Chair following discussion with the Board of Directors.

If the Chair is absent or has a conflict of interest which precludes his or her attendance for all or part of a meeting, the Committee shall be chaired by one of the other non-executive director members of the Committee.

The representative of the external auditor, head of internal audit, and counter fraud specialist have the right of direct access to the Chair of the Committee to discuss any matter relevant to the purpose, duties and responsibilities of the Committee or to raise concerns.

## Secretariat

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

- Preparation of the draft agenda for agreement with the Chair
- Organisation of meeting arrangements, facilities and attendance
- Collation and distribution of meeting papers
- Taking the minutes of meetings and keeping a record of matters arising and issues to be carried forward
- Maintaining the Committee's work programme.

## Membership

**Members with voting rights**

The Committee will comprise at least three non-executive directors who shall each have full voting rights. The Chair of the Trust shall not Chair, be a member of, nor have the right to attend Committee meetings without invitation by the Chair as and when appropriate and necessary.

The Committee is authorised to co-opt additional members to provide specialist skills, knowledge and experience. At least one Committee member should have recent and relevant financial experience.

**Ex-officio attendees without voting rights**

- Representatives of the Trust's internal auditors.
- Representatives of the Trust's external auditors.
- The Trust's counter fraud specialist who will be entitled to attend any committee meeting and have a right of access to all committee members

**In attendance without voting rights**

The following posts shall be invited to attend routinely meetings of the Committee in full or in part but shall neither be a member nor have voting rights:

- Chief Executive Officer (as Accounting Officer) who shall discuss with the Committee at least annually the process for assurance that supports the annual governance statement. The Chief Executive Officer should also be in attendance when the Committee considers the draft annual governance statement along with the annual report and accounts.
- Chief Finance Officer
- Chief Nursing Officer
- The secretary to the Committee (for the purposes described above).
- Designated deputies (as described below).



**Reviewed by Audit & risk committee in March 2026**
**Approved by the Board of Directors at its meeting in 14 May 2026**

- Any other member of the Board of Directors, senior member of Trust staff or advisor considered appropriate by the chair of the Committee, particularly when the Committee will consider areas of risk or operation that are their responsibility.

## Quorum

For any meeting of the Committee to proceed, two non-executive director members of the Committee must be present. A duly convened meeting of the Committee at which a quorum is present shall be competent to exercise all or any of the authorities, powers and discretions vested in or exercisable by the Committee.

## Attendance

Members and attendees are expected to attend all meetings or to send apologies to the chair and Committee secretary at least five clear days* prior to each meeting.

Attendees may, by exception and with the consent of the chair, send a suitable deputy if they are unable to attend a meeting. Deputies must be appropriately senior and empowered to act on behalf of the Committee attendee.

**The Committee Chair may ask any person in attendance who is not a member of the Committee to withdraw from a meeting to facilitate open and frank discussion of a particular matter.**

## Papers

Meeting agendas and papers to be distributed to members and individuals invited to attend at least five clear days* prior to the meeting.

## Reporting

The Secretary shall minute the proceedings and decisions of all meetings of the Committee, including recording the names of those present and in attendance. Draft minutes will be submitted for formal agreement at the next committee meeting.

The Committee chair shall prepare a report of each Committee meeting for submission to the Board of Directors at its next formal business meeting. The report shall draw attention to any issues which require disclosure to the Board of Directors including where executive action is continually failing to address significant weaknesses.

Issues of concern and/or urgency will be reported to the Board of Directors in between its formal business meetings by other means and/or as part of other meeting agendas as necessary and agreed with the Trust chair. Instances of this nature will be reported to the Board of Directors at its next formal business meeting.

The Committee will also report to the Board of Directors at least annually on its work in support of the annual governance statement, specifically commenting on:

- The fitness for purpose of the assurance framework
- The completeness and ‘embeddedness’ of risk management in the organisation
- The integration of governance arrangements
- The appropriateness of the evidence that shows the organisation is fulfilling regulatory requirements relating to its existence as a functioning business
- The robustness of the processes behind the quality accounts



**Reviewed by Audit & risk committee in March 2026**
**Approved by the Board of Directors at its meeting in 14 May 2026**

| The annual report should also describe how the Committee has fulfilled its terms of reference and give details of any significant issues that the Committee considered in relation to the financial statements and how they were addressed.<br><br>In addition, the Committee shall make an annual report to the council of governors in relation to the performance of the external auditor to enable the council of governors to consider whether or not to re-appoint them.<br><br>The Committee chair shall report at quarterly meetings of the Council of Governors. |
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| **Review** |
| The committee will review on an annual basis its own performance and terms of reference to ensure that it is operating effectively and in line with best practice. The outcomes of this review will be reported in writing to the Board.<br>The next scheduled review of these terms of reference will be undertaken by the Committee in March 2027 in anticipation of approval by the Board of Directors at its meeting in May 2027. |
| *** Definitions** |
| In accordance with the Trust's constitution, 'clear day' means a day of the week not including a Saturday, Sunday or public holiday. |

# Terms of reference

## Name of governance body

Finance and Performance Committee (F&PC)

## Constitution

The Finance and Performance Committee ("the Committee") is a standing committee of the Board of Directors, established in accordance with the Trust's standing orders, standing financial instructions and constitution.

## Accountability

The Committee is accountable to the Board of Directors for its performance and effectiveness in accordance with these terms of reference.

## Authority

The Committee is authorised by the Board of Directors to seek any information it requires from within the Trust and to commission independent reviews and studies if it considers these necessary, subject to approval of spend in line with scheme of delegation and reservation of power.

## Purpose

The purpose of the Committee is to assure the Board of Directors of the:

- Delivery of financial, operational and workforce performance plans and targets.

To provide this assurance the Committee will maintain a detailed overview of:

- The Trust's assets and resources in relation to the achievement of its financial plans and key strategic projects.
- The Trust's operational performance in relation to the achievement of its activity plans and key strategic projects.
- The Trust's workforce profile in relation to the achievement of key performance indicators and key strategic objectives.
- Business planning assumptions, submissions and acceptance/delivery of targets.
- The management of organisational risks appropriate to the Committee's remit

To fulfil its purpose, the Committee will also:

- Identify the key issues and risks requiring discussion or decision by the Board of Directors.
- Advise on appropriate mitigating actions.

## Duties and responsibilities

**Duties**

*Financial and operational performance*

- Review and challenge construction of operational, and financial plans for the planning period as defined by the regulators.
- Review, interpret and challenge in-year financial, project and operational performance.
- Review, interpret and challenge workforce profile metrics including sickness absence, people management, bank and agency usage, statutory and mandatory training compliance and recruitment.

- Oversee the development and delivery of any corrective action plans and advise the Board of Directors accordingly.
- Review and support the development of appropriate performance measures, such as key performance indicators (KPIs), and associated reporting and escalation frameworks to inform the organisation and assure the Board of Directors.
- Refer issues of quality or specific aspects of the Quality and Safety Committee's remit, and maintain communication between other Board sub-committees to provide joint assurance to the Board of Directors.

*Corporate risks*

- Review organisational risks, allocated to the committee for oversight, and the implementation of remedial actions.
-

*Estates and Facilities*

- Review the delivery of the Trust's estates and facilities planned maintenance programmes as agreed by the Board of Directors.
- Oversight of the development and delivery of the Estates strategy
- Oversight of key estates critical infrastructure programmes
- Consider initiatives and review proposals for land and property development and transactions prior to submission to the Board of Directors for approval.

*Information management and technology performance and development*

- Oversee the development, delivery and performance of the Trust's information governance, management and technology strategic projects and programme as agreed by the Board of Directors

*Capital and other investment programmes and decisions*

- Oversee the development, management and delivery of the Trust's annual capital programme and other agreed investment programmes.

- Evaluate, scrutinise and approve the financial validity of individual significant investment decisions (that require Board approval), including the review of outline and full business cases. Business cases that require Board approval will be referred to the Committee following initial review by the Executive Leadership Team and/or Executive sub-committee for Resources.

*Better value plans*

- To oversee the delivery of the Trust's cost improvement plans and the development of associated efficiency and productivity programmes.

Consider the merit of developed business cases for new service developments and service disinvestments within the committees remit prior to submission to the Board of Directors for approval.

**Responsibilities**

On behalf of the Board of Directors, the Committee will be responsible for the oversight and scrutiny of the Trust's:

- Monthly financial and operational performance.
- Estates strategy and maintenance programme.

The Committee will make recommendations to the Board in relation to:
- Capital and other investment programmes.
- Cost improvement plans.

## Charing

The Committee shall be chaired by a non-executive director, appointed by the Trust Chair following discussion with the Board of Directors.

If the Chair is absent or has a conflict of interest which precludes his or her attendance for all or part of a meeting, the Committee shall be chaired by one of the other non-executive director members of the Committee.

## Meetings

Meetings of the Committee shall be formal, minuted and compliant with relevant statutory and good practice guidance as well as the Trust's codes of conduct.

The Committee will meet formally bi-monthly.

The Chair of the Committee may cancel, postpone or convene additional meetings as necessary for the Committee to fulfil its purpose and discharge its duties.

Notice of each meeting confirming the venue, time and date together with an Agenda shall be circulated by the Secretary to each member of the Committee at least 5 working days prior to the date of the meeting.

## Secretariat

The Governance Officer shall be the secretary to the Committee and shall provide administrative support and advice to the chair and membership. The duties of the secretary shall include but not be limited to:
- Preparation of the draft agenda for agreement with the chair.
- Organisation of meeting arrangements, facilities and attendance.
- Collation and distribution of meeting papers.
- Taking the minutes of meetings and keeping a record of matters arising and issues to be carried forward.
- Maintaining the Committee's work programme.

## Membership

**Members with voting rights**

The following posts are entitled to membership of the Committee and shall have full voting rights:
- Three Non-Executive Directors (including Committee chair)
- Chief Executive Officer
- Chief Finance Officer
- Chief Operating Officer
- Chief People Officer
- Chief Nursing Officer OR Chief Medical Officer

**In attendance**

The following posts shall be invited to attend meetings of the Committee in full or in part, but shall neither be a member nor have voting rights.
- The secretary to the Committee (for the purposes described above).

- Any member of the Board of Directors or senior manager considered appropriate by the chair of the Committee.

## Quorum

For any meeting of the Committee to proceed, two non-executive directors and one executive director of the Trust must be present.

A duly convened meeting of the Committee at which a quorum is present shall be competent to exercise all or any of the authorities, powers and discretions vested in or exercisable by the Committee.

## Attendance

Members and attendees are expected to attend all meetings or to send apologies to the chair and Committee secretary at least five clear days* prior to each meeting.

Members must, with the consent of the chair, send a suitable deputy if they are unable to attend a meeting. Deputies must be appropriately senior and empowered to act and vote on behalf of the Committee member.

The Committee Chair may ask any person in attendance who is not a member of the Committee to withdraw from a meeting to facilitate open and frank discussion of a particular matter.

## Papers

Papers to be distributed to members and those in attendance at least three clear days in advance of the meeting.

## Reporting

The Secretary shall minute the proceedings and decisions of all meetings of the Committee, including recording the names of those present and in attendance. Draft minutes will be submitted for formal agreement at the next committee meeting.

The Chair shall prepare a report of the latest Committee meeting for submission to the Board of Directors at its next formal business meeting. The report shall draw attention to any issues which require disclosure to the Board of Directors including where executive action is continually failing to address significant weaknesses.

Issues of concern and/or urgency will be reported to the Board of Directors in between its formal business meetings by other means and/or as part of other meeting agendas as necessary and agreed with the Trust chair. Instances of this nature will be reported to the Board of Directors at its next formal business meeting.

The Committee Chair shall report at quarterly meetings of the Council of Governors.

## Review

These terms of reference shall be reviewed annually or more frequently if necessary. The review process should include the company secretarial team for best practice advice and consistency.

The next scheduled review of these terms of reference will be undertaken by the Committee in March 2027 in anticipation of approval by the Board of Directors at its

| meeting in May 2027. |
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| ***Definitions** |
| In accordance with the Trust’s constitution, ‘clear day’ means a day of the week not including a Saturday, Sunday or public holiday. |

## Terms of Reference

### Name of governance body

**Quality & Safety (Q&S) Committee**

### Constitution

The Quality and Safety Committee ("the Committee") is a standing committee of the Board of Directors, established in accordance with the Trust's standing orders, standing financial instructions and constitution.

### Accountability

The Committee is accountable to the Board of Directors for its performance and effectiveness in accordance with these terms of reference.

### Authority

The Committee is authorised by the Board of Directors to seek any information it requires from within the Trust and to commission independent reviews and studies if it considers these necessary. Delegated authority includes:

- Approval of specific policies and procedures relevant to the Committee's purpose, responsibilities and duties.
- Engagement with Trust auditors in cooperation with the Audit and Risk Committee.
- Seeking information from within the Trust and commissioning internal or independent investigations or any activity within its terms of reference if further assurance is required, subject to approval of spend in line with scheme of delegation and reservation of power.

### Purpose

The purpose of the Committee is to assure the Board of Directors of:

- The quality and safety of clinical care delivered by the Trust at either its hub site in East Grinstead or any other of its spoke sites.
- Patient, service user, family and carer satisfaction with services
- The management and mitigation of clinical risk.
- The governance of the Trust's clinical systems and processes.

In order to provide this assurance the Committee will maintain overview of:

- Health and safety
- Clinical Governance
- Management of medicines and clinical devices
- Safeguarding
- Patient experience
- Infection control
- Research and development governance
- Medical devices
- Clinical audit
- Emergency preparedness resilience and response
- Appraisal & revalidation of medical staff
- Guardian of Safe Working
- Patient safety
- Learning from deaths

To fulfil its purpose, the committee will also:

- Identify the key issues and risks requiring discussion or decision by the Board of Directors and advise on appropriate mitigating actions.
- Make recommendations to the Board about the amendment or modification of the Trust's strategic initiatives in the light of changing circumstances or issues arising from implementation.
- Work closely with other Board sub- committees as necessary.

## Duties and Responsibilities

**Duties**

- Support the compilation of the Trust’s annual quality accounts and recommend to the Board of Directors its submission to the Secretary of State.
- Approve quality priorities recommended by the Executive committee for quality and risk.
- Review the clinical audit programme and confirm to the Audit and risk committee that it adequately addresses issues of relevance and any significant gaps in assurance
- Receive a quarterly report on healthcare acquired infections and resultant actions.
- Receive and review bi-monthly integrated reports encompassing complaints, litigation, incidents and other patient experience activity.
- Refer issues related to workforce to the Finance and Performance committee and culture to the Strategy and Culture committee and seek assurance from that committee that workforce issues which impact or could impact quality of care are being effectively monitored and that robust action plans are in place
- Review bi-monthly quality components of the organisational risk register (patient safety risks) and Board assurance framework and make recommendations on areas requiring audit attention, to assist in ensuring that the Trust’s audit plans are properly focused on relevant aspects of the risk profile and on any significant gaps in the assurance of clinical quality.
- Ensure that management processes are in place which provide assurance that the Trust has taken appropriate action in response to relevant independent reports and ad hoc reports from enquiries and independent reviews and that learning from adverse events is being embedded within the workforce
- Ensure that management processes are in place to ensure that the Trust is compliant with regulatory requirements
- Ensure there are clear lines of accountability for the overall quality and safety of clinical care and risk management.
- Hold to account the Executive leadership team on all matters relating to quality, risk and governance.

**Responsibilities**

On behalf of the Board of Directors, the Committee will be responsible for the oversight and scrutiny of:

- The Trust’s performance against the three domains of quality, safety, effectiveness and patient experience.
- Review all PSIRF and never event investigations, (ideally prior to external submission) to ensure assurance about the governance of the process and the appropriateness of actions and improvements identified. If timescales do not allow this, the investigation report may be sent externally provided it has been signed off by the Executive committee for quality and risk and reviewed by the Chair of the Quality & Safety Committee.
- Compliance with essential professional standards, established good practice and mandatory guidance including but not restricted to:
    - Care Quality Commission national standards of quality and safety
    - National Institute for Care Excellence (NICE) guidance
    - National Audit Office (NAO) recommendations.
    - Relevant professional bodies (e.g. Royal colleges) guidance.
- Delivery of national, regional, local and specialist care quality targets.

## Meetings

Meetings of the committee shall be formal, minuted and compliant with relevant statutory and good practice guidance as well as the Trust’s codes of conduct.

The Committee will meet formally bi-monthly and hold seminars in the months in between.
The Chair of the committee may cancel, postpone or convene additional meetings as necessary for the Committee to fulfil its purpose and discharge its duties.

Notice of each meeting confirming the venue, time and date together with an Agenda shall be circulated by the Secretary to each member of the Committee at least 5 clear days prior to the date of the meeting.

## Chairing

The Committee shall be chaired by a Non-Executive Director, appointed by the Trust Chair following discussion with the Board of Directors.

If the Chair is absent or has a conflict of interest which precludes his or her attendance for all or part of a meeting, the Committee shall be chaired by one of the other Non-Executive Director members of the Committee.

## Secretariat

The Governance Officer shall be the secretary to the Committee and shall provide administrative support and advice to the Chair and membership. The duties of the Secretary shall include but not be limited to:

- Preparation of the draft agenda for agreement with the Chair
- Organisation of meeting arrangements, facilities and attendance
- Collation and distribution of meeting papers
- Taking the minutes of meetings and keeping a record of matters arising and issues to be carried forward
- Maintaining the Committee's work programme.

## Membership

**Members**

The following posts are entitled to membership of the committee with full voting rights:

- Three Non-Executive Directors
- Chief Nursing Officer
- Chief Medical Officer
- Chief Operating Officer

Designated deputies will attend as appropriate

The following posts may be invited to attend routinely meetings of the Committee in full or in part when required but shall not be a member or have voting rights:

- Chief Executive
- Deputy Chief Nurse
- Chief People Officer
- Head of Safety and patient experience
- Head of Quality and Compliance
- Allied Health Professional Lead
- Chief Pharmacist
- The secretary to the Committee (for the purposes described above)
- Associate Director of Research, Innovation and Improvement
- Chief Strategy Officer
- NHS Sussex ICS Quality Representative
- Other invitees as appropriate by prior agreement with the Chair

The Chair and members of the Committee shall commit to work together according to the principles established by the Trust's policy for engagement between the Board of Directors and Council of Governors.

| Quorum |
| --- |
| For any meeting of the Committee to proceed, the following combination of members must be present:<br>• Two Non-Executive Directors (incl. chair of committee)<br>• Either the Chief Nursing Officer or Chief Medical Officer<br>A duly convened meeting of the Committee at which a quorum is present shall be competent to exercise all or any of the authorities, powers and discretions vested in or exercisable by the Committee. |
| **Attendance** |
| **Members** are expected to attend all meetings or to send apologies to the Chair and Committee secretary at least five clear days* prior to each meeting. A suitable deputy should be sent to cover any absence. Deputies must be appropriately senior and empowered to act and vote on the behalf of the Committee member. Furthermore, members need to advise the Chair in advance if they have to leave the meeting early or are planning to arrive late.<br><br>The Committee Chair may ask any person in attendance who is not a member of the Committee to withdraw from a meeting to facilitate open and frank discussion of a particular matter. |
| **Papers** |
| Meeting papers shall be distributed to members and attendees at least five clear days* prior to the meeting. |
| **Reporting** |
| The Secretary shall minute the proceedings and decisions of all meetings of the Committee, including recording the names of those present and in attendance. Draft minutes will be submitted for formal agreement at the next committee meeting.<br><br>The Committee Chair shall prepare a report of each Committee meeting for submission to the Board of Directors at its next formal business meeting. The report shall draw attention to any issues which require disclosure to the Board of Directors including where executive action is continually failing to address significant weaknesses.<br><br>Papers will be circulated to all Non-Executive Directors to provide additional assurance.<br><br>Issues of concern and/or urgency will be reported to the Board of Directors in between formal business meetings by other means and/or as part of other meeting agendas as necessary and agreed with the Trust Chair. Instances of this nature will be reported to the Board of Directors at its next formal business meeting.<br><br>In the event of a significant adverse variance in any of the key indicators of clinical performance or patient safety, the responsible executive director will make an immediate report to the Committee Chair, copied to the Trust Chair and Chief Executive, for urgent discussion at the next meeting of the Committee and escalation to the Trust Board.<br><br>Final and approved minutes of Committee meetings shall be circulated to the Committee members and attendees. The Committee Chair shall provide an annual report to the Audit and Risk committee to provide assurance on the governance arrangements.<br><br>The Committee Chair shall report at quarterly meetings of the Council of Governors and facilitate the Governor working group for the Committee |
| **Review** |
| On an annual basis, the Committee will review its own performance and terms of reference, to ensure that it is operating effectively and in line with best practice. The outcomes of this review will be reported in writing to the Board. |

**Reviewed by Q&SC in February 2026**
**Approved by BoD at its meeting in May 2026**

| The next scheduled review of these terms of reference will be undertaken by the Committee in February 2027 in anticipation of approval by the Board of Directors at its meeting in March 2027. |
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| **Definitions** |
| In accordance with the Trust’s constitution, ‘clear day’ means a day of the week not including a Saturday, Sunday or public holiday. |

| Terms of reference |
|---|
| **Name of governance body** |
| Strategy and Culture Committee |
| **Constitution** |
| The Strategy and Culture Committee (“the Committee”) is a standing committee of the Board of Directors, established in accordance with the Trust’s standing orders, standing financial instructions and Constitution. |
| **Accountability** |
| The Committee is accountable to the Board of Directors for its performance and effectiveness in accordance with these terms of reference.<br>The Board will retain its responsibility for defining the strategic aims and objectives of the Trust and oversight of organisational culture. |
| **Authority** |
| The Committee is authorised by the Board of Directors to seek any information it requires from within the Trust and to commission independent reviews and studies if it considers these necessary. |
| **Purpose** |
| The purpose of the Committee is to:<br>• Provide oversight and direction regarding the development of the Trust’s strategic and sustainable future model<br>• Provide oversight and direction regarding the delivery of the QVH strategy 2025-2030, clinical ambitions and key enablers in the national context.<br>• Assist the Board in its oversight and delivery of people, culture and organisational development strategies which support the delivery of The QVH strategy 2025-2030 and ensure a sustainable future<br><br>To fulfil its purpose, the Committee will:<br>• Maintain oversight of the effective management of Board Assurance Framework and organisational risks appropriate to the committee’s remit<br>• Identify the key strategic issues, risks and opportunities requiring discussion or decision by the Board of Directors<br>• Advise on appropriate mitigating actions |
| **Duties and responsibilities** |
| **Duties**<br>*Sustainability*<br>• Detailed oversight of the development of the Trust’s strategic sustainable future model<br>• Inform proposals related to partnerships and strategic collaborations and making recommendations to the Board<br>• Influence proposals related to leadership and governance models and making recommendations to the Board |

- Oversight of key strategic engagement activities related to organisational sustainability
- Oversight of how the organisation is embedding national priorities and direction in its strategic and sustainable future model

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

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

*Risks and opportunities*
- Maintain oversight of the effective management of Board Assurance Framework and organisational risks appropriate to the committee's remit

## Chairing

The Committee shall be chaired by a Non-executive director.

If the Chair is absent or has a conflict of interest which precludes his or her attendance for all or part of a meeting, the Committee shall be chaired by one of the other Non-executive director members of the committee.

## Meetings

Meetings of the Committee shall be formal, minuted and compliant with relevant statutory and good practice guidance as well as the Trust's codes of conduct.

The Committee will meet monthly.

The Chair of the Committee may cancel, postpone or convene additional meetings as necessary for the Committee to fulfil its purpose and discharge its duties.

## Secretariat

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

- Preparation of the draft agenda for agreement with the chair.
- Organisation of meeting arrangements, facilities and attendance.
- Collation and distribution of meeting papers.
- Taking the minutes of meetings and keeping a record of matters arising and issues to be carried forward.

## Membership

**Members**

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

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

**Attendees**

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

The following posts shall be invited to attend meetings of the Committee as required according to the agenda, in full or in part, but shall neither be a member nor have voting rights:

- Deputy Chief Executive Officer
- Chief Finance Officer
- Chief Nursing Officer
- Chief Operating Officer
- Any member of the Board of Directors or senior manager considered appropriate by the chair of the Committee.

## Quorum

For any meeting of the Committee to proceed, two Non-executive directors and one executive director must be present.

## Attendance

Members and attendees are expected to attend all meetings or to send apologies to the Chair and secretary of the Committee at least five clear days* prior to each meeting.

Attendees may, by exception and with the consent of the Chair, send a suitable deputy if they are unable to attend a meeting. Deputies must be appropriately senior and empowered to act and vote on behalf of the Committee member.

## Papers

Papers to be distributed to members and those in attendance at least three clear days* in advance of the meeting.

## Reporting

Minutes of the Committee meetings shall be recorded formally and ratified by the Committee at its next meeting.

**Approved by the SCC at its meeting in February 2026**
**Approved by Board of Directors at its meeting in May 2026**

The Chair shall prepare a report of the latest Committee meeting for submission to the Board of Directors at its next formal business meeting. The report shall draw attention to any issues of concern and any significant opportunities.

**Review**

These terms of reference shall be reviewed annually or more frequently if necessary. The review process should include the company secretarial team for best practice advice and consistency.

The next scheduled review of these terms of reference will be undertaken by the Committee in March 2027 in anticipation of approval by the Board of Directors at its meeting in May 2027.

***Definitions**

In accordance with the Trust's constitution, 'clear day' means a day of the week not including a Saturday, Sunday or public holiday.

**Modern Slavery Statement**
The NHS has an important role to play in combatting modern slavery and supporting victims. But to do this we need to ensure that our staff and volunteers understand that modern slavery exists, and that they are confident and able to both recognise the signs and indicators of both victim and perpetrators and know what to do.

From 1 November 2015, specified public authorities have a duty to notify the Secretary of State of any individual identified in England and Wales as a suspected victim of slavery or human trafficking, under Section 52 of the Modern Slavery Act 2015.

**https://www.modernslaveryhelpline.org/**

**What is Modern Slavery?**

- Slavery is a violation of a person's human rights. It can take the form of human trafficking, forced labour, and bonded labour, forced or servile marriage, descent-based slavery and domestic slavery. A person is considered to be in modern slavery if they are;
  - Forced to work through mental or physical threat
  - Owned or controlled by an "employer", usually through mental or physical abuse
  - De-humanised, treated as a commodity or sold or bought as "property"
  - Physically constrained or has restrictions placed in their freedom of movement.

**Our organisation**
Queen Victoria Hospital (QVH) is a foundation trust with a Board of Directors and Council of Governors, we are accountable to local people through our public membership. We are a leading specialist centre for reconstruction and sleep. We also provide essential healthcare services for local people.

Internationally recognised for pioneering innovative treatments and techniques, we have a strong track record of excellence and successful patient outcomes. Consistently ranked among the country's top hospitals for quality of care, QVH is known for its outstanding patient satisfaction ratings.

We have a history of collaboration and provide services across a number of 'spoke sites' through our QVH@ model, as well as being a key provider in cancer pathways across the health system.

We are committed to providing a range of services and operating as an anchor institution, proactively supporting our community's well-being and tackling health inequalities. Our vision is to be a centre of excellence that rebuilds lives and supports communities for a healthier future.

**Our commitment to Prevent Slavery and Human Trafficking**
The Trust Board, all employees and volunteers, are committed to ensuring that there is no modern slavery or human trafficking in any part of our business activity and in so far as is possible to holding our suppliers to account to do likewise.

**Our approach**
Our overall approach will be governed by compliance with legislative and regulatory requirements and the maintenance and development of best practice in the fields of contracting and employment and we will:

- Work with local Integrated Care Systems when reviewing the commissioning cycle for opportunities to ensure a robust approach.
- Review our approach and publish an annual statement outlining the steps we are taking to tackle modern slavery.
- Continue to ensure that our recruitment processes are mature, requiring practices that adhere to safe recruitment principles. This includes strict requirements in respect of identity checks,

work permits and criminal records. These practices will extend to any employment agencies used by the Trust.

- Our pay structure is derived from national collective agreements and is based on equal pay principles with rates of pay that are nationally determined. The Finance and Performance Committee will hold the organisation to account in adhering to these standards and practices.
- Ensure our procurement processes provide assurance that organisations are taking relevant steps to adhere to the standards including continuously reviewing the countries that our goods are sourced from and ensuring we are aware of high risk countries where modern slavery is prevalent. We will ensure that our suppliers adhere to the minimum labour standards set out in relevant international labour and human rights laws
- Make declarations and contractual provisions with existing healthcare commissioners to ensure they understand the Trust's approach to the Act.
- In the case of children and young people at risk, adherence to the local authority Safeguarding Children Partnership multi-agency policies and procedures.
- In the case of adults at risk, adherence to the local authority Safeguarding Board multi agency policies and procedures
- All staff can access support in this regard by contacting the Named Safeguarding professionals.
- The Trust's Whistleblowing Policy, which applies to all employees, consultants, contractors and agency staff who work for the Trust is accessible via the Trust's intranet site. Alternatively concerns can be raised with the Trust's Freedom to Speak Up Guardian.
- The Trust's guidance for supporting and safeguarding victims of modern slavery, exploitation and human trafficking is available to all staff.

We will know the effectiveness of the steps that we are taking to ensure that slavery and/ or human trafficking is not taking place within our business supply chain if no reports are received from our staff, public or law enforcement agencies that indicate that modern slavery practices have been identified.

**This statement is made pursuant to section 54(1) of the Modern Slavery Act 2015 and constitutes our slavery and human trafficking statement for the financial year ending March 2026.**

**Approved by the Trust Board on 14 May 2026**

**Angela McNab, Trust Chair** **Abigail Jago, acting Chief Executive Officer**

**Page updated:**