Bundle Public Board 16 September 2026

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Angela McNab, interim Trust Chair

59.26 Draft minutes of the public meetings held on 09 July 2026 and 23 July 2026
Angela McNab, interim Trust Chair
Approval

- Minutes- PUBLIC Board meeting- 09 July 2026 DRAFT V2
- Minutes- PUBLIC Board meeting- 23 July 2026 DRAFT V1

60.26 Matters arising and actions pending from previous meetings
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- 60-26 PUBLIC Matters arising

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71.26 Ethnicity Pay Gap Report as at 31 March 2026
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72.26 Culture Diagnostic Review
Helen Edmunds, Chief people officer
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72-26 QVH Culture Diagnostics Report 2026 Board

73.26 National Cancer Patient Experience Survey
Liz Blackburn, acting Chief nursing officer
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74.26 Premises Assurance Model
Helen Edmunds, Chief people officer
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75.26 Winter Plan 2026/27
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79.26 Any other business (by application to the Chair)
Angela McNab, interim Trust Chair
Discussion

80.26 Questions from members of the public
Angela McNab, interim Trust Chair
Discussion
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.

Queen Victoria Hospital
NHS Foundation Trust

Business Meeting of the Board of Directors

Wednesday 16 September 2026

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

MEMBERSHIP
BOARD OF DIRECTORS
September 2026

Members (voting):

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

In full attendance (non-voting):

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

Annual declarations by directors 2026/27

Declarations of interests

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

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

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

Register of declarations of interests

	Relevant and material interests							
	Directorships, including non-executive directorships, held in private companies or public limited companies (with the exception of dormant companies).	Ownership, part ownership or directorship of private companies, businesses or consultancies likely or possibly seeking to do business with the NHS or QVH.	Significant or controlling share in organisations likely or possibly seeking to do business with the NHS or QVH.	A position of authority in a charity or voluntary organisation in the field of health or social care.	Any connection with a voluntary or other organisation contracting for NHS or QVH services or commissioning NHS or QVH services.	Any connection with an organisation, entity or company considering entering into or having entered into a financial arrangement with QVH, including but not limited to lenders of banks.	Any "family interest": an interest of a close family member which, if it were the interest of that director, would be a personal or pecuniary interest.	Other
Non-executive and executive members of the board (voting)								
Angela McNab Interim Trust Chair	Non executive director / Vice Chair of Kent and Medway Integrated Care Board Non executive of Dimensions UK Ltd	Shareholder (less than 5%) in Rapid Health	Nil	Nil	Nil	Nil	Nil	Member of Independent Reconfiguration Panel (NDPB) - Advisory
Jagjit Dosanjh-Elton Non-Executive Director	Non-executive director for Social Investment Business Foundation Non-executive director for The Social Investment Business Limited Non-executive director for Public Relations Communications Association Limited Director 100% Shareholder of Ingenious Exec Limited	Nil	Nil	Trustee for TB Alert	Nil	Nil	Sister works as Chief Nurse at Guys and St Thomas Trust. Brother in law works as a Cardiac Consultant at Pembury Hospital Kent	Nil
Jo Emmanuel Non-Executive Director	Nil	Independent consultancy work for different NHS bodies for mental health, none directly linked to QVH	Nil	School governor for West St Leonards primary academy school	Nil	Nil	Nil	Nil

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

Kathy Brasier Acting Chief Strategy Officer	Nil	Nil	Nil	Nil	Nil	Nil	Nil	Nil
Ross Dunworth Interim Chief Finance Officer	Shareholder and Director: Whireparish Financial Services Ltd	Nil	Nil	Nil	Nil	Nil	Nil	Nil
Helen Edmunds Chief People Officer	Nil	Nil	Nil	Nil	Nil	Nil	Nil	Nil
Tamara Everington Chief Medical Officer	Nil	Nil	Nil	Nil	Nil	Azets (Trust's external auditor) support with annual tax return including evaluation of pension tax liability	Nil	Nil
Aleema Shivji Associate Non-Executive Director	Director of 5 Westborne Villas Freehold Ltd and 5 Chatham Place Freehold Ltd	Nil	Nil	Co-Chair, Peace Direct (charity)	Nil	Nil	Nil	Nil
Vivek Chaudhri Associate Non-Executive Director	Director of Global AI Leaders Network Director of Purposeful AI NED, East London NHS Foundation Trust (ELFT) NED, National Highways	Nil	Nil	Nil	Nil	Nil	Nil	Nil

Fit and proper persons declaration

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

Register of fit and proper person declarations

	Categories of person prevented from holding office						
	The person is an undischarged bankrupt or a person whose estate has had a sequestration awarded in respect of it and who has not been discharged.	The person is the subject of a bankruptcy restrictions order or an interim bankruptcy restrictions order or an order to like effect made in Scotland or Northern Ireland.	The person is a person to whom a moratorium period under a debt relief order applies under Part VIIA (debt relief orders) of the Insolvency Act 1986(40).	The person has made a composition or arrangement with, or granted a trust deed for, creditors and not been discharged in respect of it.	The person is included in the children's barred list or the adults' barred list maintained under section 2 of the Safeguarding Vulnerable Groups Act 2006, or in any corresponding list maintained under an equivalent enactment in force in Scotland or Northern Ireland.	The person is prohibited from holding the relevant office or position, or in the case of an individual from carrying on the regulated activity, by or under any enactment.	The person has been responsible for, been privy to, contributed to, or facilitated any serious misconduct or mismanagement (whether unlawful or not) in the course of carrying on a regulated activity, or discharging any functions relating to any office or employment with a service provider.
Non-executive and executive members of the board							
Angela McNab Interim Trust Chair	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Jagjit Donsanjh-Elton Non-Executive Director	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Jo Emmanuel Non-Executive Director	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Nick Page Non-Executive Director	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Kalee Talvitie-Brown Non-Executive Director	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Tamara Everington Chief Medical Officer	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Ross Dunworth Interim Chief Finance Officer	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Liz Blackburn Acting Chief Nursing Officer	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Abigail Jago Acting Chief Executive Officer	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Helen Edmunds Chief People Officer	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Kathy Brasier Acting Chief Strategy Officer	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Aleema Shivji Associate Non-Executive Director	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Vivek Chaudhri Associate Non-Executive Director	N/A	N/A	N/A	N/A	N/A	N/A	N/A

Queen Victoria Hospital
NHS Foundation Trust

Business meeting of the Board of Directors
16 September 2026
10.00-12.00

Agenda: session held in public		
WELCOME		
58-26	**Welcome, apologies and declarations of interest** *Angela McNab, interim Trust Chair*	
STANDING ITEMS		**Purpose**
59-26	**Draft minutes of the public meetings held on 09 July 2026 and 23 July 2026** *Angela McNab, interim Trust Chair*	*Approval*
60-26	**Matters arising and actions pending from previous meetings** *Angela McNab, interim Trust Chair*	*Review*
61-26	**Staff Story** *Liz Blackburn, acting Chief nursing officer* *Helen Edmunds, Chief people officer*	*Discussion*
62-26	**Chair's report** *Angela McNab, interim Trust Chair*	*Assurance*
63-26	**Chief Executive's report** *Abigail Jago, acting Chief executive officer*	*Assurance*
PERFORMANCE		
64-26	**Integrated quality and performance report** *All executive directors*	*Assurance*
COMMITTEE ASSURANCE REPORTS		
65-26	**Quality and safety assurance** *Jo Emmanuel, Non-executive director and committee Chair*	*Assurance*
66-26	**Financial, workforce and operational performance assurance** *Nick Page, Non-Executive Director and committee Chair*	*Assurance*
67-26	**Strategy and culture assurance** *Angela McNab, interim Trust Chair and committee Chair*	*Assurance*
STRATEGY		
68-26	**Research & Innovation Strategy update** *Tamara Everington, Chief medical officer*	*Assurance*
ANNUAL REPORTS		
69-26	**Workforce Race Equality Standard and Workforce Disability Equality Standard Annual Reports 2025/26** *Helen Edmunds, Chief people officer*	*Information*

70-26	**Gender Pay gap Report as at 31 March 2026** *Helen Edmunds, Chief people officer*	*Information*
71-26	**Ethnicity Pay Gap Report as at 31 March 2026** *Helen Edmunds, Chief people officer*	*Information*
72-26	**Culture Diagnostic Review** *Helen Edmunds, Chief people officer*	*Information*
73-26	**National Cancer Patient Experience Survey** *Liz Blackburn, acting Chief nursing officer*	*Assurance*
FOR APPROVAL		
74-26	**Premises Assurance Model** *Helen Edmunds, Chief people officer*	*Approval*
75-26	**Winter Plan 2026/27** *Kathy Brasier, acting Chief strategy officer*	*Approval*
76-26	**Provider Capability Assessment 2026** *Abigail Jago, acting Chief executive officer*	*Approval*
GOVERNANCE & RISK		
77-26	**Board Assurance Framework** *Jamie O'Callaghan, interim Company secretary* *All executive directors*	*Assurance*
78-26	**Committee Terms of Reference** *Jamie O'Callaghan, interim Company secretary*	*Approval*
MEETING CLOSURE		
79-26	**Any other business (by application to the Chair)** *Angela McNab, interim Trust Chair*	*Discussion*
MEMBERS OF PUBLIC		
80-26	**Questions from members of the public** *We welcome relevant, written questions on any agenda item from our staff, our members or the public. To ensure that we can give a considered and comprehensive response, written questions must be submitted in advance of the meeting (at least three clear working days). Please forward questions to qvh.corporategovernance@nhs.net clearly marked "Questions for the board of directors". Members of the public may not take part in the Board discussion. Where appropriate, the response to written questions will be published with the minutes of the meeting.* *Angela McNab, interim Trust Chair*	

	Minutes (DRAFT)	
Meeting:	**Board of Directors (session in public)** **10.00-12.00 09 July 2026** **Learning and Development Centre, QVH**	
Present:	Angela McNab (AM)	Interim Trust Chair (voting)
	Jagjit Dosanjh-Elton (JDE)	Non-executive director (voting)
	Jo Emmanuel (JE)	Non-executive director (voting)
	Kalee Talvitie-Brown (KTB)	Non-executive director (voting)
	Abigail Jago (AJ)	Acting Chief executive officer (voting)
	Tamara Everington (TE)	Chief medical officer (voting)
	Liz Blackburn (LB)	Acting Chief nursing officer (voting)
	Helen Edmunds (HE)	Chief people officer (non-voting)
	Hugh Cronshey (HC)	Deputy director strategic finance
	Aleema Shivji (AS)	Associate Non-executive director (non-voting)
	Vivek Chaudhri (VC)	Associate Non-executive director (non-voting)
In attendance:	Jamie O'Callaghan (JOC)	Interim Company secretary
	Ellie Simpkin (ES)	Governance manager (minutes)
	Cat Bradshaw (CB)	Head of nursing (for patient story)
Apologies:	Nick Page (NP)	Non-executive director (voting)
	Ross Dunworth (RD)	Interim Chief finance officer (voting)
	Kirsten Timmins (KT)	Chief operating officer (non-voting)
Members of the public:	Four members of staff, one member of the public (for patient story) and 14 governors	

27-26	**Welcome, apologies and declarations of interest** The Chair opened the meeting welcoming members of the Board and those observing the meeting. The Chair reminded those observing the meeting that they were not invited to participate in discussions and that there would be an opportunity to ask questions at the end of the meeting. Apologies were received from RD (HC was attending as his deputy), KT and NP. There were no declarations of interest other than those already recorded on the register of interests.
28-26	**Draft minutes of the public meeting held on 14 May 2026** The Board agreed that the minutes of the public Board meeting held on 14 May 2026 were a true and accurate record and **approved** them on that basis.
29-26	**Matters arising and actions pending from previous meetings** Action 7 (65 week waits) - The Board noted that the trajectory for the remainder of 2026/27 is being reviewed and will be shared at the next Finance & performance committee. Action 1 (addressing health inequalities) - The Board noted that it is recognised that this is a complex area requiring improvement. A pilot programme of work is planned at one of the spoke sites, focusing on analysing the drivers of patient 'Did Not Attend' by deprivation and piloting interventions. Progress is captured in the Integrated Quality Performance Report with additional quarterly reporting to the Quality & safety committee. The Board **noted** the verbal and written updates for the actions.
30-26	**Patient story**

	The Board welcomed the patient to the meeting to share her experience of having a mastectomy as a BRCA1 carrier. She spoke of her positive experience of therapeutic input in the lead up to her surgery, however, she described the distress caused by inconsistent communication on the agreed arrangements for her husband to be present during the pre-op and to visit her briefly following her surgery. She was feeling very anxious about her surgery and wanted her husband for support. Although her husband was eventually allowed to be with her both before and after her surgery the experience negatively affected the remainder of her stay. She did not feel listened to and interactions with staff left her feeling that control was being taken away from her at a vulnerable time. She only stayed in hospital for two nights which she understood wasn't very long for the type of surgery she had. The experience has impacted on her willingness to undergo further treatment and procedures. She explained that coming from a background in social work, she felt disempowered when she is used to being in control. Many people in her situation would not feel able to raise their concerns and it was important to her to be able to share her story to help make changes. CB thanked the patient for sharing her story, explaining that the patient being at the heart of our care is a strongly established ethos here at QVH. In response to the complaint, a full investigation was carried out to establish the timeline of events and identify the staff groups involved in order to identify learning for all involved. Findings were reviewed with teams to identify opportunities for improvement and develop a consistent approach to supporting patients during admission. The team has considered both potential barriers and benefits of patients being given the opportunity to be accompanied by a nominated support person and a 'Plus One' Protocol has been developed. This aims to improve the patient experience and reduce anxiety by enabling enhanced emotional support for patients undergoing major or particularly distressing procedures. A Standard Operating Policy (SOP) has been developed and introduced to allow patients to bring one accompanying person into the admissions waiting area, with clear guidance to address the operational challenges identified. The SOP has been disseminated to all relevant teams and implemented with immediate effect. The patient has kindly agreed to review the SOP for her perspective as a patient. This complaint has resulted in a positive service improvement that balances operational requirements with patient-centred care, supporting patients to feel more reassured and supported during what can be a highly stressful experience. The Board thanked the patient for speaking so openly about her personal and traumatic experience and shared their regret over the negative impact it has had on her. The Board hoped that she could take some comfort knowing that her courage in sharing her story has led to positive improvements for future patients. The Board reflected that the most significant theme they had heard was the feeling of not being listened to and recognised that this reflected a broader challenge of ensuring care remains truly patient-centred rather than paternalistic. Healthcare relies on trusting relationships between patients and staff and that maintaining and strengthening that trust is fundamental to everything the Trust does. The Board thanked the patient for having the courage to speak up and thanked CB for explaining the changes that have been made as a result of the patient sharing her story.
31-26	**Chair's report** AM presented the report to the Board, highlighting the following: - Progressing the Trust's strategic partnership remains a key priority. Key decisions on the Memorandum of Understanding and leadership and governance arrangements are due to be considered by partner Boards later in July 2026. - The Trust welcomes Nick Page and Kalee Talvitie-Brown who have joined the Board as Non-Executive Directors. The Board records its thanks to Peter O'Donnell, Shaun O'Leary and Russell Hobby whose terms of office as Non-Executive Directors concluded on 30 June 2026. - The QVH Star Awards will take place on 10 July 2026, providing an opportunity to recognise and celebrate the contribution of colleagues across the Trust.

	The Board **noted** the contents of the report.
32-26	**Chief Executive's report** AJ presented the report to the Board, highlighting that: - The Trust has started the year from a quality, urgent care and financial perspective in a strong position. There remains financial risk in 2026/27 due to a gap in the Better Value Cost reduction programme and there is ongoing focus on the delivery of the schemes. - There are challenges in planned care performance and there is exceptional focus from the team in this area. - The Trust's quarter 4 National Oversight Framework (NOF) position has declined to 42 out of 134 acute provider trusts, compared to 29 out of 134 in quarter 3. The drivers for this are primarily the staff survey results and elective care access performance, both of which have been discussed previously by the Board and continue to be areas of focus. It should be noted that, excluding the impact of Deficit Support Funding, QVH would have been positioned within Segment 1. - There is good traction across the Trust's strategic programmes. Good progress is being made with the East Grinstead Community Diagnostic Centre (CDC) build. Issues are being addressed as they arise and the works remain on track for an autumn opening. - AJ recorded her thanks to staff, particularly the Estates and Theatres teams, for their work during the recent period of exceptionally warm weather to keep the number of cancellations to a minimum and the Digital team for their response to the loss of data centres. - The Trust welcomes Ross Dunworth, Finance Director at Royal Surrey NHS Foundation Trust, who joined QVH as Interim Chief Finance Officer. The Board welcomed the progress being made with the CDC and queried whether the performance targets will be revised following the opening of the new building, noting the challenges in achieving current activity targets. TE explained that an increase in last year's activity levels has been delivered, however, the plan for a 35% increase in activity was very ambitious. Pathway opportunities are being explored. It is hoped that improvements in the underpinning processes, alongside engagement with GPs, will support future performance. Strong relationships with primary care are a key enabler and the appointment of a GP as the CDC Clinical Lead is strengthening GP engagement. The risk to financial performance, should an increase in CDC activity not be achieved is acknowledged. In response to a question on the most topical areas from the staff survey, HE explained Executive directors have met with managers from each department to discuss the areas of decline and the action being taken. It is recognised that staff may be feeling the impact of the reduction in posts and the impact that this may have on morale. AJ acknowledged the importance of delivering financial savings through different and more sustainable ways of working, rather than through cost reduction alone, and the importance of working with colleagues to achieve this. The Board noted an apparent disconnect between nursing staffing levels at QVH, which are still above other trusts, and anecdotal feedback from staff on their experience. LB recognised the need to continue listening to staff feedback, ensuring concerns are understood, and to work collaboratively with colleagues to ensure they understand the metrics and are supported in ways of working differently. The Board **noted** the contents of the report.
33-26	**Integrated quality and performance report** AJ presented the report to the Board and provided an update on operational performance, highlighting that:

- Urgent and Emergency Care (Minor Injuries Unit) performance remains strong and consistently above national standards.
- DM01 performance is behind plan at an aggregate level. Imaging performance is ahead of plan, however, there continues to be challenges in sleep due to an increase in referrals of c.70%. Demand growth is beginning to plateau, but this remains a key area of focus.
- Referral to Treatment (RTT) performance at Month 1 was 61.3% against a plan of 62.4%. Month 2 performance improved to 62.2%, with further improvement anticipated in Month 3. The main driver of underperformance continues to be first outpatient appointments. Work is underway on a targeted action plan which will inform a revised trajectory which will be reported to the next Finance and performance committee.
- In relation to long waits, performance against the 52-week standard was achieved in Month 1. Challenges remain within Oral and Maxillofacial Surgery (OMFS) and breast reconstruction pathways. A further update on the plan to eliminate waits over 65 weeks outside of breast reconstruction pathways will be provided to the Finance and performance committee.
- The total waiting list remained behind plan. It is reducing, with waiting validation being undertaken. AJ noted that without the increase in demand for sleep services and OMFS activity, performance would be ahead of plan. She remains confident that recovery can be achieved.
- Cancer performance - the Faster Diagnosis Standard (FDS) was below plan in Month 1 but is improving. Performance against the 62-day standard was below plan in Month 1 but is also improving. The teledermatology pathway continues to be developed and additional funding has been secured from the Cancer Alliance to provide further resource.

JDE noted the complexity of the operational picture and asked whether there is sufficient understanding of the baselines when setting performance targets, including demand assumptions and the factors within and outside the Trust's control. AJ confirmed that baseline positions and demand growth assumptions are understood. Capacity constraints within some services means that relatively small changes in demand can have a significant impact on performance. She acknowledged that there is scope to strengthen demand and capacity analysis further, noting that challenges vary across services and some pathways are inherently more complex than others. She is confident that the Trust can achieve its targets through the implementation of planned actions.

JE queried whether there is granular understanding of the outpatient capacity constraints to enable the Trust to be predictive. Referring to the operational performance benchmarking which shows the Trust ranked twelfth out of thirteen specialist trusts in some performance areas, she asked whether improvement is expected in those areas. AJ advised that improvement should be seen over coming months. She noted that it can be hard to make like-for-like comparisons with other specialist hospitals due to the nature of their services. She emphasised the importance of remaining ambitious, looking at benchmarking positions, when considering future trajectories.

The Board thanked AJ for the further detail on operational performance, noting that progress against the improvement trajectories will continue to be monitored by the Finance and performance committee.

TE provided an update on Key Strategic Objective 2, noting that the clinical workforce is engaged in understanding, anticipating and addressing the operational performance challenges. Work continues on embedding the QVH Way. Research is gaining more breadth with the partnership with the University of Sussex progressing positively. The Trust is performing well in relation to the experience of resident doctors. Educational opportunities

	are expanding, with the Trust welcoming its first Foundation Doctor through a partnership with Surrey and Sussex Healthcare NHS Trust. HE provided an update on workforce. She reported that staff numbers were slightly above plan in Month 1 but this reduced in Month 2. The areas with high sickness rates have been identified; theatres is one of these areas. There is no one particular reason and rates are being driven by long term sickness. There was a slight increase in bank and agency usage in Month 2 due to sickness cover. A dashboard has been developed to improve oversight of Mandatory and Statutory Training and appraisal compliance. Month 2 data shows an improvement in appraisals compliance. Discussion was had on the active management of sickness absence, particularly in theatres as an outlier. HE advised that there is no single common reason for sickness absence. Managers are actively managing individual cases, with some staff progressing through formal sickness management processes. She confirmed that the long term sickness absences are not work-related. HC provided an update on financial performance. The Trust reported an overall Month 1 deficit slightly ahead of the plan. Month 1 Income performance was adversely impacted by CDC underperformance. Underperformance within Plastics and OMFS has been partly offset by outpatient activity. There was an adverse variance in pay in Month 1. Although the Trust is reporting full delivery of Month 1 efficiency savings, the Trust needs to accelerate schemes to ensure delivery of the full year plan. There is transparency on the gap and work is being carried out to understand the risk-adjusted value of schemes. The Efficiency Steering Group is monitoring progress and identifying action needed. The Trust has received confirmation of £3.6 million of estate funding, enabling progression of priority works including the theatre roof, asbestos remediation and fire safety. The Board discussed the shortfall in the Trust's Better Value Programme (currently £1.5m - £2m) and confidence in the ability to address the gap. HC advised there is underspend in some areas which may help to mitigate the gap, however, these are non-recurrent and further work is required to develop a robust forecast and assess where budgets that may no longer be required. Good progress has been made over recent weeks in further developing the Trust's efficiency programme. The Board requested that a more detailed analysis of the Better Value Programme shortfall is provided within the next version of the IQPR narrative. **ACTION HC** In response to a question on whether the Trust will be able to recover the CDC income shortfall during quarter 2, HC explained that some recovery is expected but this is an area of risk for the Trust. KB provided an update on partnership working and engagement activity. As well as the strategic partnership, collaboration opportunities with SASH are also being explored. The Trust's Engagement plan has been developed which aims to support a stronger and more visible patient voice. The Board **noted** the contents of the report.
34-26	**Quality and safety committee assurance** JE introduced the report to the Board, highlighting that the committee has scrutinised the quality impact of current operational performance challenges. Progress is being made in addressing the historical incident backlog and the committee has received good assurance on the delivery of clinical audit work.

	In response to a question on Mental Capacity Act (MCA) compliance, TE explained that there is good training compliance with face-to-face training delivered by surgical group. Focus is now on the application of training and a monthly audit cycle which is providing learning for teams. The Board reviewed the following annual reports 2025-26: - Learning from Deaths: There were no avoidable deaths in 2025-26. Overall, the Learning from Deaths process at QVH operated as intended, providing assurance that deaths were identified, reviewed proportionately, and learning shared where relevant. - Safeguarding (Adult and Children): Governance has been strengthened and the Trust has contributed to learning reviews. There is improved and bespoke training. MCA compliance continues to be an area of focus and work continues to align safeguarding with digital systems such as Archie and strengthen the audit programme. - Infection and Control: The Trust maintained compliance throughout the year. Incident levels remain low and there is learning from incidents. Collaborative working with the Estates team has improved. Embedding robust and targeted auditing is an area for improvement. - Patient Experience (formerly complaints): There was an increase in the number of complaints in 2025-26, in line with local and national trends. Plans for the coming year included embedding the Patient Experience Group to strengthen and embed the patient voice. JE acknowledged the significant work undertaken to meet complaint response times and noted the development of the Clinical learning forum which supports the strengthening directorate leadership. - Appraisal & Revalidation: Processes to support appraisal and revalidation of the medical workforce are well established and supported. An internal audit did not identify concerns and progress is being made to further improve quality as well as the number of appraisals. The Board **noted** the contents of the report, **noted** the contents of the annual reports presented for assurance and **ratified** the Professional standards: framework for quality assurance and improvement (FAQI) Annual Report 2025-2026 which confirms that the Trust is compliant with the regulations.
35-26	**Financial, workforce and operational performance assurance.** JDE presented the report to the Board, explaining that the delivery of key performance targets continues to be an area of focus for the committee. Good progress is being made on the delivery of the major projects and the committee has discussed the challenges and risks associated with the PAS replacement. She highlighted the suggestion that the progress of the East Grinstead CDC build could be featured more heavily on the QVH website as a good news story. The Business plan for the replacement MRI scanner is due to be considered by the committee at its next meeting. The Board **noted** the contents of the report.
36-26	**Strategy and culture assurance** JE presented the report to the Board, highlighting the matters that the committee has considered beyond the strategic partnership including the children's model of care and the engagement with GPs, which is key in driving the local strategic ambition. The Board **noted** the contents of the report.
37-26	**Audit and risk assurance**

	JDE presented the report to the Board, commending staff for a successful year end and audit conclusion. The Trust's external auditors issued an unmodified audit opinion on the accounts and the improved grip and control is reflected in the 2025/26 Value for Money assessment which concluded with no significant weakness identified. The Counter Fraud Functional Standard Return (CFFSR) 2026 resulted in an overall rating of green. She highlighted the importance of not being complacent and ensuring improvements are fully embedded. The committee recognises improvement to the Board Assurance Framework but there is work to do to now move from it being used as reference document to a tool to inform decision making. The Board **noted** the contents of the report.
38-26	**Bi-annual Safe Staffing and Nursing Workforce Review** LB introduced the report to the Board, explaining as proposed in the Board in February 2026, staffing models have now been safely adjusted following inpatient ward reconfiguration and estate works, with no adverse impact on patient safety or quality indicators. Improved rostering practices have improved workforce deployment and there is a reduction in reliance on agency and bank staffing. There is greater visibility of Care Hours per Patient Day (CHPPD) metrics. CHPPD remains higher than other organisations with QVH positioned in Quartile 4 in comparison analysis of QVH against other providers. The recent bed reconfiguration and associated adjustments to staffing models have led to anecdotal reports of staff feeling concerned over their ability to safely care for patients. Engagement is taking place with staff to support understanding of what is safe and concerns are being triangulated against complaints, incidents and Freedom to Speak Up reporting. The Board highlighted the importance of continuing this engagement with staff. The Board **noted** the deployment of safe staffing levels in all inpatient areas, that the Trust meets the benchmarks recommended by the Royal College of Nursing, the Integrated Care System and the National Institute for Health and Care Excellence and that the staffing levels and skill mix are effectively reviewed.
39-26	**Bi-annual update on Digital Strategy** TE presented the report to the Board. Key achievements delivered against the QVH Digital Strategy in the last 18 months. Detailed work has ensured that the Trust is now 'standards met' for the Data Security Protection Toolkit. There is now a better understanding of the Trust's cyber risk with a separate cyber Board Assurance Framework and cyber dashboard. Optimisation of Archie Electronic Patient Record is ongoing and there is now a clear 'line of sight' to the Trust becoming paperless over the next three years. The replacement of the Patient Administration System (PAS), planned for November 2026, remains a key priority. Work is underway mapping pathways to understand how the new system will operate and where improvements can be made. Securing NHS England approval is currently a significant risk to delivery. Capital funding is another challenge, with limited additional central funding available for digital programmes. AS highlighted the potential risks associated with AI bias and the exclusion of datasets by AI tools and the impact on marginalised communities. TE noted that AI tools used by the Trust are not informing algorithms and that staff training included awareness of the limitations and risks associated with AI use. The Board sought assurance regarding the risks associated with the PAS programme and contingency arrangements should implementation be delayed. TE advised that the current PAS could continue to operate if required, although delays would impact wider digital developments. The Trust is fully engaged with NHS England over the approval processes. In response to a question on the benefit realisation and the optimisation of Archie provided by the PAS, TE explained that work is underway to map processes. HC noted that the

	Better Value Programme included non-pay savings associated with digital transformation, including reduced postage costs, with full-year savings estimated at approximately £400k. The Board **noted** the contents of the report.
40-26	**Board Assurance Framework** JOC presented the report to the Board, highlighting that there have been no changes to risk scores since the previous Board review. Work continues to develop the Board Assurance Framework (BAF), including monthly review at the Executive huddle to ensure alignment across the strategic risks. The work programmes will be reviewed to ensure that the BAF is appropriately informing committee and Board business. The BAF is an important tool to ensure continued grip on the Trust's principal risks and assurances, especially during the period of organisational change. A standalone Cyber strategic risk has been developed and is presented to the Board for approval. The Board noted that the Access BAF will be reviewed and rescored once revised performance trajectories have been agreed. The Regulation BAF will also be reviewed in light of the positive 2025/26 audit outcome and the removal of the Trust's additional licence conditions. The Board **confirmed** that the BAF appropriately reflects the principal risks that may impact delivery of the Trust's strategic objectives and **approved** the inclusion of the standalone Cyber strategic risk within the BAF.
41-26	**Annual review of Standing Orders, Standing Financial Instructions and Scheme of Delegation & Reservation of Powers** JOC presented the report to the Board, explaining that no substantive amendments are proposed. The Audit & risk committee has considered the revisions and recommends them to the Board for approval. It was noted that amendments may be required in due course to reflect any strategic partnership arrangements with Royal Surrey NHS Foundation Trust and Ashford and St Peter's Hospitals NHS Foundation Trust. The Board **approved** the Standing Orders, Scheme of Delegation & Reservation of Powers, and Standing Financial Instructions.
42-26	**Company secretary's report** JOC presented the report to the Board. Assurance has been provided to the Audit & risk committee that the Trust remains compliant with the NHS England Fit and Proper Persons Test (FPPT) Framework and associated legislative requirements. The Trust Chair completed the annual FPPT assessment and submitted confirmation of the fitness of all Board members to the NHS England Regional Director by the 30 June 2026 deadline. The Nomination & remuneration committee has completed its annual review of its Terms of Reference and recommends them to the Board for approval without amendment. The Board **noted** the compliance with Fit and proper persons (FPPT) requirements and **approved** the Nomination and remuneration committee terms of reference.
43-26	**Any other business (by application to the Chair)** There was no further business and the meeting closed.
44-26	**Questions from members of the public** <u>Question</u> Are there any areas of the conflict for the Trust in delivering the new Patient Administration System (PAS) in November 2026 while progressing the strategic partnership arrangements?

	Response Different teams within the Trust are working on the PAS and supporting the implementation of the strategic partnership and as such there is no risk in delivering these programmes concurrently.

	Minutes (DRAFT)	
Meeting:	**Board of Directors (session in public)** **14.00-15.00 23 July 2026** **Education Centre, QVH**	
Present:	Angela McNab (AM)	Interim Trust Chair (voting)
	Jagjit Dosanjh-Elton (JDE)	Non-executive director (voting)
	Jo Emmanuel (JE)	Non-executive director (voting)
	Kalee Talvitie-Brown (KTB)	Non-executive director (voting)
	Nick Page (NP)	Non-executive director (voting)
	Abigail Jago (AJ)	Acting Chief executive officer (voting)
	Tamara Everington (TE)	Chief medical officer (voting)
	Kathy Brasier (KB)	Acting Chief Strategy Officer (non-voting)
	Aleema Shivji (AS)	Associate Non-executive director (non-voting)
	Vivek Chaudhri (VC)	Associate Non-executive director (non-voting)
In attendance:	Jamie O'Callaghan (JOC)	Interim Company secretary
	Ellie Simpkin (ES)	Governance manager (minutes)
	Karen Jackson (KJ)	Deputy Chief Nursing Officer
Apologies:	Ross Dunworth (RD)	Interim Chief finance officer (voting)
	Kirsten Timmins (KT)	Chief operating officer (non-voting)
	Liz Blackburn (LB)	Acting Chief nursing officer (voting)
	Helen Edmunds (HE)	Chief people officer (non-voting)
Members of the public:	11 governors in person, 6 governors attending virtually and two members of staff observing the meeting.	
51-26	**Welcome, apologies and declarations of interest** The Chair opened the meeting, welcoming members of the Board and those observing the meeting. The Chair reminded those observing the meeting that this was a meeting held in public and that observers were not invited to participate in discussions. It was noted that there would be an opportunity for questions at the conclusion of the meeting. Apologies were received from RD, HE and LB, with KJ attending on behalf of LB. There were no declarations of interest other than those already recorded on the register of interests. AM reflected on the significance of the meeting and the important milestone that the proposed strategic partnership represented in securing the long-term sustainability of the Trust. The Board formally recorded its thanks to AM, AJ, KB and JOC for their leadership and contribution in progressing the partnership arrangements. Board members recognised the significance of the decision before the Board and welcomed the collaborative approach that had brought the organisations to this stage	
52-26	**QVH Strategic Partnership Governance and Transition Arrangements** KB presented the report, providing background to the strategic partnership programme and the work undertaken since the Board approved the ASPH/RSFT Group as QVH's preferred strategic partner in December 2025. She explained that the proposed arrangements represented the next phase of the partnership and had been developed following extensive engagement with stakeholders across the three organisations and NHS England. JOC introduced the governance proposals and highlighted three key elements of the report: • the Memorandum of Understanding (MoU); • the proposed Group leadership arrangements; and • the proposed Group governance arrangements. The Board noted that the MoU established the framework through which Ashford and St Peter's Hospitals NHS Foundation Trust, Royal Surrey NHS Foundation Trust and Queen Victoria Hospital NHS Foundation Trust would work collaboratively whilst remaining	

	separate NHS Foundation Trusts and legal entities. The MoU preserves the sovereignty, statutory responsibilities and local accountability of each Trust and establishes clear arrangements for governance, leadership and decision-making across the Group. The Board discussed the proposed leadership model, including the introduction of a shared Group Chair and Group Chief Executive alongside dedicated QVH leadership arrangements. Members noted that these arrangements are intended to strengthen organisational resilience whilst ensuring that local leadership, decision-making and accountability remain in place. The Board also noted that no further partnership-related changes to executive or non-executive structures are proposed during the initial implementation period. The Board considered the risks associated with implementation, including leadership capacity, staff engagement and maintaining local leadership visibility. Assurance was provided that these risks had been recognised within the transition programme and that appropriate mitigations would continue to be developed and monitored throughout implementation. Governors welcomed the partnership and recorded their thanks to AM, AJ, KB, JOC and the previous Trust Chair for their leadership in progressing the arrangements. It was recognised that the partnership is founded on a patient-centred approach and presents opportunities to improve patient pathways, further develop services at QVH and create additional opportunities for staff. The Board: • **approved** the Memorandum of Understanding between Ashford and St Peter's Hospitals NHS Foundation Trust, Royal Surrey NHS Foundation Trust and Queen Victoria Hospital NHS Foundation Trust; • **supported** the proposed initial Group leadership and governance arrangements; • **noted** the key risks associated with implementation and the mitigating actions proposed to support a safe and effective transition.
53-26	**Any other business (by application to the Chair)** There was no further business and the meeting closed.
54-26	**Questions from members of the public** <u>Question</u> Governor colleagues at Royal Surrey have shared concerns regarding the Group Chair and Group Chief Executive's capacity to dedicate sufficient time to QVH. How will this be managed? <u>Response</u> JOC explained that the partnership leadership structure would provide strategic oversight across all three organisations whilst dedicated local leadership would remain in place at QVH. The proposed Managing Director and Deputy Chair arrangements would provide day-to-day operational and Board leadership within the Trust. The effectiveness of the arrangements would be kept under review as the partnership develops and future governance arrangements across the Group would continue to be considered. <u>Question</u> What will the new partnership be called? <u>Response</u>

	It was confirmed that the branding of the Group remains under consideration by the participating Trusts.

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**
7	March 2026	148-26	65 week waits	Share trajectory to reach zero 65 week waits with the Finance and performance committee	~~**KT**~~ **KB**	~~**June 2026***~~ **September 2026**	May 2026: Forecast for Q1 shared and discussed at the May 2026 Finance and performance committee. The trajectory for the remainder of 2026/27 will be shared with the committee for discussion at the June 2026 meeting. July 2026: The trajectory for the remainder of 2026/27 is in progress and will be shared at the next Finance and Performance Committee. September 2026: Trajectory finalisation delayed due to Business Intelligence capacity. Discussions are underway across the partnership for potential support.	**Pending**
1	May 2026	08-26	Bi-annual assessment of addressing health inequalities	Update to be provided outlining the targeted actions that will be taken in relation to the deprivation gradient and how demonstrable improvement will be achieved including when measurable targets will be set.	**LB**	**July 2026***	July 2026: Through the development of the Trust health inequalities dashboard, the data identifies areas of unwarranted variation in access and attendance across deprivation and ethnicity cohorts, with patients from the most deprived communities being approximately five percentage points more likely to wait over 18 weeks than those from the least deprived areas. We recognise that this is a complex area requiring improvement. A pilot programme of work is planned at one of our spoke sites targeting areas of known deprivation. This activity will focus on analysing the drivers of patient 'Did Not Attend' by deprivation, including appointment timing, specialty, access issues and booking processes. Findings will be used to pilot interventions, including enhanced reminders and flexible booking arrangements for patients from the most deprived groups.	**Closed**
4	July 2026	33-26	Integrated quality and performance report	More detailed analysis of the Better Value Programme (BVP) shortfall to be provided within the next version of the IQPR narrative.	**HC/RD**	**September 2026**	August 2026: Summary of the schemes that are contributing to the BVP shortfall have been included in the Month 03 Cost Improvement update.	**Closed**

Report cover-page					
References					
Meeting title:	Board of Directors				
Meeting date:	16/09/2026	**Agenda reference:**	**62-26**		
Report title:	Chair's report				
Sponsor:	Angela McNab, interim Trust Chair				
Author:	Angela McNab, interim Trust Chair				
Appendices:	None				
Executive summary					
Purpose of report:	To update the Board of Directors on Chair, non-executive director and governor activities since the last meeting.				
Summary of key issues	• Board approval of the Memorandum of Understanding establishing the strategic partnership between Ashford and St Peter's Hospitals NHS Foundation Trust, Royal Surrey NHS Foundation Trust and Queen Victoria Hospital NHS Foundation Trust. • Progress in implementing the strategic partnership, including development of governance, leadership and oversight arrangements. • Appointment of Tamara Everington as Managing Director of QVH. • Recruitment of the Group Chair and QVH Deputy Chair, led by the Council of Governors' Appointments Committee. • Governor involvement in stakeholder engagement panels supporting the recruitment of the Group Chief Executive and Group Chair. • Recognition of Abigail Jago's contribution to QVH at her final Board meeting prior to taking up the role of Chief Executive at North Middlesex University Hospital and Community Services. • Continued engagement with staff through Chair visits to clinical services and recognition of colleagues through the QVH Star Awards.				
Recommendation:	The Board is asked to **note** the contents of the report.				
Action required	Approval	**Information**	Discussion	Assurance	Review
Link to key strategic objectives (KSOs):	**KSO1:** ***To deliver outstanding care***	**KSO2:** ***To innovate and improve***	**KSO3:** ***To be an excellent employer***	**KSO4:** ***To deliver sustainable services***	**KSO5:** ***To collaborate with others***
Implications					
Board assurance framework:	None				
Organisational risk register:	None				
Regulation:	None				
Legal:	None				
Resources:	None				
Assurance route					
Previously considered by:	NA				
	Date:		Decision:		
Next steps:	NA				

Report to:	Board of Directors
Agenda item:	62-26
Date of meeting:	9 September 2026
Report from:	Angela McNab, interim Trust Chair
Report author:	Angela McNab, interim Trust Chair
Date of report:	16 September 2026
Appendices:	None

Chair's report

Introduction

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

The reporting period has been marked by significant progress in the implementation of the Trust's strategic partnership following approval of the Memorandum of Understanding by the partner Boards in July. The report also provides an update on leadership and governance developments across the partnership, governor involvement in a number of significant appointments processes and continued engagement with staff and stakeholders.

I have continued my programme of visits across the Trust, including visits to the Minor Injuries Unit, Rehabilitation Services and Outpatients Department. I am grateful to colleagues for taking the time to share their experiences and demonstrate the high standard of care being delivered across our services. A further visit to Theatres is planned later this month.

As this is my final meeting as Interim Chair of QVH, I would like to take the opportunity to thank Board members, governors, colleagues and stakeholders for their support during my tenure. It has been a privilege to serve the Trust during a period of significant change and opportunity. I am particularly grateful for the commitment and professionalism shown by colleagues across QVH in continuing to deliver outstanding care for patients while supporting the development of the Trust's strategic partnership and future leadership arrangements.

Board of Directors

On 23 July 2026, the Board of Directors approved the Memorandum of Understanding establishing the strategic partnership between Ashford and St Peter's Hospitals NHS Foundation Trust, Royal Surrey NHS Foundation Trust and Queen Victoria Hospital NHS Foundation Trust. I was pleased that governors were able to attend the public meeting and observe the Board's consideration of this important decision.

Since approval of the Memorandum of Understanding, the focus of the partner organisations has moved from development of the proposals to implementation of the agreed arrangements. I have continued to work closely with colleagues across the partnership as governance structures, leadership arrangements and programme oversight mechanisms are established.

Alongside implementation of the partnership arrangements, work has also progressed in relation to the recruitment of the future Group Chair and QVH Deputy Chair. These appointments will be important in providing long term leadership and governance arrangements for both the partnership and the Trust.

A significant milestone during the reporting period has been the appointment of Tamara Everington as Managing Director of QVH. Previously serving as Chief Medical Officer, Tamara will provide executive leadership for the Trust as we continue to develop our strategic partnership. I would like to congratulate Tamara on her appointment and wish her every success in her new role.

This meeting also marks the final Board meeting of Abigail Jago as Chief Executive of QVH. Abigail leaves the Trust to take up the role of Chief Executive of North Middlesex University Hospital and Community Services within the Royal Free London Group. On behalf of the Board, I would like to place on record our sincere thanks for her leadership, dedication and commitment to QVH. Abigail has led the organisation through a period of significant change, whilst maintaining a clear focus on the delivery of high-quality patient care and securing the Trust's future through the development of the strategic partnership. We wish her every success in her new role and thank her for the lasting contribution she has made to QVH.

Staff Recognition
On 10 July, I was delighted to host the QVH Star Awards, my first awards ceremony as Chair. The event provided a wonderful opportunity to celebrate the dedication, skill and compassion of colleagues from across the Trust and to recognise the outstanding contribution they make every day in delivering high-quality care and services for our patients.

Alongside Abigail Jago, I was proud to present the Chair and Chief Executive Award for Outstanding Contribution, recognising an individual or team that had made an exceptional impact on patients, colleagues and the wider organisation. The awards showcased the breadth of talent, commitment and professionalism that exists throughout QVH and served as a powerful reminder of the values that underpin the Trust's success.

I would like to offer my congratulations to all nominees and award winners and to thank everyone involved in organising such a successful and enjoyable event. The evening was a fitting celebration of the people who make QVH such a special organisation.

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

Governors have remained closely involved in a number of significant developments during the reporting period. Following the approval of the Memorandum of Understanding in July, governors have continued to receive updates regarding implementation of the strategic partnership and have maintained a strong interest in the future governance and leadership arrangements.

The Council of Governors' Appointments Committee is currently leading the recruitment process for the Group Chair and the QVH Deputy Chair. I would like to thank governors involved in this work for the considerable time and commitment they are contributing to these important appointments.

Governors have also played an important role in the recruitment processes for the Group Chief Executive and Group Chair through participation in stakeholder engagement panels. Their involvement has helped ensure that the perspectives of members, patients and local communities have informed these appointments and

demonstrates the valuable contribution governors make to the Trust's leadership and governance arrangements.

I remain grateful for the continued support, challenge and engagement provided by governors as the organisation moves into the next phase of its development.

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

Queen Victoria Hospital
NHS Foundation Trust

Report cover-page					
References					
Meeting title:	Board of Directors				
Meeting date:	16/09/26	**Agenda reference:**	**63-26**		
Report title:	Chief Executive Officer (CEO) report				
Sponsor:	Abigail Jago, Acting Chief Executive Officer				
Author:	Kathy Brasier, Deputy Chief Strategy Officer, Allison Hunter, Strategy Support Officer				
Appendices:	None				
Executive summary					
Purpose of report:	To update on key developments, achievements and risks since the last Board meeting.				
Summary of key issues	QVH continues to perform strongly across a number of key areas, including the delivery of high-quality patient care, urgent care performance, and achievement of the year-to-date financial plan. Notably, the Trust achieved the joint highest overall patient experience score in England in the latest Care Quality Commission (CQC) Adult Inpatient Survey as well as performing well in the cancer survey, reflecting the commitment, expertise and compassion of staff. Challenges remain in recovering planned care access standards. Sustained growth in demand for Sleep, Oral and Maxillofacial Surgery (OMFS) and skin continues to drive waiting list growth and impact performance. Whilst early signs of improvement are evident in some areas, further progress is required to deliver agreed trajectories and improve timely access to care. Demand growth remains a risk. Progress continues in delivery of strategic priorities, aligned with the ambitions of the NHS 10 Year Health Plan. Key developments include mobilisation for the implementation of a new Patient Administration System (PAS), which will strengthen digital capabilities and progress also continues on the Community Diagnostic Centre (CDC), which will increase diagnostic capacity and improve access for patients, although the opening is now scheduled for November due to construction delays. A significant milestone has been reached in the development of the Strategic Partnership with Ashford and St Peter's Hospitals NHS Foundation Trust and Royal Surrey NHS Foundation Trust, with a Memorandum of Understanding now in place. This provides a strong foundation for deeper collaboration supporting long term service sustainability. Key organisational future risks relate to operational recovery, financial sustainability, infrastructure resilience and organisational resilience as we transition to the partnership. Whilst overall risk scores remain broadly unchanged focus continues on accelerating risk mitigation.				
Recommendation	The Board is asked to **NOTE** the contents of the report.				
Action required	Approval	**Information**	Discussion	Assurance	Review
Link to key strategic objectives (KSOs):	**KSO1:**	**KSO2:**	**KSO3:**	**KSO4:**	**KSO5:**
	To deliver outstanding care	***To innovate and improve***	***To be an excellent employer***	***To deliver sustainable services***	***To collaborate with others***
Implications					
Board assurance framework:	All				
Organisational risk register:	All				
Regulation:	None				
Legal:	None				
Resources:	Resource impact as identified within the report.				
Assurance route					

Report to:	Board Directors
Agenda item:	63-26
Date of meeting:	16 September 2026
Report from:	Abigail Jago, Acting Chief Executive Officer
Report author:	Abigail Jago, Acting Chief Executive Officer Allison Hunter, Project Support Officer Kathy Brasier, Deputy Chief Strategy Officer
Date of report:	09 September 2026
Appendices:	None

Chief Executive Officer (CEO) report

Alert

- **Financial Position:** QVH remains on track against the financial plan. However there remains risk in 2026/27 due to a gap in the Better Value Cost reduction programme. Work is ongoing led by the Interim Chief Finance Officer to develop and deliver schemes to close the remaining gap.
- **Planned Care Performance:** Performance against plan remains variable. Cancer 62-day performance is improving and is expected to recover in September through planned workforce and capacity interventions. RTT performance remains behind trajectory, with activity delivery above plan in several key services. DMO1 remains the most challenged area due to Sleep diagnostics. Confidence is highest in cancer recovery and moderate in RTT recovery, with further actions underway to address demand growth.
- **Organisational Risk:** Key organisational future risks relate to operational recovery, financial sustainability, infrastructure resilience and organisational resilience as we transition to the partnership. Whilst overall risk scores remain broadly unchanged focus continues on accelerating risk mitigation.
- **Major Projects:** The Community Diagnostic Centre will now open in November due to construction delays. The programme will increase diagnostic capacity and improve access for local patients.

Assure

- **Capital Delivery:** Delivery of the 2026/27 capital programme is progressing within the expected financial envelope and will support further reduction in high level estates risks through critical estates funding, alongside accelerating the next phase of the Trust's digital transformation programme. The Trust has applied for capital funds to deliver projects across the Trust. Funding has been confirmed for key areas, including estates safety work. Digital funding remains outstanding. The Patient Administration System (PAS) replacement programme remains subject to funding uncertainty and continues to be closely monitored.
- **Delivery of Key Strategic Objectives (KSOs):** The Trust continues to make progress against its KSOs during 2026/27. Directorate triumvirate teams have developed deliverable objectives, against the agreed strategic priorities, including the development of the teledermatology pathway and expansion of the Local Anaesthetic Unit.
- **Strategic Partnership:** Following more than seven months of collaborative planning, analysis and assurance work, the Boards of all three trusts have approved QVH joining the Ashford and St Peters Hospital NHS Foundation Trust and Royal Surrey Foundation Trust (ASPH/RSFT) group representing an important milestone. The Memorandum of Understanding (MoU) between the three organisations, which sets out how we will work together and governance arrangements, has been signed and came into effect from 23 July. Alongside the MoU, the Boards have agreed the proposed leadership arrangements which include a shared CEO and Chair, QVH Deputy Chair and QVH Managing Director. A benefits realisation framework is being developed across the group to identify, monitor

and deliver clinical, operational and financial benefits arising from the partnership arrangements.
- **Urgent and Emergency Care:** performance remains consistently above national standards.

Advise
- **Appointment:** Tamara Everington, our Chief Medical Officer, has been appointed as QVH Managing Director and we are working together to ensure a smooth handover and continuity of leadership.
- **Survey Results:** QVH achieved the joint highest overall patient experience score in England in the latest CQC Adult Inpatient Survey, with patients rating their overall experience 9.3 out of 10 compared to the national average of 8.2 out of 10. QVH also achieved positive results in the 2025 National Cancer Patient Experience Survey, achieving on overall rating of 8.9 out of 10, with most measures meeting or exceeding expectations
- **Communication and Engagement:** Communications and engagement has continued as plans progress to expand the existing Ashford and St Peter's Hospitals NHS Foundation Trust (ASPH) and Royal Surrey NHS Foundation Trust group (RSFT) to include QVH. Activity has focused upon the communication of the July Board meeting outcome and leadership changes, ensuring consistent messaging and timely updates for staff, governors and stakeholders.

National and Local Updates

Health Secretary

The Right Honourable Yvette Cooper was appointed Secretary of State for Health and Social Care on 20 July 2026. She was previously Secretary of State for Foreign, Commonwealth and Development Affairs.

National Director of Patient Experience

NHS England has appointed a charity Chief Executive Officer to the new role of National Director of Patient Experience. National Voices Chief Executive Jacob Lant will take up the role in the autumn and will oversee the creation of a new 'patient experience directorate' across NHSE and the Department of Health and Social Care.

National Quality Strategy

The National Quality Strategy for NHS-funded care, published in July 2026, provides a structured approach to making quality the organising principle of NHS-funded care in England over the next decade. It sets out a shared approach to quality across three interdependent domains: safety, effectiveness and experience, recognising all three must improve together to deliver consistently high-quality care. It seeks to improve health outcomes, reduce health inequalities, and increase patient satisfaction through a system-wide approach to quality improvement. In August 2026, this was supplemented by Quality Management Systems (QMS) implementation guidance, providing practical support in a consistent and systematic way.

Quality and Safety

Quality Priorities

All three Quality Priorities are progressing in Quarter 1, including strengthening the Trust's approach to clinical outcomes through sharing internal best practice, health inequalities reporting and Patient School provision, while enhancing the infrastructure and governance needed to improve patient care.

Access to care

Cancer: Faster Diagnosis Standard (FDS) has been challenged in July and August as expected primarily due to skin service pressures. Early indications demonstrate an improving position for September, as planned, following interventions including pathway improvements and addressing capacity constraints in key areas such as teledermatology. 62 day performance was behind plan in July and August driven by a material increase in demand; performance would have been on track if demand was in line with previous trend. A September improvement is expected. 31Day performance remains on track.

Referral to Treat (RTT): RTT remains challenged. The total waiting list size continues to be above plan, however the rate of increase is reducing on a month by month basis. Plastic Surgery, Orthodontics and Ophthalmology remain broadly aligned to planned waiting list trajectories. The overall variance is primarily driven by Sleep and Oral maxillo facial surgery (OMFS). Sleep continues to deliver activity above plan, however, sustained referral growth has outweighed these gains and resulted in continued waiting list growth. Recovery actions include further capacity expansion and productivity improvements.

DMO1: Performance remains behind plan driven by sleep demand. Work continues to optimise and increase capacity to address the shortfall. Commissioner conversations are in progress.

Adult Inpatient Survey

I am delighted to share that Queen Victoria Hospital has achieved the joint highest overall patient experience score in England in the latest Care Quality Commission (CQC) Adult Inpatient survey.

The survey asked patients across 130 acute and specialist NHS trusts about their experience of care. Patients rated their overall experience at QVH **9.3 out of 10**, compared with a national average of 8.2 out of 10. The results show that patients felt they were treated with kindness, compassion, dignity and respect. This is something everyone at QVH should be incredibly proud of as it reflects the professionalism, skill and dedication shown by colleagues across the Trust every day.

National Cancer Patient Experience Survey

The National Cancer Patient Experience Survey (NCPES) 2025 which was published in July highlighted positive patient experiences at QVH, with an overall care rating of **8.9 out of 10** and 98% of patients saying they were always treated with respect and dignity whilst in hospital. Six areas, including communication, involvement in care, emotional support and dignity and respect, scored significantly above expectations.

Workforce

The Management Essentials programme and Resilience and Change Management workshops continue to be delivered. Coaching and mentoring is taking place across various teams. Culture review work is underway with a number of teams across the trust to support team cohesion and foster better working relationships.

There is an enhanced focus on appraisal completion, led by the executive leadership team and senior managers to ensure staff have time with their managers to review objectives and discuss development needs, opportunities and wellbeing.

Following publication of the NHS Staff Survey results, Executive-led engagement sessions have been undertaken across the Trust to better understand areas of concern and develop targeted improvement plans. Key themes include workforce capacity, communication, leadership visibility, wellbeing and recognition. Actions are now being progressed through

directorate governance arrangements, with regular oversight through the Strategy and Culture Committee.

National recognition for support to the Armed Forces community
In July, the Trust received the Defence Employer Recognition Scheme (ERS) Silver Award, recognising its commitment to supporting reservists, veterans, military families and the wider Armed Forces community. This builds on the trust's Veteran Award accreditation, ERS Bronze Award and signing of the Armed Forces Covenant in 2023.

In August, the Trust further strengthened this commitment by beginning to host the local Veterans Breakfast Club, providing a regular opportunity for veterans, serving personnel and military families to connect and access community support.

Celebrating our QVH Team

QVH Star Awards
In July, we held our annual QVH Star Awards, celebrating the exceptional contribution of colleagues and volunteers across the Trust. Supported by the Queen Victoria Hospital Charity, the awards attracted more than 300 staff nominations and over 60 patient nominations for the Outstanding Patient Experience Award, recognising individuals and teams who exemplify our values through outstanding patient care, teamwork, leadership, innovation and service improvement.

The evening also celebrated educational and professional achievements, many supported through bursaries from the League of Friends of Queen Victoria Hospital and Queen Victoria Hospital Charity. Colleagues were recognised for between 25 and 45 years of NHS service, representing a remarkable 1,315 years of service collectively. We also presented the inaugural Bob Marchant Award, supported by the League of Friends of Queen Victoria Hospital and established in memory of Bob Marchant, whose association with QVH spanned almost 70 years. The award recognises an individual who demonstrates the loyalty, dedication and commitment that Bob embodied throughout his life and service to the hospital.

The awards highlighted the commitment, expertise and compassion that underpin the high-quality care we provide for patients every day. As this was my final Star Awards as Chief Executive, it was a particular privilege to celebrate the people who make QVH such a special organisation.

Values in Practice (VIP) Award Winners
Our Values in Practice (VIP) Awards continue to celebrate colleagues who exemplify our values and make a positive contribution to the culture, teamwork and success of the Trust.

Our June VIP Award joint winners were Helen Newman, Theatres Manager and Marc Gough, Estates Officer. Recognised for their response during the first heatwave of the year, their proactive management of theatre temperatures and humidity helped ensure patient services continued safely while many organisations experienced disruption. Helen demonstrated being supportive and challenging, while Marc embodied succeeding together over achieving alone, with their leadership, expertise and collaboration supporting the best possible outcomes for patients and colleagues

Our July VIP Award winner was Drashti Patel, Healthcare Science Practitioner, who was recognised for demonstrating our value of succeeding together over achieving alone. During a particularly busy period, Drashti went above and beyond to support colleagues, maintain an efficient laboratory service and help deliver high quality patient care. Her professionalism, positivity and commitment to teamwork have made her a highly valued member of the Histopathology team.

Regional recognition for Community Diagnostic Centre innovation

The innovative work taking place within our Community Diagnostic Centre received regional recognition in July when Ollie Charman, Service Manager, was selected as one of NHS England South East's 78 Faces of the NHS. The campaign celebrates colleagues whose work is helping to deliver the NHS 10 Year Health Plan, with Ollie recognised for his leadership in developing innovative diagnostic pathways that are improving patient access, experience and outcomes.

Connection with Teams

I have enjoyed continuing to visit and connect with teams across the period. During visits with colleagues in Finance and Procurement, we had positive discussions about the Trust's future direction and partnership plans, with staff recognising opportunities for collaboration and procurement benefits. Colleagues also shared feedback on the importance of clear communication around estates works and maintaining a supportive working environment. It was particularly encouraging to hear that the Procurement team felt well informed about Trust business and engaged with the opportunities ahead, reflecting a shared commitment to supporting QVH's future ambitions while continuing to deliver high-quality services.

Leadership Changes

I would like to thank Kirsten Timmins, who left QVH in mid-August, for her contribution as Chief Operating Officer. On behalf of colleagues across the Trust, I wish her every success for the future.

Kathy Brasier, Acting Chief Strategy Officer, will provide executive leadership for the operational team in the coming months, working closely with Ashley Hunt, Deputy Chief Operating Officer.

I am delighted to share that Tamara Everington has been appointed as Managing Director at Queen Victoria Hospital. Tamara will take up the position before my departure, ensuring a smooth handover and continuity of leadership.

As this is Angela McNab's final Board meeting as Interim Chair of QVH, I would like to take the opportunity to thank her for her significant contribution to the Trust in this capacity. Angela has provided strong and effective leadership during an important period for the organisation, supporting the Board and Executive team as we have progressed a number of key strategic priorities. I am personally grateful for the support, guidance and constructive challenge and would like to express my sincere thanks.

Closing Remarks

As this is my final report as Acting Chief Executive Officer, I would like to thank QVH colleagues, Governors**,** Board members and external stakeholders for their support throughout a period of significant organisational transition. Together, we have navigated a significant period in our history, focusing on stabilising the organisation and laying the foundations for our future through our partnership work. I am immensely proud of what we have achieved, and of the commitment, compassion and professionalism I see across our teams every day.

Looking ahead, I am confident that QVH is well placed for the future. The organisation has a strong reputation for delivering outstanding specialist care, a committed workforce and a clear strategic direction. The strategic partnership arrangements provide an important opportunity to strengthen services, improve sustainability and build on the unique strengths of the Trust for the benefit of patients, staff and local communities.

QVH has been an important part of my professional life for many years and means a great deal to me personally. I would like to sincerely thank all our staff and volunteers for your dedication, resilience and commitment to our patients and to each other. It has been an honour to work alongside such talented and caring people and a privilege to serve as Acting Chief Executive Officer**.**

Recommendation
The Board is asked to:

- **NOTE** the contents of the report

Report cover-page					
References					
Meeting title:	Board of Directors				
Meeting date:	16/09/2026	**Agenda reference:**	**64-26**		
Report title:	Integrated Quality and Performance Report Month 3				
Sponsor:	Kathy Brasier, Acting Chief Strategy Officer				
Author:	Allison Hunter, Strategy Support Officer				
Appendices:	Appendix – Integrated Quality and Performance Report (IQ&PR) M3 slide pack				
Executive summary					
Purpose of report:	To discuss the Month 3 Integrated Quality and Performance Report 2026/27				
Summary of key issues	**KSO 1** – **To deliver outstanding care:** RTT, Cancer and Diagnostic standards remain below trajectory, driven by sustained demand growth within Sleep, OMFS, Skin and Head & Neck services. Waiting list growth remains above plan, although improvements were seen in clock-stop delivery, elective throughput and reductions in both the >65 and >78 week cohorts during Month 3. **KSO 2** – **To innovate and improve:** Research, innovation and continuous improvement programmes continue to support service transformation, productivity and clinical effectiveness. Key developments include progress with the RI&E Centre, expansion of the research pipeline and delivery of QVH Way projects generating operational, quality and financial benefits. **KSO 3** – **To be an excellent employer:** Workforce metrics remain broadly stable, with vacancy rates reducing and appraisal and mandatory training compliance improving. Key performance issues remain sickness absence levels above target, workforce turnover pressures and continued reliance on bank staffing within operational services. **KSO 4** – **To deliver sustainable services:** The Trust delivered its planned Month 3 financial position with a £0.34m year-to-date deficit in line with plan and achieved its efficiency target. Key issues include underperformance against activity and income plans in CDC and selected specialties, delivery of the full-year Better Value Programme, and management of key programme risks across Digital Transformation, CDC, Estates Infrastructure and Sussex Pathology Network programmes. **KSO 5** – **To collaborate with others:** Strategic Partnership implementation remains on track, with assurance processes progressing across partner organisations. Work continues through the Provider Collaborative programme to develop Single Point of Access pathways, improve access arrangements and support future service transformation opportunities.				
Recommendation:	Trust Board is requested to review the Month 3 IQ&PR position				
Action required	Approval	Information	Discussion	Assurance	**Review**
Link to key strategic objectives (KSOs):	**KSO1:**	**KSO2:**	**KSO3:**	**KSO4:**	**KSO5:**
	To deliver outstanding care	***To innovate and improve***	***To be an excellent employer***	***To deliver sustainable services***	***To collaborate with others***
Implications					
Board assurance framework:	BAF 4- long term sustainability (the IAF supports the delivery of the Trust's strategy BAF5- compliance (addresses the well led review recommendations, supports the implementation of continuous improvement methodology				

Organisational risk register:	CRR – organisational risk register in development			
Regulation:	ICS, NHS England, CQC			
Legal:	None			
Resources:	None			
Assurance route				
Previously considered by:	Executive Leadership Team, Quality & safety committee, Finance & performance committee			
	Date:	10.08.26/01.09.26	Decision:	On to Trust Board
Next steps:				

Queen Victoria Hospital
NHS Foundation Trust



Queen Victoria Hospital

Integrated Quality and Performance Report

Month 3: June 2026

BALANCED SCORECARD

Queen Victoria Hospital
NHS Foundation Trust

Priority Metrics	M12 target	Latest month	Planned trajectory in month	Actual performance in month	Previous Month	Summary	Confidence in delivery (RAG)
Breakeven YTD	£0.63m (deficit)	Jun-26	£0.34m (deficit)	£0.34m (deficit)	£0.61m (deficit)	The Trust's Income and Expenditure position was in line with the plan in month	
RTT 18 Week Wait Performance	69.4%	Jun-25	63.2%	62.32%	62.26%	Not achieving target in month and Q1.	
Cancer 62 days	80%	May-26	75.9%	75.00%	71.43%	Not achieving target. Common cause – no significant change	
% Overall FFT Recommendation Rate	90%	Jun-26	90%	94.90%	95.10%	Achieving target. Special cause - concerning variation.	
Trust sickness rate – Rolling 12 months	3.8%	Jun-26	3.9%	4.42%	4.39%	Not achieving target in month. Special cause - concerning variation.	

Major Project	This Month	Overall Status	Last Month	Summary
To deliver the Community Diagnostic Centre (CDC) programme at East Grinstead		On track		Timeline for October is tight. Site handover date confirmed however there is a short window to opening.
Strategic Partnership Transition and Implementation		On track		Strategic Partnership continues to progress at pace following a period of shared planning, analysis, and assurance.
To deliver the **Digital Transformation** Programme		On track		Prioritised projects all progression. Financial risk to programme sustainability from December 26.
To deliver the **Key Estates Infrastructure Projects (MRI scanner, RI&E Hub)**		On track		Task and finish groups established for both MRI and RI&E Centre. Designs commissioned.

CEO SUMMARY

Queen Victoria Hospital
NHS Foundation Trust

Alert

- Delivery of KSO 1 (Outstanding Care) remains challenged by continued underperformance against key elective, diagnostic and cancer standards. RTT performance was 62.3% against a trajectory of 63.2%, with the waiting list increasing to 21,893 pathways, primarily driven by sustained referral growth within Sleep and OMFS services. Whilst waiting list pressures remain, growth slowed during June as clock stop delivery increased.
- Long wait performance improved during the month, with reductions in both the 78-week and 65-week cohorts. However, the size of the 40-51 week cohort continues to present a risk to future RTT performance and remains a key area of focus.
- Diagnostic performance achieved 86.7% against a trajectory of 91.0%, with underperformance predominantly driven by Sleep Diagnostics where increased demand continues to exceed available capacity. Cancer performance remains under pressure, with urgent suspected cancer referrals increasing by 15.2% year to date. Rising demand, outpatient capacity constraints and diagnostic delays within Skin and Head & Neck services continue to impact delivery of both the Faster Diagnostic Standard (FDS) and 62-day cancer standard.
- Development of the East Grinstead Community Diagnostic Centre continues to progress. There is a risk of a short delay which is being worked through with contractors. The CDC will play an important role in supporting future diagnostic capacity, pathway redesign and neighbourhood-based care, directly contributing to delivery of KSO 4 (Sustainable Services).

Assure

- The Board can be assured that there remains significant organisational focus on addressing these challenges through strengthened performance management arrangements and targeted recovery interventions. Delivery is being closely monitored through the Trust's performance framework, including direct Chief Executive oversight of performance meetings, ensuring clear accountability for recovery actions and timely escalation of risk.
- There are encouraging signs of improvement. Clock stop delivery exceeded trajectory during June and elective throughput increased, supporting recovery across several specialties. Theatre productivity was adversely impacted by increased trauma demand, a rise in on-the-day cancellations and periods of exceptionally high temperatures that resulted in humidity-related challenges within theatre. With theatre activity increasing from 1,021 procedures in May to 1,146 in June. Weekly productivity reviews, specialty exception reporting and implementation of the standby patient pathway continue to support delivery of KSO 4 (Sustainable Services) through improved utilisation of available capacity.
- Diagnostic services outside Sleep continue to perform strongly, with MRI, Ultrasound, DEXA and Neurophysiology services maintaining excellent performance.
- Progress against the Trust's strategic priorities continues. Work to advance the proposed Strategic Partnership is progressing at pace and remains on track. This represents a significant enabler for delivery of KSO 5 (Collaboration with Others), supporting greater resilience, service sustainability and opportunities for future development through partnership working. Preparation for the PAS development is also continuing to plan.

Advise

- Delivery of specialty recovery plans across Plastics, Sleep and OMFS remains a key priority during Quarter 2. Whilst recovery actions have been identified, continued pace of implementation and benefit realisation will be critical to improving RTT, long wait and diagnostic performance and supporting delivery of KSO 1 (Outstanding Care).
- The Trust will maintain a particular focus on outpatient capacity, diagnostic recovery, theatre productivity and pathway redesign, alongside targeted interventions within Skin and Head & Neck cancer pathways. Continued collaboration with commissioners, Cancer Alliance partners and referring organisations will be essential to managing sustained demand growth and supporting recovery of cancer standards, whilst also advancing delivery of KSO 5 (Collaboration with Others).
- Overall, whilst performance against a number of access and cancer standards remains below plan, there are encouraging signs of operational improvement. The recovery actions underway are directly aligned to delivery of KSO 1 (Outstanding Care) through improved access and outcomes, KSO 4 (Sustainable Services) through productivity, CDC development and sustainable service delivery, and KSO 5 (Collaborations with Other) through the Strategic Partnership and wider system collaboration. The Board can be assured that these priorities are receiving sustained executive attention, supported by CEO-led oversight and targeted interventions to accelerate recovery and support delivery of the Trust's strategic objectives.

Abigail Jago
Acting Chief Executive Officer

Queen Victoria Hospital
NHS Foundation Trust

KSO1

To deliver outstanding care

Ambition

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

Board Assurance Framework

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

2026/27 Annual Objectives

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

2026/27 Annual goals

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

KSO1 EXECUTIVE SUMMARY

Queen Victoria Hospital
NHS Foundation Trust

General summary
Month 3 continued to reflect pressure across a number of the Trust's key operational access standards, driven by sustained growth in referral demand and capacity constraints across several specialist services. RTT, Cancer and Diagnostic performance remain below trajectory, with the greatest impact continuing to be seen within Sleep, Skin and Head & Neck pathways. Despite these pressures, the Trust has maintained high levels of activity during the month, supporting reductions in both the 78-week and 65-week waiting cohorts and improvements in overall clock stop delivery.

Delivery of Access Targets

- The overall RTT waiting list increased to 21,893 pathways in M3 from 21,770 pathways in M2, against a planned position of 20,256. Whilst waiting list growth continued during June, the increase of 123 pathways was significantly lower than in previous months and reflects improved clock stop delivery and elective throughput. Variance against plan remains concentrated within Sleep and OMFS, with referral demand continuing to exceed planned assumptions. Recovery activity remains focused on increasing theatre and outpatient productivity, targeted waiting list validation, additional activity sessions and implementation of specialty recovery plans supporting Referral to Treatment (RTT) improvement through Q2 and Q3.
- Performance against the national long wait agenda improved during June, with the number of patients waiting over 78 weeks reducing from 13 to 9 and those waiting over 65 weeks reducing from 42 to 35. Whilst this demonstrates continued improvement, the Trust remains above trajectory for 52-week waits, with Plastics accounting for the majority of the remaining long-wait cohort. Recovery plans include additional theatre capacity, weekend operating lists, consultant-led recovery initiatives, standby patient pathways and recruitment into vacant clinical posts. Current trajectories indicate that all non-Breast patients are expected to be removed from the >65-week cohort by September 2026.
- Diagnostic performance remained below trajectory during Month 3, achieving 86.7% against a planned position of 91.0%. Underperformance continues to be driven almost entirely by Sleep Diagnostics. Whilst Sleep remains the principal constraint, performance across the wider diagnostic portfolio continues to be strong, with MRI, CT, Ultrasound, DEXA and Neurophysiology services performing at or near expected standards. Recovery work remains focused on increasing home testing capacity, pathway redesign, productivity improvements and demand management initiatives to improve compliance with the six-week standard.
- Cancer performance continues to be affected by rising urgent suspected demand, increasing treatment activity and operational pressures across Skin and Head & Neck services. Cancer Board reporting identified continued pressure across outpatient, diagnostic and treatment pathways alongside a year-to-date increase in urgent suspected cancer referrals. Recovery plans remain in place across all areas of variance and continue to be monitored through established governance arrangements.
- Theatre utilisation reduced to 80.1% in June from 81.6% in May, although activity increased to 1,146 procedures (May: 1,021). Variation in utilisation remains most evident within Corneo services, whilst Plastics continues to show sustained improvement. Weekly speciality utilisation reviews, implementation of the standby patient pathway and additional recovery activity are supporting improved throughput and form a key component of elective recovery plans.

Key Risk Summary:
Sustained referral growth within Sleep and Oral & Maxillofacial Surgery (OMFS) continues to drive waiting list growth above trajectory and remains the principal risk to delivery of RTT and diagnostic recovery plans. Plastics continues to represent the Trust's most significant long-wait risk, accounting for the majority of patients waiting over 52 weeks and a large proportion of the remaining 65-week cohort. Whilst recovery plans across Plastics and OMFS include additional theatre capacity, workforce recruitment, productivity improvements and targeted recovery activity, delivery remains dependent on successful implementation of these schemes and continued reduction of the 40–51 week cohort through Q2 and Q3.

Continued..

Kathy Brasier
Acting Chief Strategy Officer

Liz Blackburn
Acting Chief Nursing Officer

KSO1 EXECUTIVE SUMMARY

Queen Victoria Hospital
NHS Foundation Trust

Quality metrics

- Overall performance demonstrates a strong position in patient experience, safety, and staffing, alongside key areas requiring focused improvement. Patient experience remains excellent, with Friends and Family Test (FFT) at 95.1%, consistently above the national benchmark and reflecting high levels of patient satisfaction. The National cancer survey is due in July 2026 and the Care Quality Commission (CQC) inpatient survey results in August 2026.
- Safer staffing compliance is strong at 99%, with Trust care hours per patient day (CHPPD) appropriately reflecting acuity within specialist services such as Burns and Critical Care. Triangulation of staff feedback both formal and informal is collated alongside the Trust safety metrics.
- Ethnicity recording remains below expected levels at 84.7%, with limited improvement, particularly within Plastics.
- Complaint volumes remain elevated compared to the same period last year, with recurring themes relating to treatment and Trust administration.
- Venous thromboembolism (VTE) risk assessment compliance has a noted improvement to 93% which reflects the changes made to the criteria for inclusion for assessment. New exclusions have been approved by the Acting Chief Nursing Officer (ACNO) and Chief Medical Officer (CMO) and reflect the national guidelines.

Kathy Brasier
Acting Chief Strategy Officer

Liz Blackburn
Acting Chief Nursing Officer

KSO1 BALANCED SCORECARDS

QUALITY & SAFETY METRICS

Queen Victoria Hospital
NHS Foundation Trust

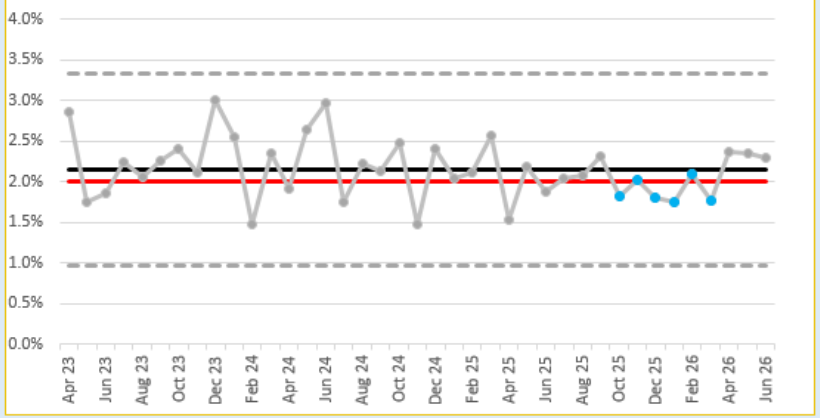
Metric	Latest Month	Target	Variation	Assurance	Actual	Actual Previous Month	Mean	LCL	UCL	Summary
Ethnicity recording	Jun-26	95%			84.44%	84.79%	81.49%	78.98%	83.99%	Special Cause - improving variation
Care Hours Per Patient Day (CHPPD)	Jun-26				11.3	12.1	13.21	10.21	16.21	Special Cause - concerning variation
Falls per 1,000 Occupied Bed Days	Jun-26	7			7.2	8.1	4.11	-3.07	11.29	Common cause - no signficant change
Hospital Aquired PU Per 1,000 Occupied Bed Days	Jun-26	0			1.2	1.4	0.78	-1.55	3.11	Common cause - no signficant change
% Complaints Responded On Time	Jun-26	90%			88.89%	90.00%	91.62%	65.60%	117.63%	Common cause - no signficant change
Safer Staffing Compliance	Jun-26	90%			99.52%	99.35%	99.64%	98.55%	100.74%	Common cause - no signficant change
% Overall FFT Recommendation Rate	Jun-26	90%			94.90%	95.10%	95.20%	94.42%	95.98%	Special Cause - concerning variation
% Overall FFT Response Rate	Jun-26	25%			19.17%	20.14%	20.37%	17.09%	23.64%	Common cause - no signficant change
Readmissions< 30 Days	Jun-26	2%			2.29%	2.36%	2.15%	0.97%	3.33%	Common cause - no signficant change
VTE Risk Assessment	Jun-26	95%			93.15%	91.72%	93.34%	82.26%	104.42%	Special Cause - concerning variation

Metric	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Apr-26	May-26	Jun-26
Number of Complaints	6	7	6	9	9	9	9	6	6	10	8	9	9	7	8
Number of Open CAS Alerts	0	0	0	1	0	0	0	1	1	2	1	1	1	1	0
Number of Patient Falls Incidents	1	5	4	5	4	1	2	2	2	1	3	1	5	6	6
Number of QVH Acquired Pressure Ulcers Cat. 2 and above	2	0	2	1	1	1	0	0	0	0	0	1	1	1	1
Never Events declared	0	1	0	0	0	0	0	1	0	0	0	0	0	0	0
Medication Incidents (No and low harm)	9	6	10	15	12	12	4	10	10	16	35	31	27	16	26
Medication Incidents (Moderate harm or above)	0	0	0	0	1	0	0	0	0	0	0	0	0	0	0
Internal Investigation declared	0	0	0	0	1	0	0	0	1	1	0	0	0	0	1
Patient safety incident investigations declared	0	0	1	0	0	0	0	0	0	0	0	0	0	0	0
Mortalities	1	0	0	1	0	0	0	0	0	0	0	0	0	0	0
Hospital Acquired CDI, MRSA, E.Coli, MSSA	0	1	0	1	0	0	0	0	0	0	0	0	0	0	0
Occupied Bed Days	781	848	800	933	704	739	860	778	676	799	721	821	806	738	838
Oliver McGowan Training Compliance	91.9%	91.5%	91.8%	92.2%	92.4%	92.9%	92.4%	93.1%	93.1%	93.7%	93.3%	93.6%	93.9%	94.0%	94.3%

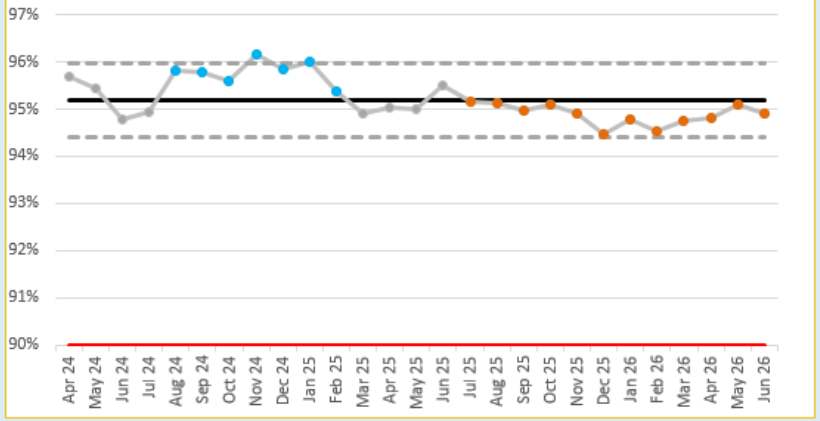
QUALITY & SAFETY METRICS

Queen Victoria Hospital
NHS Foundation Trust

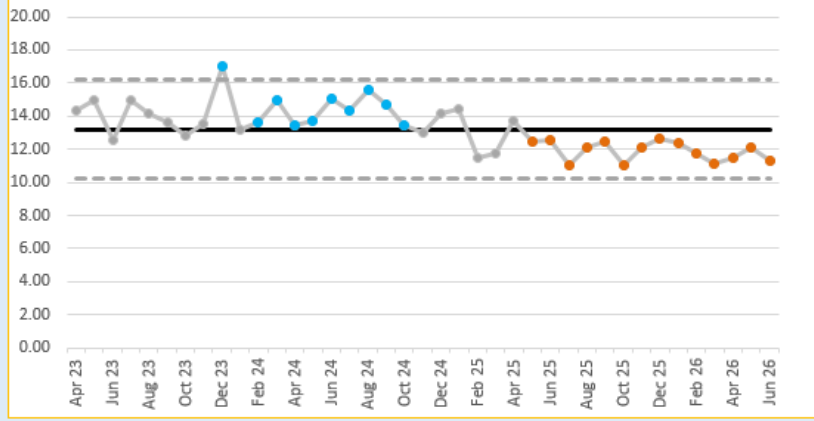
Readmissions< 30 Days



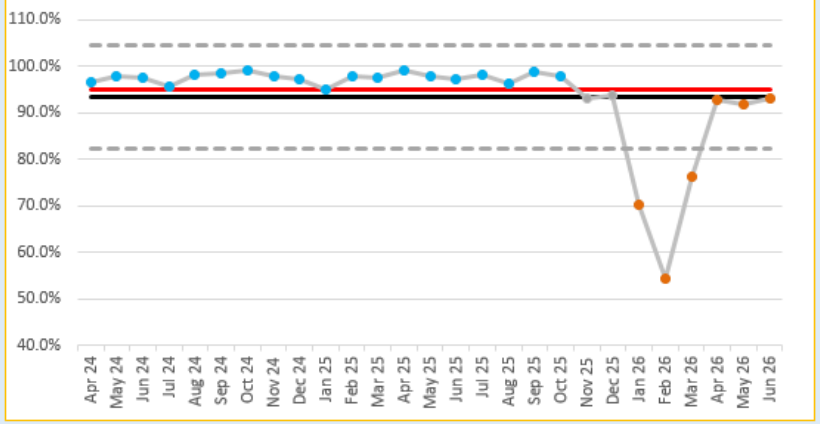
% Overall FFT Recommendation Rate



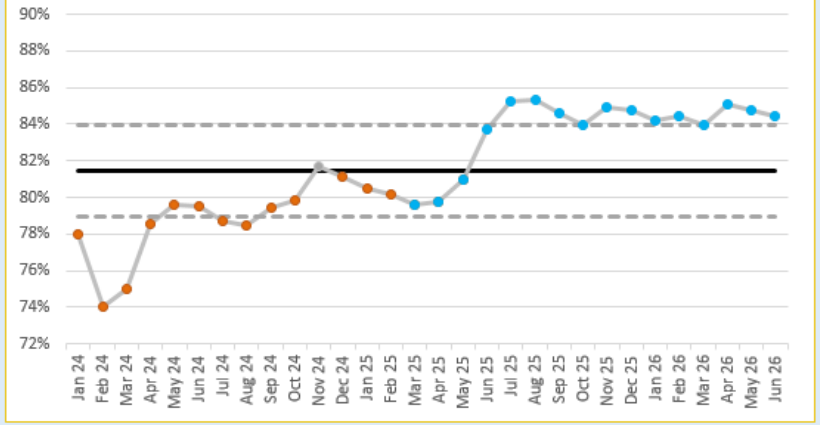
Care Hours Per Patient Day (CHPPD)



VTE Risk Assessment



Ethnicity Recording



Safer Staffing Compliance - Trust

	Planned staff			Actual staff			June 2026
DAY	RN	NA	HCA	RN	NA	HCA	
	3,772.00	161.00	1,391.50	3,737.50	161.00	1,380.00	*Total Hrs Planned and Actual*
				99.1%	100.0%	99.2%	*% Planned Hrs Met*
			5,324.50			5,278.50	*Total Hrs Planned & Actual - Combined reg & support*
						99.14%	*% Planned Hrs Met - Combined reg & support*
NIGHT	Planned staff			Actual staff			
	RN	NA	HCA	RN	NA	HCA	
	3,335.00	80.50	759.00	3,335.00	80.50	759.00	*Total Hrs Planned and Actual*
				100.0%	100.0%	100.0%	*% Planned Hrs Met*
			4,174.50			4,174.50	*Total Hrs Planned & Actual - Combined reg & support*
						100.00%	*% Planned Hrs Met - Combined reg & support*
Combined	Planned staff			Actual staff			
	RN	NA	HCA	RN	NA	HCA	
	7,107.00	241.50	2,150.50	7,072.50	241.50	2,139.00	*Total Hrs Planned and Actual*
				99.5%	100.0%	99.5%	*% Planned Hrs Met*
			9,499.00			9,453.00	*Total Hrs Planned & Actual - Combined reg & support*
						99.52%	*% Planned Hrs Met - Combined reg & support*

SPC Chart Key:

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

KSO1 AREAS OF FOCUS

Queen Victoria Hospital
NHS Foundation Trust

Area	Summary, impact, and actions
Ethnicity Recording	Recording remains at 84.4%, primarily due to lower completion rates within Plastics. Targeted actions are in place, including focused engagement with Plastics teams to address local barriers, strengthened accountability through regular performance reporting, and reinforcement of ethnicity data capture within routine admission and outpatient processes. Progress continues to be closely monitored to drive sustained improvement.
Falls	6 falls in total. 5 inpatient falls with no harm noted. Development of Fall Oversight Group to capture after action reviews and themes. 1 fall in the car park resulting in moderate harm, not RIDDOR (reporting of injuries, diseases and dangerous occurrences regulations) reportable. Immediate review of environment and actions in place. Regular contact with patient made.
Pressure ulcers	One hospital acquired grade two pressure ulcer noted in month which is medical device related. Full investigation complete and feedback given to staff.
% Complaints Responded On Time	8 complaints were received, with a compliance of 88.9%, this is due to a delay with one complaint that required clinical input.
Safer Staffing Compliance / Care Hours Per Patient Day (CHPPD)	Our safer staffing compliance is at 99.5%, and Trust CHPPD 11.3. This data is triangulated with both formal (staff survey and pulse survey) and informal feedback. Staff are reporting feeling tired and burned out. Bank shifts to cover sickness is not being filled and is noted. The following actions have been identified: • Undertake a focused review of areas reporting highest levels of tiredness and burnout. • Triangulate sickness, turnover, overtime, annual leave, and wellbeing data at ward/service level. • Conduct targeted staff engagement sessions or "listening events" to better understand underlying pressures. • Promote and monitor uptake of wellbeing support services.
Never Events	None
Mortalities	None
% Overall FFT (Friends & Family Test) Recommendation Rate	Overall FFT recommendation rate is 94.9% and above the national target of 90%. This indicates a high level of patient satisfaction, with many of our patients reporting a positive experience and willing to recommend the hospital. This reflects strong patient confidence in the quality of care provided. The CQC inpatient survey results are due in August 2026.
Venous Thromboembolism (VTE) Risk Assessment	Compliance with VTE risk assessments has significantly risen to 93%, this reflects the changes made to the criteria for assessment and agreed exclusions for patients undergoing a local anaesthetic procedure.
Mental Capacity Act (MCA)	Ongoing monthly audit shows errors in Mental Capacity Act (MCA) assessments and associated consent processes. Feedback and learning loop established, new face to face training planned to also address legislative change in Deprivation of Liberty Safeguards practice. There is currently no confirmed commencement date for the Liberty Protection Safeguards (LPS). Deprivation of Liberty Safeguards (DoLS) remain in force. Following a Government announcement in October 2025, a national consultation on implementation of LPS is expected during 2026, after which a revised implementation timetable will be determined

KSO1 BALANCED SCORECARDS

Queen Victoria Hospital
NHS Foundation Trust

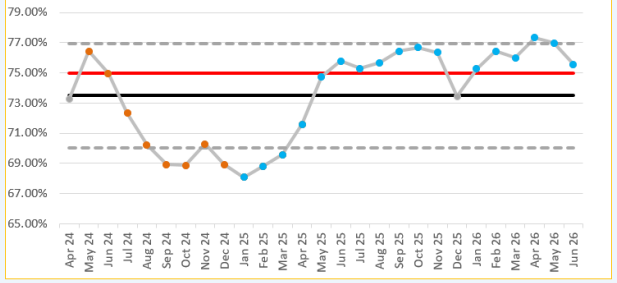
OPERATIONAL PERFORMANCE METRICS

Metric	Latest Month	Target	Variation	Assurance	Actual	Actual Previous Month	Mean	LCL	UCL	Summary
RTT 18 week wait performance - first appointment	Jun-26	75.00%			75.56%	76.98%	73.50%	70.04%	76.95%	Special Cause - improving variation
RTT 18 Week Wait Performance	Jun-26	69.40%			62.32%	62.26%	60.42%	57.64%	63.21%	Common cause - no signficant change
RTT Waiting List	Jun-26	-			21,893	21,770	18796.69	18022.63	19570.75	Special Cause - concerning variation
RTT >40 Weeks	Jun-26	-			1,358	1,417	1423.41	1253.94	1592.88	Special Cause - improving variation
RTT >52 Weeks	Jun-26	-			228	254	376.10	303.37	448.83	Special Cause - improving variation
RTT >52 Weeks as a proportion of Waiting List	Jun-26	1.00%			1.04%	1.17%	2.03%	1.67%	2.38%	Special Cause - improving variation
RTT >65 Weeks	Jun-26	-			35	42	58.00	25.73	90.27	Special Cause - improving variation
% CDC VWA vs plan	Jun-26	100.00%			85.11%	86.58%	85.59%	81.65%	89.53%	Common cause - no signficant change
% VWA vs plan	Jun-26	100.00%			88.55%	106.84%	97.92%	62.32%	133.52%	Common cause - no signficant change
Cancer 28 Day FDS	May-26	81.50%			81.45%	76.79%	81.86%	70.37%	93.35%	Common cause - no signficant change
Cancer 31 Days	May-26	94.00%			85.06%	83.76%	86.05%	76.19%	95.91%	Common cause - no signficant change
Cancer 62 Days	May-26	80.00%			75.00%	71.43%	77.28%	62.47%	92.09%	Common cause - no signficant change
Outpatient Productivity - Patient Initiated Follow Ups (PIFU)	Jun-26	2.00%			2.16%	1.80%	1.83%	1.28%	2.38%	Common cause - no signficant change
Outpatient Productivity - Missed Appointment Rate	Jun-26	4.00%			6.94%	1.11%	5.14%	3.79%	6.49%	Special Cause - concerning variation
Diagnostics 6 Week Wait Performance	Jun-26	92.00%			86.70%	87.66%	86.65%	79.14%	94.15%	Special Cause - improving variation
UEC 4 Hour Performance	Jun-26	98.00%			98.44%	98.96%	99.17%	97.68%	100.66%	Common cause - no signficant change
Theatre Productivity - % of Cancellations on the Day	Jun-26	5.00%			6.14%	3.31%	4.95%	1.08%	8.83%	Common cause - no signficant change
Theatre Elective Utilisation - QVH Site (Capped)	Jun-26	85.00%			80.11%	81.60%	82.09%	77.36%	86.81%	Special Cause - concerning variation
NHS App appointments available	Jun-26	70.00%			84.91%	85.18%	84.72%	83.09%	86.35%	Common cause - no signficant change

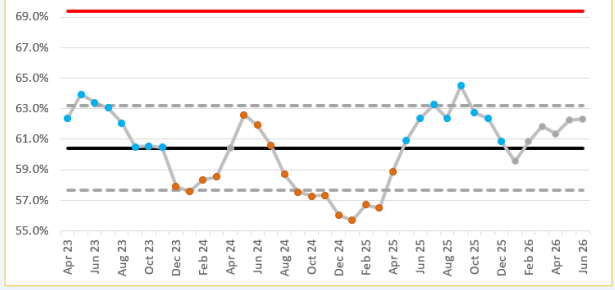
OPERATIONAL PERFORMANCE METRICS

Queen Victoria Hospital
NHS Foundation Trust

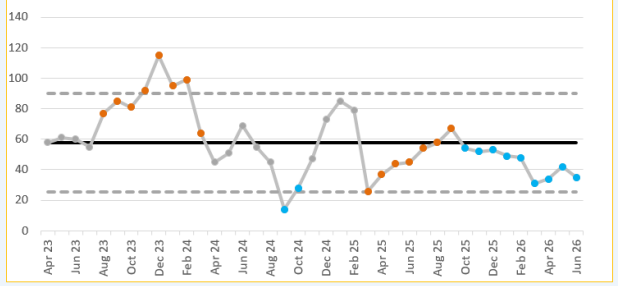
RTT 18 week wait performance - first appointment



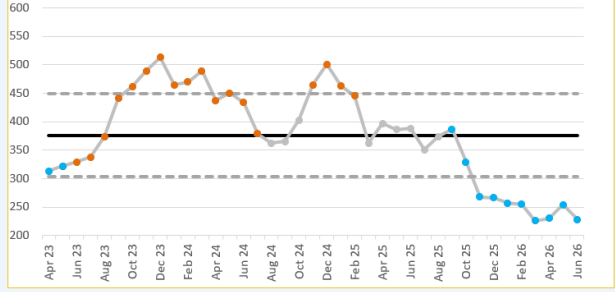
RTT 18 Week Wait Performance



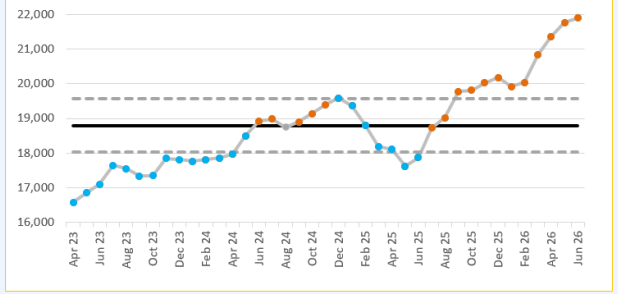
RTT >65 Weeks



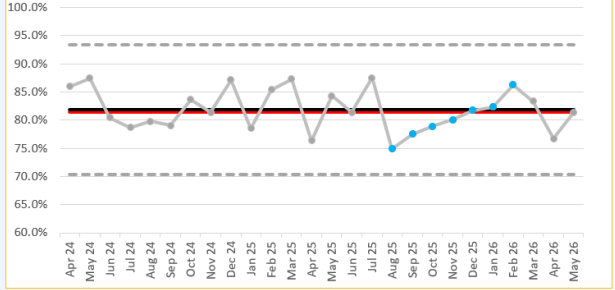
RTT >52 Weeks



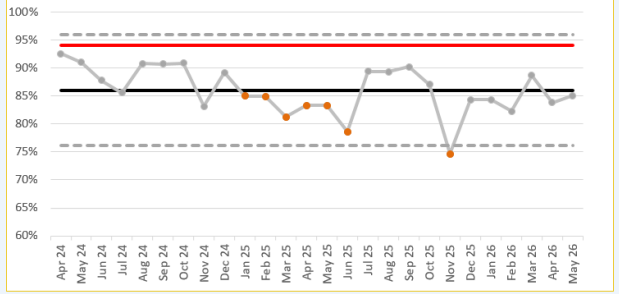
RTT Waiting List



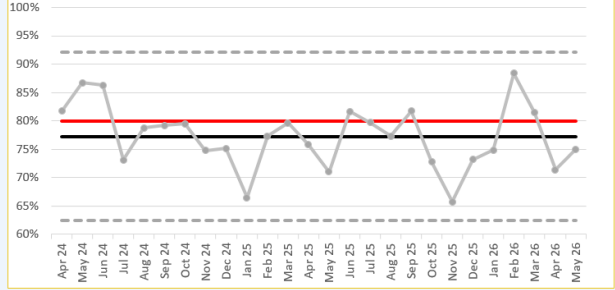
Cancer 28 Day FDS



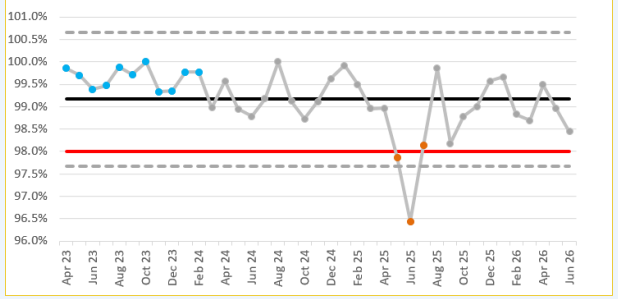
Cancer 31 Days



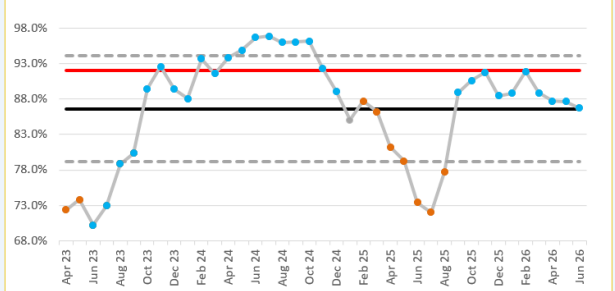
Cancer 62 Days



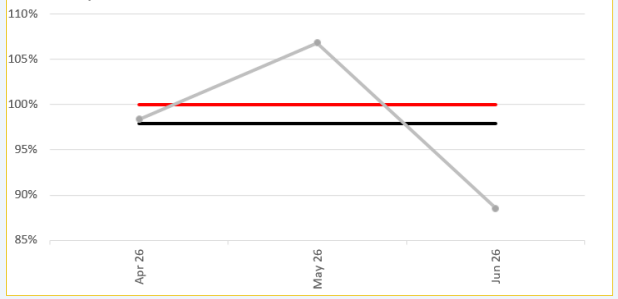
UEC 4 Hour Performance



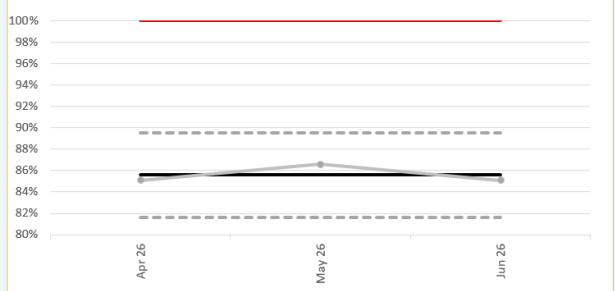
Diagnostics 6 Week Wait Performance



% VWA vs plan



% CDC VWA vs plan



Trajectories- Operational performance

Queen Victoria Hospital NHS Foundation Trust

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

Key

Performance achieved trajectory

Performance did not achieve trajectory

Benchmarking - Operational performance

Queen Victoria Hospital
NHS Foundation Trust

Group	Metric	Value	Latest Month	Specialist Rank	Specialist Rank (out of)	England Rank	England Rank (out of)
A&E / Minor Injury Unit	All 4 Hour Waits Performance	98.44%	Jun-26	1	3	4	139
Cancer Treatment	FDS Performance	81.45%	May-26	6	12	57	134
	31 days Performance	85.06%	May-26	12	13	12	134
	62 days Performance	75.00%	May-26	8	13	48	137
Diagnostics (DM01)	Under 6 Weeks Performance	87.69%	May-26	11	13	54	153
Referral To Treatment	Within 18 Weeks Performance	62.26%	May-26	13	13	110	148

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

KSO1 AREAS OF FOCUS

Queen Victoria Hospital
NHS Foundation Trust

Area	Month Plan	Summary, impact and actions
RTT> 65 week waits		• The Trust reported 35 patients waiting over 65 weeks and 9 patients waiting over 78 weeks at the end of M3, reducing from 42 and 13 patients respectively in M2. The remaining long-wait cohort is predominantly within Breast Reconstruction pathways where complex tertiary activity continues to impact recovery. Weekly long-wait reviews, prioritised scheduling and targeted validation remain in place, alongside additional theatre capacity and consultant-led recovery initiatives. Current trajectories indicate that all non-Breast patients are expected to be removed from the >65-week cohort by September 2026.
RTT>52 week waits	226	• The number of patients waiting over 52 weeks reduced from 254 in M2 to 228 in M3, although performance remains above the planned trajectory of 218 patients. Plastics and OMFS continue to account for the majority of the cohort, whilst the size of the 40–51 week waiting list remains a key risk to future performance. Recovery actions include additional theatre capacity, weekend operating lists, improved theatre productivity, workforce recruitment and specialty-level oversight of at risk patients.
RTT 18 Week Wait Performance	64.0%	• RTT performance improved marginally from 62.2% in M2 to 62.3% in M3 but remains below the planned trajectory of 63.2%. Whilst increased clock stop activity has slowed waiting list growth, demand continues to exceed capacity in key specialties. Plastics and Sleep remain the largest contributors to underperformance and are subject to weekly recovery oversight. Plastics recovery plans include additional weekend activity, consultant-led Super Saturday lists, standby patient utilisation, evening theatre sessions and recruitment into vacant clinical posts, whilst Sleep continues to focus on expansion of home testing pathways and additional diagnostic capacity. These actions are expected to support improved elective throughput during Q2 and Q3.
RTT Waiting List	20,141	• The RTT waiting list increased by 123 pathways during June, from 21,770 in M2 to 21,893 in M3, remaining 1,637 pathways above plan. Growth continues to be concentrated within Sleep and OMFS services, where referral volumes continue to exceed planned assumptions. Discussions are ongoing with commissioners regarding Sleep to better understand the drivers of increasing referral demand and changes in referral practices. Alongside this work, specialty recovery plans continue to focus on increasing activity, improving productivity and reducing the impact of sustained referral growth on waiting list performance.
Cancer 28 Day FDS (Faster Diagnostic Standards)	81.4%	• FDS performance met the planned trajectory in M2. However, performance from M3 to M5 is expected to be challenging due to the high demand in urgent suspected cancer referrals, with referrals remaining above baseline. This demand is creating first appointment capacity pressures, leading to lower compliance with the 14-day appointment standard. Both Skin and Head & Neck pathways continuing to experience the greatest pressure due to outpatient capacity constraints across QVH and spoke sites. Recovery actions include additional USC capacity, enhanced Patient Treatment List (PTL) oversight and pathway optimisation to improve timely access to diagnostics and diagnosis.
Cancer 31 Days	85.5%	• 31-day performance remained below trajectory during M2, with the majority of breaches occurring within Skin pathways. Increasing treatment volumes and ongoing capacity pressures within specialist treatment pathways (Skin Sentinel Lymph Node Biopsy (SLNB)) continue to impact delivery of the standard, we have seen a 27% increase in cancer treatments year to date. Work continues to focus on maximising theatre utilisation, maintaining prioritisation of cancer activity and improving pathway management to reduce delays between diagnosis and treatment.

KSO1 AREAS OF FOCUS

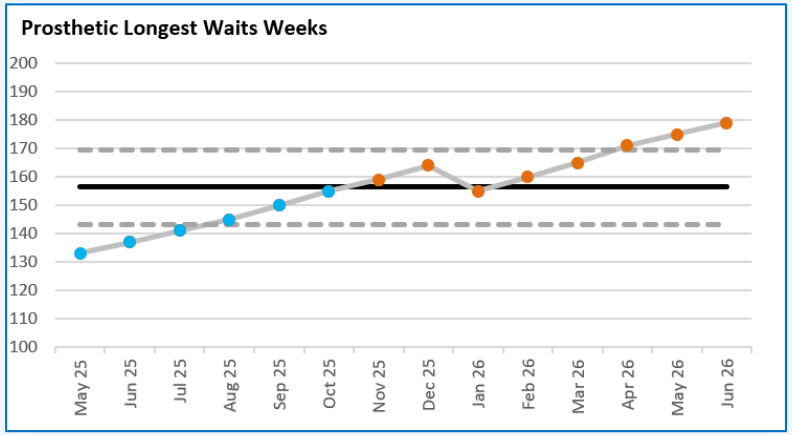
Queen Victoria Hospital
NHS Foundation Trust

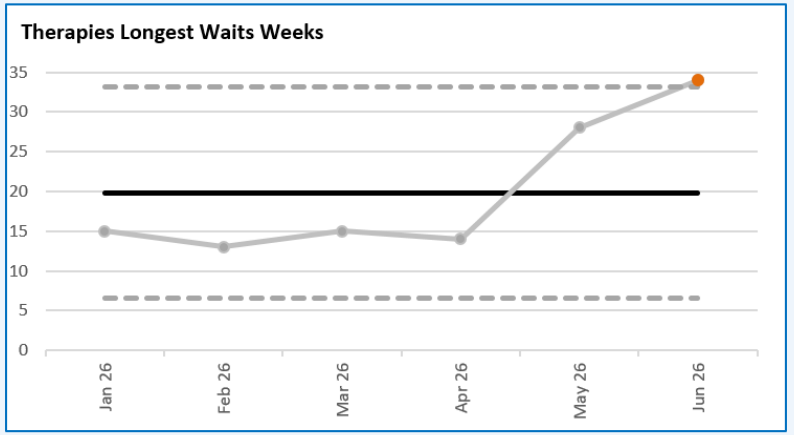
Area	Month Plan	Summary, impact and actions
Cancer 62 Days	75.7%	• 62-day performance remained below trajectory during M2, driven by increasing urgent suspected cancer demand and ongoing capacity constraints across Skin (Medway and Conquest a key pinch point for theatre capacity) and Head & Neck pathways. The backlog increased to 108 patients, with Skin accounting for 71 patients and Head & Neck remaining a key area of pressure. Enhanced PTL oversight, pathway validation and escalation processes remain in place to reduce delays and improve pathway performance.
Diagnostics 6 Week Wait Performance	90.8%	• DM01 performance remains below trajectory, with M2 performance achieving 87.7% against a trajectory of 90.8%. Sleep Diagnostics continues to be the principal driver of underperformance due to sustained referral growth, limited inpatient diagnostic capacity and equipment constraints. The service remains under enhanced operational oversight, with recovery actions focused on expansion of home testing, review of inpatient capacity, additional diagnostic equipment options and pathway redesign. Wider diagnostic services continue to perform strongly and remain broadly compliant with expected standards.
% CDC Value Weighted Activity (VWA) vs plan	100%	• CDC activity remained below plan during Quarter 1, delivering 83% of planned activity in M3. Underperformance continues to be driven by lower than anticipated activity within Sleep Studies, Respiratory Diagnostics and Ophthalmology pathways, despite continued high demand across the wider diagnostic portfolio. • Whilst overall activity remains below trajectory, a number of diagnostic services continue to perform strongly, and recovery is expected during Quarter 2 as referral pathways mature and activity increases across existing CDC services. • The East Grinstead CDC programme remains on track, with the building now watertight and internal construction and groundworks progressing. Current plans remain for operational opening in October 2026, providing additional diagnostic capacity and supporting future activity growth and recovery against plan.
Theatre capped utilisation		• Theatre utilisation was 80.1% in M3, compared to 81.6% in M2, remaining broadly in line with pre-Archie EPR baseline performance despite significant operational pressures. Productivity was adversely impacted by a combination of increased trauma demand, a rise in on-the-day cancellations to 6.1% in June in comparison to 3.3% in M2, and periods of exceptionally high temperatures that resulted in humidity-related challenges within theatre environments, intermittently affecting theatre availability and operational flow. Collectively, these factors reduced opportunities to maximise available theatre capacity and contributed to the marginal reduction in utilisation. • Despite these challenges, activity increased from 1,021 procedures in May to 1,146 procedures in M3, demonstrating continued improvement in throughput. Plastics utilisation improved to 82.5%, whilst Corneo remains the largest area of variation at 72.7%. • Weekly theatre transformation reviews, specialty utilisation reviews and exception reporting remain in place to identify and address causes of underutilisation, reduce cancellations and improve productivity, with a focus on reducing variation within Corneo services.
Minor Injuries Unit (MIU) 4 Hour Performance	98.0%	• MIU performance achieved 98.44% in M3 against a trajectory of 98.1%, continuing a sustained period of strong performance. The service remains consistently above national expectations with no significant operational pressures identified and is forecast to maintain performance above trajectory through Quarter 2.
% Value Weighted Activity (VWA) vs plan	100%	• VWA performance is currently reported at 88.1% of plan in M3, with an adverse variance of £549.9k. Experience from M2 demonstrated a significant improvement following completion of cashing-up and clinical coding, with performance improving from 101% of plan (£39.3k favourable) at initial reporting to 106% of plan (£260.3k favourable) following validation. Further improvement in the M3 position is therefore anticipated as the cashing-up process is completed, whilst recovery activity remains focused on Plastics and Maxillofacial services.

KSO1 BALANCED SCORECARD

Queen Victoria Hospital NHS Foundation Trust

OPERATIONAL PERFORMANCE METRICS - Prosthetics and Therapies



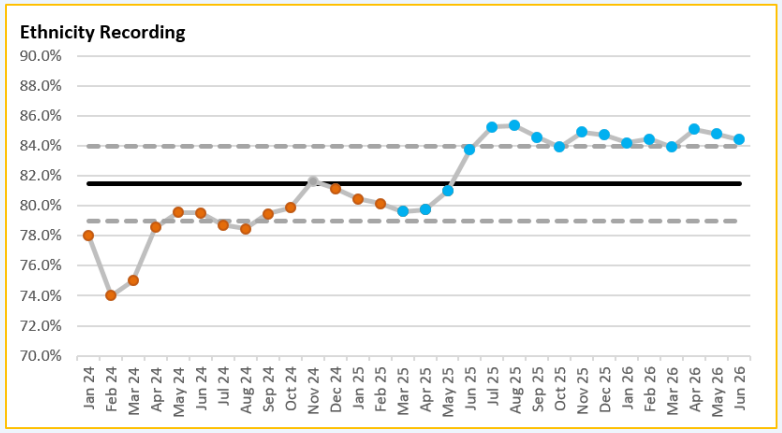


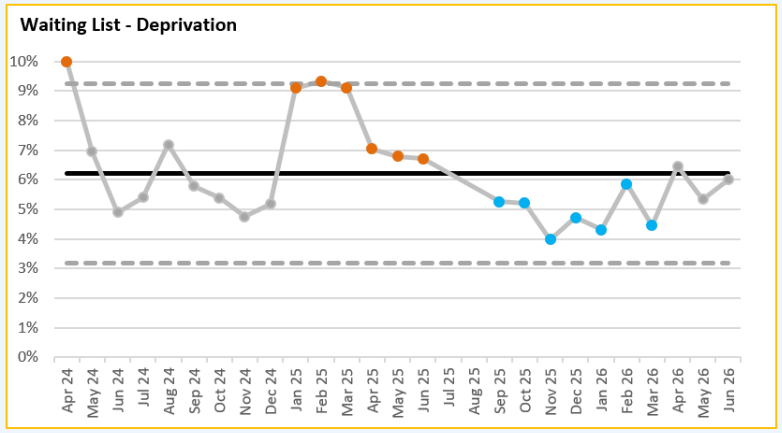
Area	Summary, impact and actions
Non-RTT Prosthetics longest week waits	At present longest waiter is 179 weeks; there are 85 patients on the Waiting list (for prosthetic treatment/new device) reflecting a stable wait list size for the last 3 months and 103 patients on the Care list overdue for a review/revision appointment down from 116 last month (Care list total is 244 patients).
Non-RTT Therapies longest week waits	At the end of Month M3, the Trust had 450 patients on the waiting list for a first consultation within therapist led clinics, with the longest wait at 36 weeks (within SLT- a small service with 34 on WL total) The total WL has been increasing steadily over the last 5 month due to vacancies, Bank usage in M3 increased to address this backlog and is predicted to bring the SLT longest waiter to 16 weeks by M4. Speech and Language Therapy (SLT) and Hand therapy have been successful in recruiting – start dates TBC but estimate is Oct 2026.

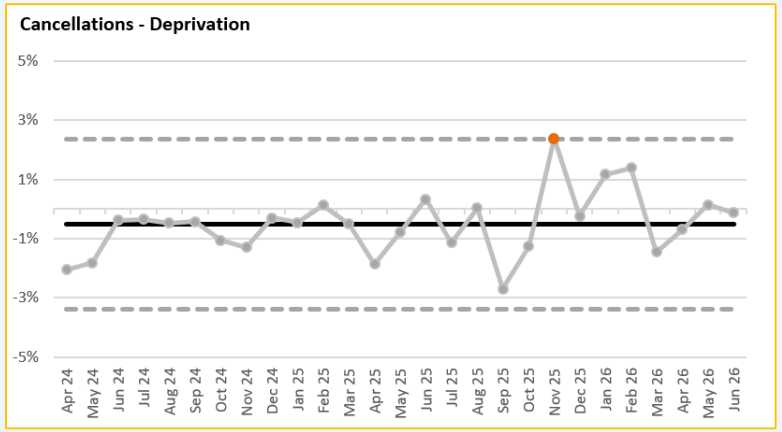
HEALTH INEQUALITIES PRIORITY PROGRESS

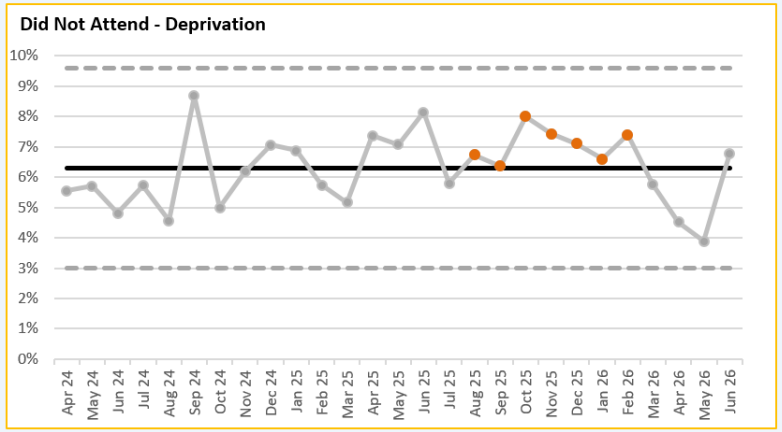
Queen Victoria Hospital
NHS Foundation Trust

Note that there are data quality issues with these metrics - Ethnicity is not known for new patients until they attend site and the Index of Multiple Deprivation depends on up-to-date post code information and mapping.









Metric - Jun-26	Black (M, N, P)	White (A, B, C)	Asian (H, J, K, L)	Mixed (D, E, F, G)	Other (R, S)	Not Assigned	Total
Did Not Attend - Ethnicity Groups rolling 6 months	8.66%	4.45%	6.41%	7.70%	6.60%	9.11%	5.42%

Area	Summary and actions
Ethnicity Data Improvement	Ethnicity data completeness measures the percentage of patient records that include an ethnicity. The Trust position currently remains static at 84%, below the 95% target. Improvement efforts focus on areas with the largest gaps (Plastics, OMFS, Therapies), standardising key processes (check-in, first appointment, data entry), establishing clear ownership and monitoring, and providing guidance, training, and communication support.
Waiting List / Deprivation Variation	For patients from the most deprived areas who are being offered their first outpatient appointment, replace standard appointment letters with a telephone call. This will help identify any barriers to accessing our services and enable appropriate support to be offered, reducing the risk of (Did not attend) DNAs, cancellations, and delays to their care pathway. Include the IMD decile information within the RTT PTL to support proactive pathway management for patients at greater risk of disengagement, using telephone contact where appropriate instead of written correspondence. Review and update the consultant to review process to include an additional consideration for patients from the most deprived areas, ensuring they are not disadvantaged and are supported to access timely care.
Patient-led Cancellations / Deprivation Variation	Continue to focus on specialties and sub-specialties with high DNA rates, particularly where patients from the most deprived communities are disproportionately represented. The review of DNAs over the past three months at spoke sites has been completed, with workshops being developed.
DNA / Deprivation Variation	
DNA / Ethnicity Variation	

KSO2

To innovate and improve

Ambition

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

Board Assurance Framework

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

2026/27 Annual Objectives

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

2026/27 Annual goals

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

KSO2 EXECUTIVE SUMMARY

Queen Victoria Hospital
NHS Foundation Trust

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

The Task and Finish Group for the Research, Innovation and Education Centre continues to meet bi-weekly with key progress including engagement with current teams around what we should consider as part of this resource. Stakeholder engagement planning is now underway using a Continuous Improvement approach to co-design the development to ensure that the result is an inspirational and innovative space collaboratively designed with our teams, colleagues and Queen Victoria Hospital Charity.

Progress continues to be made with the Research and Governance review, a newly developed study pipeline document was shared at the Research Governance Group meeting which will be maintained as a live document further supporting and strengthening our governance, oversight and planning needs to meet our strategic objectives. At this meeting, four potential new research studies were discussed with further feasibility to be undertaken to optimise set up success.

A revised and updated Innovation and Intellectual Property Policy is nearing completion for which training and engagement is planned within various existing forums later this year. This will ensure that all Trust colleagues feel encouraged and confident to innovate within their areas of expertise and are supported to do this with clear guidance and process.

We have been successful in recruiting a Commercial Research Lead and awaiting their start date later in the Summer. This one-year fixed term post will build our links with life science and Industry partners, create a sustainable pipeline of commercial studies and create a QVH 'playbook' to share with commercial partners showcasing our credentials as a specialist and reliable research partner.

QVH recently received congratulations and thanks from the Trial Manager for the GRACE study having just randomised the 3000th participant to this national trial. This study is linked with our breast and plastics patients and is looking at the impact of the use of anti-embolic stockings in the prevention of Deep Vein Thrombosis (DVT) and remains a recruiting study contributing to patient care. We have also now confirmed an exciting new study commencing September in Sleep Services for patients with Obstructive Sleep Apnoea, this is an interventional trial using a new device to trigger breathing during sleep and measure the results. It is hoped that this could help reduce the long-term health impact on the large group of patients who are diagnosed with this disorder.

Tamara Everington
Chief Medical Officer

KSO2 EXECUTIVE SUMMARY

Queen Victoria Hospital
NHS Foundation Trust

The QVH Way underpins all improvement and transformation programmes:
Our latest QVH Way celebration event took place recently where ten of our newly qualified Continuous Improvement (CI) Champions were presented with their certificates for their Yellow and Green Belt accreditations. Colleagues from the Board and across the Trust joined the celebration following which each graduate presented their project poster and the benefits of the improvement project undertaken. Graduates answered questions related to the improvement made and sustainability planned to ensure any gains are maintained.

The projects spanned clinical, operational and financial / productivity improvements including : -

- Enhanced staff competency and patient safety in Critical Care by standardisation of protocols relating to arterial line management. This also led to reduction of wastage in consumables and potential cost savings
- A project to develop a scorecard model to monitor financial performance of contracts with costings and breakeven models for our clinics
- Cost savings and implementation of 'kanban' (a visual stocking system) by reduction of wastage associated with emergency resuscitation medicines boxes
- Implementation of a process for monitoring demand and capacity for clinics to ensure utilisation is optimised and wasted slots minimised

Representing QVH by networking with senior improvement leaders nationally, the Associate Director of Research, Innovation and Improvement was successful in securing a place at the Bernard Crump Memorial Masterclass with Goran Henriks demonstrating how he has led transformational improvement of Health and Care systems in Sweden. There are plans to explore ways in which we can share the learning from this internationally successful health system here at QVH including how we might use some of the key take aways such as a 'living library' of service users willing to share experiences of each of our services to support our improvement work. Goran also called organisations to action around the underpinning message of his talk "the most important part of our system is what the patient knows about it" which further supports our desire to embed Experienced Based Co-design (EBCD) in our improvement work. Our EBCD projects have all commenced following training last month and ongoing coaching will follow.

Medical Education and Library:
The next Resident Doctors induction will be in August and we will welcome around 20 new starters to the organisation. To help ensure that Resident Doctors are intrinsic to our learning culture, there will be a new item on the programme relating to feedback and learning from incidents. September's induction will be focused on new Dental Core Trainees joining the organisation, and in October we will welcome new registrars in OMFS and Plastic Surgery.

The experience of Resident Doctors and Dentists is closely scrutinised within regular local focussed groups. Feedback is managed via an issues log with closed issues fed back to those impacted. Further progress is being made in relation to the Resident Doctor 10-point plan with the installation of new lockers in the theatres block. The General Medical Council (GMC) survey of resident doctors in training results are due 21 July and will be reported on once analysed.

Recruitment for the new Specialty, Associate Specialist, and Specialist (SAS) doctors Lead has progressed and a new lead has been appointed. This lead will hold responsibility for ensuring that all SAS doctors are supported in their development and career progression and, that the Trust is maximising the opportunity this vital staff group offers us.

The John Cobbett lecture and microsurgery competition took place on Mon 6 July, with an excellent keynote speech from Professor Raja Sabapathy from the Ganga Institute in India. The Ganga institute is a world-renowned plastics and orthopaedic centre which has grown from 38 to 650 beds and Professor Sabapathy helped us understand the drivers to success.

The library team now have trial access until March 27 to a new repository to centrally store and make accessible all QVH-related publications, conference abstracts and posters and this has been advertised to all staff. The library team are now providing AI training to staff and feedback on the value from this is extremely positive.

Tamara Everington
Chief Medical Officer

KSO3

To be an excellent employer

Ambition

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

Board Assurance Framework

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

Queen Victoria Hospital
NHS Foundation Trust

2026/27 Annual Objectives

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

2026/27 Annual goals

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

KSO3 EXECUTIVE SUMMARY

Queen Victoria Hospital
NHS Foundation Trust

General summary

Month 3 workforce performance remains broadly stable against plan, with substantive staffing at 1072.3 whole time equivalent (WTE), marginally above target of 1069.87 WTE. Vacancy levels have reduced slightly to 2.07% (22.66 WTE) remaining within the Trust's tolerance, with pressures concentrated in Plastics, Sleep, and Anesthetics. Time to hire has slightly increased (28.4 days vs 27.8 in M2), with variation driven by onboarding delays, notably due to visa clearance.

Sickness absence remains just above 4%, with continued "concerning variation" across Theatres, Canadian Wing, Critical Care and Radiography. Drivers remain seasonal illness and Musculoskeletal (MSK), with administrative and nursing staff groups most affected. Agency usage has decreased to 5 WTE, primarily in Core Clinical & Community Services (CCCS), alongside a small rise in bank usage (67.67 WTE), reflecting operational demand in Theatres.

Turnover has marginally increased to 12.15%. No grievances were raised. Workforce governance continues to strengthen, with job plan sign-off reaching 82% and appraisal compliance improving to 85.7%. Mandatory training compliance has slightly increased (91.1%).

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

The Organisational Development & Learning (OD&L) continue to support managers across the organisation with their action plans for areas of focus from the NHS 2025 survey. Coaching and mentoring support is being provided to support leaders across a number of teams. Behaviour framework workshops continue to be delivered – further dates have been identified starting Sept 26.

Leadership Capability (Trust, Directorate)

Change workshops, coaching skills for managers, appraisal training and Managers Essentials Programme continue to be delivered. Oliver McGowan face to face Tier 2 training is progressing with 19.8% of staff who require the training having completed it to date. Tier 1 dates have been released to start delivery in September 2026.

21.89% of annual leave has been booked and taken up to 30 June 2026. Medical and Dental staff and nursing staff are currently below 20%. The booking / taking of annual leave is being reviewed each month at the directorate IQPR meetings and at the temporary staffing reduction oversight meetings.

Helen Edmunds
Chief People Officer

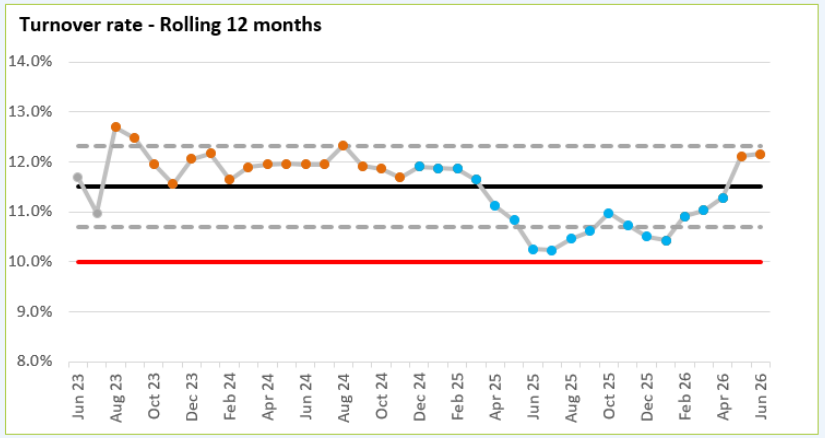
KSO3 BALANCED SCORECARD

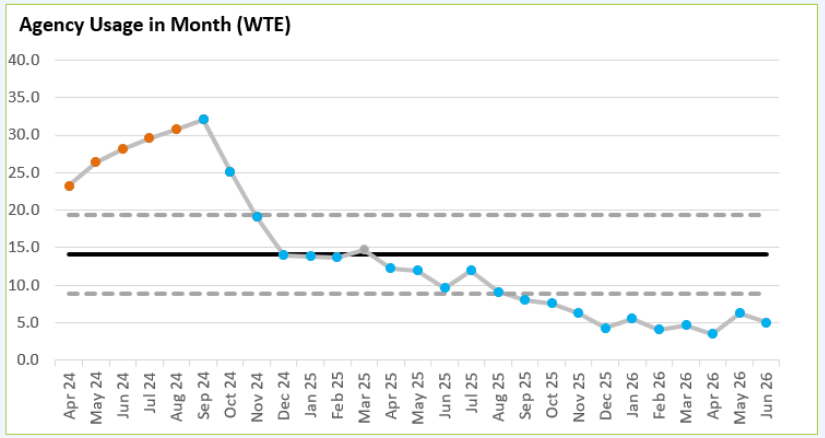
Queen Victoria Hospital
NHS Foundation Trust

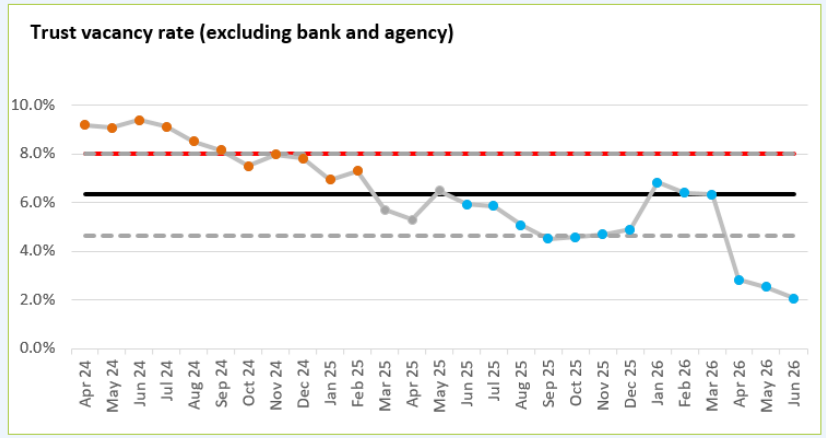
Metric	Latest Month	Target	Variation	Assurance	Actual	Actual Previous Month	Mean	LCL	UCL	Summary
Trust vacancy rate (excluding bank and agency)	Jun-26	8.0%			2.07%	2.54%	6.33%	4.65%	8.02%	Special Cause - improving variation
Vacancies - Incl Bank & Agency	Jun-26	8.0%			0.55%	1.18%	1.82%	-0.17%	3.80%	Common cause - no signficant change
Average Time to Hire - Days	Jun-26	53.0			28.41	27.75	53.36	22.23	84.49	Special Cause - improving variation
Turnover rate - Rolling 12 months	Jun-26	10.0%			12.15%	12.11%	11.50%	10.69%	12.32%	Special Cause - concerning variation
Sickness absence rate - Rolling 12 months	Jun-26	3.9%			4.42%	4.39%	3.92%	3.80%	4.04%	Special Cause - concerning variation
Appraisal Rate	Jun-26	90.0%			85.74%	83.62%	83.66%	80.71%	86.61%	Common cause - no signficant change
Statutory & Mandatory Training Compliance	Jun-26	90.0%			91.09%	90.19%	91.78%	90.63%	92.94%	Common cause - no signficant change
Agency Usage in Month (WTE)	Jun-26	-			5.02	6.28	14.12	8.85	19.40	Special Cause - improving variation
Bank Usage in Month (WTE)	Jun-26	-			67.67	65.54	74.83	57.02	92.64	Common cause - no signficant change
Annual Leave Taken	Jun-26	-			21.89%	16.18%	45.20%	10.15%	80.25%	Common cause - no signficant change

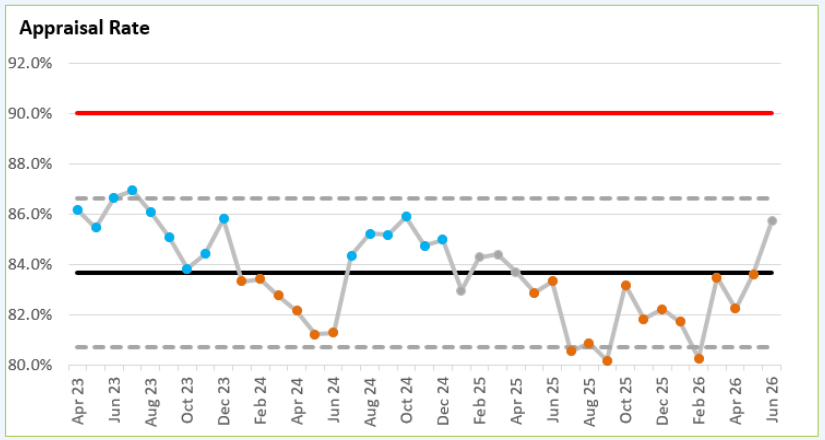
EXCELLENT EMPLOYER KEY METRICS

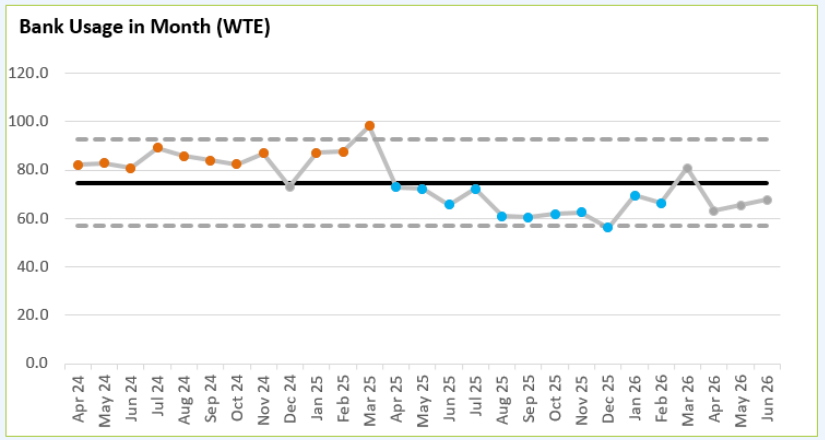
Queen Victoria Hospital
NHS Foundation Trust

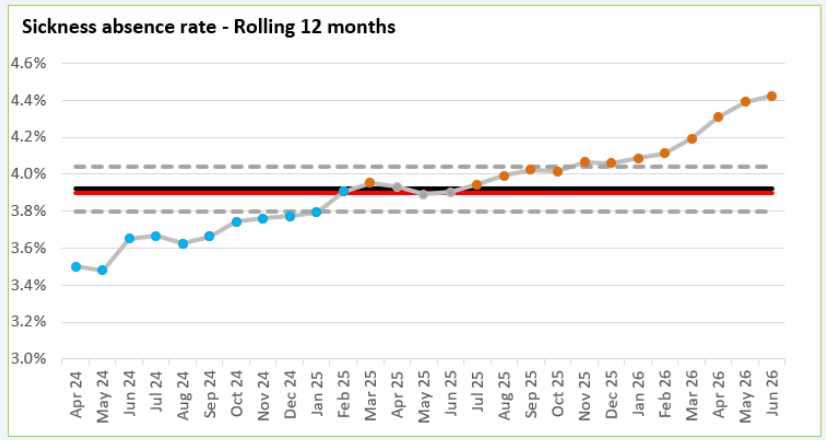












KSO3 AREAS OF FOCUS

Queen Victoria Hospital
NHS Foundation Trust

Area	Summary, impact and actions
Trust vacancy rate (excluding bank and agency)	M3 shows staff in post WTE (substantive staff) at 1072.30 (against a submitted plan of 1069.87 WTE). Vacancies excluding bank and agency usage has decreased from 2.54% to 2.07% (22.66 WTE). The Trusts highest areas of vacancies in M3 are within Plastics (12.16 WTE) Sleep (7.18 WTE) and Anesthetics (6.15 WTE)
Average Time to Hire - Days	Slight increase in M3 to 28.41 days up from 27.8 days in M2. An internal mover in Corneo Plastics required a new Disclosure and Barring Service (DBS) check and this caused a delay in clearance (42 days total). Three other delays within Maxillofacial, Sleep and CDC were due to visa requirements.
Sickness Absence Rate - Rolling 12 Months	This measure continues to show 'concerning variation' and continues at a current level of marginally above 4%. The highest areas of sickness in M3 continued in Theatres, Canadian Wing, Critical Care, and Radiography. The highest staff groups for sickness continue in admin & clerical and nursing. The most common reason for sickness absence are consistently cough, cold and flu, followed by gastrointestinal problems and musculoskeletal (MSK). The Employee Relations team undertake a monthly deep dive into sickness areas to provide focussed support for managers. Rolling 12-month long term sickness is 2.45% and short-term sickness is 1.97%.
Agency Usage In Month (WTE)	Agency usage has decreased in M3 from 6.3 WTE to 5 WTE. Usage consisted of 3.2 WTE in Core Clinical & Community Services (CCCS), 1.6 WTE Perioperative Care, and 0.21 WTE Plastics & Burns (Canadian Wing N&M). CCCS 1.23 WTE Healthcare Scientist in Sleep, 0.87 WTE Additional Professional & Technical in Pharmacy, 1.01 WTE Allied Health Professional (AHP) in Radiology and 0.09 Additional Clinical Services in Histopathology. Perioperative services was in Critical Care (N&M), Recovery (AHP), and 1.17 WTE in Theatres (AHP & N&M).
Bank Usage In Month (WTE)	Bank usage has increased slightly from 65.54 WTE in M2 to 67.67 WTE in M3. This slight increase in M3 is on trend with previous years. Perioperative services have the highest usage at 25.27 WTE followed by CCCS with 13.67 WTE. Admin and Clerical , Nursing & Midwifery and Additional Clinical Services staff groups had the highest usage (23.42 WTE, 20.27 WTE, 9.31 WTE). Within Perioperative Services, Theatres have the greatest share of bank usage (39.8%).
Grievances raised	0 grievances raised in M3
% Job plans complete	16 job plans signed off in June 2026 with 5% sitting in consultant sign off, 1% in sign off by manager, 3% 2nd sign off and 0% in 3rd sign off. The Trust currently has 82% of job plans signed off. M3 sees the continuation of no pay effecting sign off until job plan is in 3rd sign off and work is ongoing on cleansing and correcting any historic pay vs Job plan discrepancies. More emphasis going forward in a structured chasing process to bring compliance up further.
Turnover rate	Turnover remains stable with a marginal increase from 12.11% in M2 to 12.15% in M3. For operational triumvirate's OMFS & Eyes has the highest turnover (12.69%) followed by Plastics & Burns (12.39%).
Statutory and mandatory training	M3 has seen an increase in mandatory and statutory training (MAST) compliance from 90.2% in M2 to 91.1% in M3. Basic Life support, clinical moving & handling, safeguarding children and Information Governance are the focus for improvement. Infection control level 1, 3 yearly is now mandatory for all staff. Trust wide comms is detailing this change.
Appraisal rate	There is ongoing work to achieve 90% appraisal completion, with focus on managers who departments have low compliance. M3 saw an increase from 83.6% in M2 to 85.7%. The number of appraisals outstanding >3 months has increased from 91 in M2 to 94 in M3, with focused work underway with senior managers in areas where rates of completion are low.

KSO4

To deliver sustainable services

Ambition

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

Board Assurance Framework

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

Queen Victoria Hospital
NHS Foundation Trust

2026/27 Annual Objectives

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

2026/27 Annual goals

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

KSO4 EXECUTIVE SUMMARY

Queen Victoria Hospital
NHS Foundation Trust

Summary Financial Position

For the Month of June, the Trust reported a Year to Date (YTD) Income and Expenditure deficit of £0.34m, which was in line with plan and a cash position of £9.8m. The position includes £0.3m of non-recurrent benefits of which £0.1m related to M3.

Key drivers of position include:

- **Income** - **Activity income** Estimated activity income £0.18m adverse to plan due to £0.14m of Community Diagnostic Centre (CDC) underperformance with further £50k underperformance in clinical activity in relation to plastics and max-fax day cases, which is partly offset by over-performance in sleep outpatient procedures. **Other income** is behind plan YTD (£0.03m) Key drivers include underperformance on car parking income plan and across directorate positions.
- **Pay:** Overspent in month by £0.14m and £0.38m mainly driven by slippage on pay better value schemes offset in non-pay.
- **Non-pay including Non-operational Expenditure**: £0.23m favourable to plan in month and £0.59m for the YTD. The YTD position is driven by reduced spend across clinical supplies, other non-pay and bank interest income and partly due to non-recurrent benefits.

Better Value Programme (BVP)

The Trust is reporting full delivery of the M3 efficiency programme and whilst there is a continued reliance on other mitigating items, there has been a notable improvement in the delivery of the core programme and the percentage contribution has increase to 74% from 62%. The forecast for the current schemes is projecting a shortfall of £1.5m, although work is in progress to identify further mitigations and alternative schemes to bridge this gap which are expected to ensure delivery of the full programme.

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

- A design solution for the repair to the main theatre roof has been agreed by the Trust with work underway for the next stage.
- Ongoing programmes of work are underway relating to fire compliance.
- A first design for the building works for the installation of the MRI machine has been provided to the task and finish group.
- A tender for a project to refurbish a room for Cone Beam Computer Tomography (CBCT) is being evaluated

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

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

Ross Dunworth
Interim Chief Finance Officer

KSO4 EXECUTIVE SUMMARY

Queen Victoria Hospital
NHS Foundation Trust

Metric	Latest Month	Target	Variation	Assurance	Actual	Actual Previous Month	Mean	LCL	UCL	Summary
Breakeven YTD	Jun-26	-£0.34m			-£0.34m	-£0.61m	-0.36	-1.02	0.31	Common cause - no signficant change
Cash at Bank YTD	Jun-26	£11.10m			£9.80m	£11.60m	9.94	3.51	16.37	Common cause - no signficant change
Capital Spend YTD	Jun-26	£0.35m			£2.90m	£1.40m	4.62	-4.59	13.83	Common cause - no signficant change
Efficiencies YTD	Jun-26	£1.61m			£1.61m	£1.04m	3.71	0.26	7.15	Common cause - no signficant change
BPPC (NHS & Non NHS) - volume	Jun-26	95%	L		74.4%	67.1%	0.88	0.81	0.95	Special Cause - concerning variation
BPPC (NHS & Non NHS) - value	Jun-26	95%		F	90.4%	88.2%	90.3%	85.7%	94.9%	Common cause - no signficant change
Agency spend 30% reduction on 25/26	Jun-26	£0.13m		F	£0.13m	£0.13m	0.10	0.00	0.21	Common cause - no signficant change
Agency staff spend as % of total staff spend	Jun-26	2%		P	0.65%	0.56%	0.95%	0.41%	1.49%	Common cause - no signficant change
Bank spend 10% reduction on 25/26	Jun-26	£0.75m			£0.78m	£0.76m	0.60	-0.11	1.30	Common cause - no signficant change
Total Pay cost per Worked WTE	Jun-26				£5,838.34	£5,911.71	5706.08	5478.20	5933.95	Common cause - no signficant change
Subject Access Requests - Total Received	Jun-26				101	75	87.94	57.43	118.46	Common cause - no signficant change
Subject Access Requests - % Closed within 30 calendar days	May-26	100%	H		100.0%	100.0%	95.5%	82.1%	108.9%	Special Cause - improving variation
Freedom of Information requests – Total Received	Jun-26				64	47	51.15	16.92	85.38	Common cause - no signficant change
Freedom of Information requests – % Closed within 20 working days	May-26	80%			63.83%	76.19%	66.6%	42.8%	90.4%	Common cause - no signficant change

KSO4 EXECUTIVE SUMMARY

Queen Victoria Hospital
NHS Foundation Trust

Capital

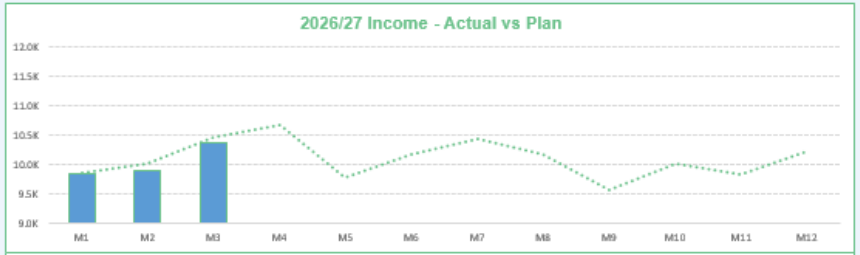
	In Month £'000			Year to Date £'000			Forecast Outturn £'000s		
	Plan	Actual	Variance	Plan	Actual	Variance	Plan	Actual	Variance
IT	0	0	0	0	0	0	200	200	0
Medical Equipment	125	6	(119)	0	6	6	100	100	0
Estates Maintainance	63	0	(63)	190	60	(130)	426	378	(48)
Sussex Pathology Network	52	28	(24)	156	101	(55)	620	620	0
EPR	0	151	151	0	431	431	1,000	1,200	200
CDC	0	1,313	1,313	0	2322	2,322	3,873	5,443	1,570
Other Capital	0	0	0	0	0	0	1,565	-	(1,565)
Total	240	1,498	1,258	346	2920	2,574	7,784	7,941	157

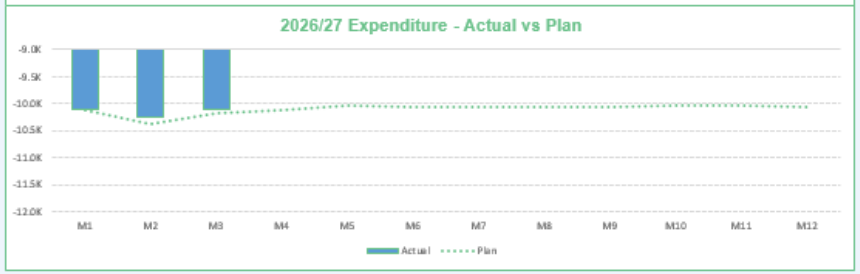
Income and Expenditure

	In Month £'000			Year to Date £'000			Forecast Outturn £'000s		
	Plan	Actual	Variance	Plan	Actual	Variance	Plan	Actual	Variance
Income									
Patient Activity Income	9,983	9,958	(25)	28,900	28,728	(172)	115,985	115,985	0
Other Operating Income	474	407	(67)	1,423	1,390	(33)	5,241	5,241	0
Total Income	10,457	10,365	(92)	30,323	30,118	(205)	121,226	121,226	0
Pay									
Substantive	(6,153)	(6,294)	(141)	(18,524)	(18,918)	(394)	(73,443)	(73,443)	0
Bank	(256)	(262)	(6)	(789)	(775)	14	(2,992)	(2,992)	0
Agency	(44)	(37)	7	(132)	(129)	3	(542)	(542)	0
Total Pay	(6,453)	(6,593)	(140)	(19,445)	(19,822)	(377)	(76,977)	(76,977)	0
Total Non-Pay	(2,952)	(2,733)	219	(8,865)	(8,364)	501	(34,818)	(34,831)	(13)
Total Non Operational Expenditure	(795)	(783)	12	(2,385)	(2,301)	84	(9,548)	(9,535)	13
Total Expenditure	(10,200)	(10,108)	92	(30,695)	(30,487)	208	(121,343)	(121,343)	0
Surplus/(Deficit)	257	257	(0)	(372)	(369)	3	(117)	(117)	0
Technical Adjustments	10	9	(1)	30	29	(1)	118	118	0
Adjusted Surplus / (Deficit)	267	266	(1)	(342)	(340)	2	1	1	0

Efficiency

	In Month £'000			Year to Date £'000			Forecast Outturn £'000s		
	Plan	Actual	Variance	Plan	Actual	Variance	Plan	Actual	Variance
Pay - Establishment Reviews	226	116	(111)	593	376	(218)	2,959	3,042	83
Pay - Corporate Service and Digital Transformation	90	69	(21)	262	175	(87)	1,200	1,116	(84)
Pay - Bank	11	8	(3)	32	24	(8)	150	142	(8)
Pay - Agency	2	-	(2)	5	-	(5)	25	20	(5)
Pay - Other	32	-	(32)	94	-	(94)	431	-	(431)
Non-Pay - Procurement	101	51	(50)	303	153	(150)	1,343	1,136	(207)
Non-Pay - Other	39	283	244	117	757	640	523	1,222	699
Non-Pay Corporate Service and Digital Transformation	49	19	(30)	147	67	(80)	642	583	(60)
Income - Non-patient care	18	24	6	54	58	4	204	217	13
Income - Other	1	-	(1)	3	1	(2)	15	15	0
Total	569	569	-	1,610	1,610	0	7,492	7,492	0





	Annual Target	Forecast Outturn
Income & Expenditure	£0.0m	£0.0m
Cash at bank	£5.6m	£5.6m
Capital Spend	£7.8m	£7.8m
Efficiencies	£7.49m	£7.49m
BPPC (NHS & Non-NHS)		
Volume	95.0%	91.9%
Value	95.0%	93.6%

Trust Better Value Programme

Queen Victoria Hospital
NHS Foundation Trust

Better Value Programme:

	Annual Plan £000				M03 Year-To-Date £000		
Theme	NHSE Plan	Latest Estimate	Indicative Forecast	Variance	NHSE Plan	Actual	Variance
Clinical Productivity & Efficiency	£3,479	£3,552	£2,814	(£738)	£719	£518	(£201)
Corporate and Partnership	£1,250	£1,054	£1,017	(£38)	£274	£175	(£99)
Grip and Control	£680	£692	£381	(£312)	£153	£46	(£107)
Digital Transformation	£380	£250	£213	(£38)	£84	£25	(£59)
Commercial and other income	£269	£398	£304	(£94)	£69	£134	£65
Admin Review	£500	£275	£28	(£248)	£108	£0	(£108)
Temporary Staffing	£175	£97	£97	£0	£37	£24	(£13)
Planned Non-Recurrent items	£759	£759	£759	£0	£166	£272	£106
Other Mitigating Items		£415	£415	£0		£415	£415
Grand Total	**£7,492**	**£7,492**	**£6,026**	**(£1,466)**	**£1,610**	**£1,610**	**£0**

Additional schemes are being worked up and are expected to ensure forecast delivery.

Better Value Programme (BVP):
The Trust is reporting full delivery of the M3 efficiency requirement and whilst there is a continued reliance on other mitigating items, there has been a notable improvement in the delivery of the core programme and the percentage contribution has increase to 74% from 62%. The current forecast is projecting a shortfall of circa £1.5m within the current plan, although work has begun to identify further mitigations and alternative schemes which are expected to ensure delivery of the overall plan.

Productivity indicators:
The final full year implied productivity metric for 2025/26 has been published and our implied productivity growth over last year is 0.1% - i.e. our productivity is essentially flat vs last year. Our cost weighted activity growth is 2.9% but this has come with a real terms resource growth of 2.80%. Although the national methodology has limitations, the deterioration in productivity over the last two months of 2025/26 is reflected in the Trust's own activity data, although not quite at the same extent. This is particularly obvious in the comparison between the volume and value of the elective in-patients completed in March 2026 vs March 2025

The proportion of OPA that are either first attendances or procedures continues to exceed the 46% target and demonstrates that the continued focus on utilising OP clinics to see these patients is paying dividends, particularly in the Sleep Disorder service. This benefit is reflected in our income position.

Key Productivity Indicators:

Source	Metric	Latest Month	Latest Month	Target	Distance from Target	5 mth Trendline
Model Hospital	Productivity Growth (YTD vs Prior Year)	Mar-26	0.10%	3.00%	-2.90%	
Model Hospital	Workforce Productivity Growth (YTD vs Prior Year)	Mar-26	3.60%	3.00%	0.60%	
OP Dashboard	Proportion of OPA that are First or OPROC	May-26	48.10%	46.00%	2.10%	

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

Outpatient Attendance (OPA)
Outpatient Procedures (OPROC)

KSO4 AREAS OF FOCUS

Queen Victoria Hospital
NHS Foundation Trust

Area	Summary, impact and actions
Breakeven YTD	The Trust reported a deficit position of £0.34m YTD for M3, which was on plan. Estimated **Activity income** was £0.18m adverse due to Clinical Diagnostics Centre (CDC) £0.14m and other surgical daycase underperformance partly offset by over-performance in sleep outpatient procedures. This income under delivery is partially offset by expenditure underspends. **Pay** is overspent by £0.38m, mainly due to under delivery of better value schemes. **Non-pay including Non-operational Expenditure** was £0.59m favourable to plan across clinical supplies, other non-pay and bank interest income. The main risks to breakeven will be delivery of the £7.5m Better value programme and delivery of the income and activity target.
Cash at Bank YTD	The Trust's cash balance at M3 was £9.8m, which continues to be supported by capital cash earmarked for completion of the Community Diagnostic Centre (CDC).
Capital Spend YTD	Capital expenditure at Month 3 totals £2.9m, which is above the planned £0.5m for the period. This variance reflects the phasing of the plan, with actual expenditure being incurred in line with the CDC build. The total annual capital allocation is £8.0m. Of this, £5.5m is expected to be spent on the CDC and £1.2m on (Electronic Patient Record (EPR), with the remaining balance allocated across Estates, IT, and Sussex Pathology Network (SPN). The capital programme is awaiting the outcome of national bids, the Trust plan is reliant on some of these being awarded.
Efficiencies (Cost Improvement Plans) YTD	The Trust is reporting full delivery of the M3 efficiency requirement and whilst there is a continued reliance on other mitigating items, there has been a notable improvement in the delivery of the core programme and the percentage contribution has increase to 74% from 62%. The current forecast is projecting a shortfall of circa £1.5m, although work is in progress to identify further mitigations and alternative schemes which are expected to deliver the overall programme.
Better Payment Practice Code (BPPC) (NHS & Non-NHS) Volumes	74.4%
BPPC (NHS & Non-NHS) Values	90.4%
Agency spend 30% less than 25/26	Broadly on plan in month (£1k adverse) on a YTD target of £0.1m. Key usage areas are within CDC which are expected to reduce in coming months
Agency Spend Less than 2% of Total Pay Bill	Ahead of plan (0.65 % YTD and 0.56% in month)
Bank spend reduction of 10% of Total Pay Bill	Broadly on target YTD (1k adverse)
Pay Spend	£0.38m adverse to plan for YTD mainly due to non-delivery of Better Value schemes. Pay slightly improved on YTD trend with a slight reduction in medical temporary spend. Pay spend will need to reduce in order to achieve the control total
Non-Pay Spend including non-operational expenditure	£0.59m favourable to plan due to lower than planned spend in clinical supplies, other non pay and interest income above plan. The position is supported by c0.25m of non-recurrent benefits YTD

KSO4 PROJECT REPORT

Queen Victoria Hospital
NHS Foundation Trust

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

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

Reporting Month: May 26

Overall Status: Amber

Fire Doors:
- Installation of new fire doors in Canadian (C) Wing is going well and is due for completion by August 2026. The team have now moved into Ross Tilley and are progressing well with good collaboration from the clinical team. Critical areas (Burns, Critical Care Unit (CCU), Head & Neck, Margaret Duncombe) have been surveyed by fire door specialists with the next phase being planned using a risk-based prioritisation of works.

Fire alarm:
- NHSE funding has been secured, and next phase L1 Fire alarm system upgrade is being planned in A wing, (in Patient areas) Corneo Plastics, prosthetics/MacMillian and Rehabilitation/Day Hospital/Speech therapy.

Kitchen Boiler:
- Project now moving to the snag stage, to allow connection to the temporary boilers.

Estates Workshop:
- Project waiting on power connection and lead time on final components.

Theatre Dampers:
- Specification being built for future tender pack, more intrusive surveys are required to be carried out of hours.

MRI:
- Location requirements have been identified with first design draft in progress. Surveys to begin shortly to support tender specification development. MRI shortlisted to two equipment manufacturers and site visits taken place. Decision on preferred supplier expected shortly. Task and Finish group meeting fortnightly.

Research Education and Innovation Centre:
- Terms of Reference (TORs) complete and fortnightly Task and Finish Group meetings in place. Design consultants engaged to consider options.

Milestone		Start Date	Expected Completion Date	Commentary
Fire Doors C Wing		8th June 20026	8th August 2026	Works commenced and are progressing well at present
MRI equipment purchased		15th May 2026	31st July 2026	Two equipment manufacturers shortlisted and contract will shortly be awarded after agreement through the appropriate approvals process.

KSO4 PROJECT REPORT

Queen Victoria Hospital
NHS Foundation Trust

Digital Transformation Programme

Exec Lead: CMO
Lead: PMO/Head of EPR

Reporting Month: May 26

Overall Status: Amber

The Digital Transformation Programme remains at Amber status and is under active management. 14 workstreams are currently rated either red or amber with Artificial Intelligence (AI) the exception being rated Green. Executive focus remains on Patient Administration System (PAS) replacement with a planned go live of November 2026, Radiology Information System (RIS) procurement and Sussex Pathology Network (SPN) delivery. Digital capacity across all teams is a significant risk and a number of items have been deferred to 2027 including non-critical Archie EPR prioritisaion and eConsent. The overall programme position reflects a broad and active portfolio, with positive progress being made in electronic prescribing and medicines administration (ePMA), Electronic Discharge Notification (EDN), Patients Know Best (PKB), AI, hardware/access and patient-facing digital initiatives.

There has been tangible movement across several amber workstreams, including ePMA build and validation activity (with 16/17-year-old prescriptions expected to go live in August and Paediatrics in October), EDN delivery planning (initial GP sites planned for August), Patient Know Best (PKB)/patient communication activity (switching off of paper records for patients registered on PKB), AI governance development (Ambient Voice Technology (AVT) pilot being planned for September) and hardware deployment. However, delivery remains dependent on specialist capacity, PAS system readiness, operational engagement, Business Intelligence (BI) / reporting availability and timely progression of planned milestones. Several workstreams also share common dependencies, meaning delays in one area may affect wider programme delivery.

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

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

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

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

KSO4 PROJECT REPORT

Queen Victoria Hospital
NHS Foundation Trust

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

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

Progress has been made within the following areas:
1. Works continue on site in East Grinstead. The building is now watertight and works focused on internal construction and groundworks.
2. The roof, concrete flooring and the steel structure have now completed.
3. Activity against plan for CDC activity in June 2026 was 83%. Quarter 1 is likely to be under plan, however it is expected that there will be recovery against plan in Quarter 2.

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

Milestone	Start Date	Expected Completion Date	Commentary
Operational opening of the centre	15/09/2026	12/10/2026	Transition plan drawn up for move of services.
Construction completion on East Grinstead site.	01/09/2025	14/09/2026	Steel installation. laying of concrete and roof completed. Centre now watertight. Opening of centre expected in October 2026.

Date Raised	Risk Description	Mitigating Actions
04/04/2025	Actual CDC activity vs plan.	Continued remedial actions being taken to bring back to plan.
01/05/2026	Project may go over budget because contingency has been used.	Close scrutiny of spend.

KSO4 PROJECT REPORT

Queen Victoria Hospital NHS Foundation Trust

Sussex Pathology Network (SPN)

Exec Lead: CMO
Lead: PMO

Reporting Month: Month 3 - June

Overall Status: R / A / G
Amber

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

LIMS/Order Comms (ICE) – Digital Project Managers and Clinisys continue to work closely to progress the re-baseline exercise with an agreed outcome expected by the end of July. Testing phases per discipline will start when all test entry criteria is met. OCS pages, panels and rules build is ongoing. Cerebro installation at QVH (sample tracking system) is continuing with a test workstation configured to facilitate user acceptance testing (UAT) with the new LIMS environment.
Digital Histopathology (DHP) - Prior to deployment of WinPath Enterprise which enables full integration with DHP, the project at QVH has necessitated a number of workarounds to mimic the interoperability between current end of life systems which has delayed the go-live. Most technical challenges have now been resolved, and the project is progressing through quality acceptance. Go-live target is now July 2026
Digital Infrastructure - Point of care testing (PoCT) UHSx local server setup is ongoing to allow connectivity from QVH to the Cobas Infinity solution. A new PoCT contract is in place and the team is investigating the position in terms of upgrading devices. QVH is working with UHSx who is leading on the SECTRA contract for PACS-based reporting (PBR) with training sessions being provided by Sectra in July.
Managed Service Contract (MSC) – Moderation sessions commenced this month with a target to complete by mid-July. Dialogue period is the next area of significant focus. Discussions taking place with NHSE regarding requirements of the FBC and associated governance timeline with an aim to reduce both (contract award predicted - end Sept 2027)
Network Formation and Laboratory Operating Model (LOM) - The Network Formation work continues with support from Execs from each member organisation within SPN. This will go to the Sussex Provider Collaborative in July 2026 for discussion. LOM outline business case (OBC) is progressing with a site-agnostic preferred way forward until LIMS/MSC implemented. A future state LOM expected to take effect from approx. 2030/31

Milestone	Start Date		Expected Completion Date	Commentary
MSC – Evaluation and moderation of pre-submission tender documents	June 2026		July 2026	Evaluations to commence in June with moderation through to July 2026
LIMS/OCS - Completion of review of all outstanding CCNs by Clinisys	April 2026		July 2026	Once completed, a re-baselined plan between Clinisys and SPN will be drafted and signed off
DHP – QVH go-live for digital slide scanning and reporting	April 2026		July 2026	Dependent on final configuration of Sectra/Trust patient ID data flow, testing anticipated June/July 2026
LOM – Continuation of OBC development	June 2026		Aug 2026	NHSE Transformation Unit to model options based on current state baseline

Date Raised	Risk Description	Mitigating Actions
April 2026	Lack of confirmed external NHSE funding to support programme costs for FY26/27	Trusts have agreed to proceed at risk. Partial funding has been offered to support DHP based projects but not LIMS and Order Comms.
April 2026	LIMS/OCS remains in exception without an agreed plan to meet proposed go-live windows (issue)	SPN & Clinisys actively negotiating re-baselined CCN and reviewing project timelines to identify opportunities to streamline programme activities

KSO5

To collaborate with others

Ambition

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

Board Assurance Framework

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

2026/27 Annual Objectives

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

2026/27 Annual goals

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

KSO5 EXECUTIVE SUMMARY

Queen Victoria Hospital
NHS Foundation Trust

Strategic partnership (implementation and transition)

- Implementation of the strategic partnership is progressing and remains on track. ASPH and RSFT Boards will consider the next stage of assurance and decision making at their Board meetings during week commencing 20 July 2026. Throughout this collaborative partnership process, delivering high-quality patient care and supporting our staff remain the highest priorities. As the partnership develops, each organisation will continue operating as an independent trust, contributing as an equal partner and maintaining its individual identity and local accountability

Engagement (internal/ external)

- Engagement continues to support progress towards the strategic partnership. On 23 June 2026, 107 colleagues from 39 departments and teams attended a walk-in workshop, which ran between 12 and 7pm, providing them with an opportunity to discuss key developments across the organisation, including the East Grinstead Community Diagnostic Centre, Better Value programme, digital transformation, estates infrastructure and partnership working, as well as ask questions. Staff feedback from the workshop indicated positiveness support for change that preserves and builds upon QVH's established strengths and identity.

Provider Collaboratives (Acute and neighbourhood, including SPoA)

- QVH has identified ten priority specialities, including cardiology, sleep medicine and facial palsy, for enhanced triage and advice and guidance processes in line with the Surrey and Sussex Single Point of Access collaboration programme. Due to the specialist nature of QVH services, the specialities identified contain a number of sub-specialities that will require a full review prior to development. Pathway mapping is underway across all specialities to identify opportunities for pathway redesign and straight to test models where clinically appropriate.

Kathy Brasier
Acting Chief Strategy Officer

Interpretation of Summary Icons for Statistical Process Charts

Queen Victoria Hospital NHS Foundation Trust

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

SPC Chart Key:

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

GLOSSARY

Queen Victoria Hospital
NHS Foundation Trust

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

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

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

Report cover-page					
References					
Meeting title:	Board of Directors				
Meeting date:	16/09/2026		**Agenda reference:**	**65-26**	
Report title:	Quality and safety committee assurance				
Sponsor:	Jo Emmanuel, Non-executive Director, committee Chair				
Author:	Jo Emmanuel, Non-executive Director, committee Chair Katie Ally, Governance Officer				
Appendices:	None				
Executive summary					
Purpose of report:	To alert, assure and advise the Board regarding matters considered at the last committee meeting.				
Summary of key issues	– Elective recovery remains challenged, with RTT, diagnostic and cancer performance below trajectory, particularly within Sleep, OMFS, Plastics, Skin and Head & Neck services; however, the committee received assurance that recovery actions - including additional activity, theatre productivity initiatives and pathway redesign - remain in place, alongside continued improvement in long-wait performance. – Cancer pathways remain under pressure from rising urgent suspected cancer referrals and diagnostic delays, particularly within Skin and Head & Neck services; action plans are in place and progress continues to be monitored. – Workforce challenges, sickness absence pressures and estate capacity constraints continue to present operational risks and remain under active review, with further assurance reporting requested by the committee. – New organisational risks relating to the Laboratory Information Management System (LIMS) programme and unsupported ICE system continue to be monitored through executive governance arrangements. – The committee received good assurance on patient safety, noting continued reduction of the historic Datix backlog, improved incident management and some evidence of cultural and organisational learning. – The National Cancer Patient Experience Survey demonstrated excellent patient experience outcomes and strong feedback, which the committee recommended to Trust Board; Friends and Family Test performance also remains above target. – Good progress continues against the Quality Priorities Programme, including work on health inequalities, ethnicity recording and patient outcomes measurement, alongside positive assurance received on NICE compliance, clinical audit governance and Emergency Preparedness arrangements. – Reflecting these strengthened controls, improved patient safety performance and assurance arrangements, the committee reviewed the Quality BAF and supported a proposed reduction in the quality risk score from nine to six, subject to continued monitoring of key quality risks.				
Recommendation:	The Board is asked to **note** the contents of this report and the assurance provided by the Quality & Safety Committee, whilst recognising the continued operational and strategic risks associated with elective recovery, diagnostics, cancer performance, workforce capacity, digital transformation and estates resilience				
Action required	Approval	Information	Discussion	**Assurance**	Review
Link to key strategic objectives (KSOs):	**KSO1:** *To deliver outstanding care*	**KSO2:** *To innovate and improve*	**KSO3:** *To be an excellent employer*	**KSO4:** *To deliver sustainable services*	**KSO5:** *To collaborate with others*

Implications				
Board assurance framework:	The committee reviewed the BAF risk relevant to its remit at the meeting			
Organisational risk register:	The committee received the organisational risk register at the meeting.			
Regulation:	None			
Legal:	None			
Resources:	None			
Assurance route				
Previously considered by:				
	Date:		Decision:	
Next steps:				

Report to: Board of Directors
Agenda item: 65-26
Date of meeting: 16 September 2026
Report from: Jo Emmanuel, Non-executive Director, committee Chair
Report author: Jo Emmanuel, Non-executive Director, committee Chair
Date of report: 02 September 2026
Appendices: None

Sub-committee assurance report
Quality & Safety committee held on 1 September 2026

Key agenda items

- **Executive Committee for Quality & Risk assurance report**
- **Integrated Quality & Performance Report (Month 3)**
- **Quality Priorities Delivery Progress Quarter 1**
- **GMC Doctors in Training Survey**
- **Patient Safety Overview and Update Quarter 1**
- **PLACE Inspection Report**
- **National Cancer Patient Experience Survey**
- **NICE and Clinical Audit Programme Delivery**
- **Emergency Preparedness, Resilience and Response update**
- **Board Assurance Framework and Organisational Risk Register**
- **Committee Effectiveness Review**

Alert

- Performance against elective recovery, diagnostic and cancer standards remains below trajectory, with continued operational pressures affecting delivery. Recovery plans remain in place and continue to be monitored through established governance arrangements.
- Workforce, sickness absence and capacity constraints continue to present risks to service delivery and organisational resilience. The committee requested ongoing assurance regarding mitigation actions and their effectiveness.
- The committee reviewed key quality and patient safety indicators, noting improvements in incident management processes and oversight arrangements, whilst recognising a number of areas requiring continued focus and monitoring.

- The committee reviewed the strategic quality risks reflected within the Board Assurance Framework and received assurance regarding the adequacy of current controls, mitigating actions and governance arrangements.

Assure

- The committee received assurance that recovery actions remain in place across RTT, diagnostics and cancer pathways, including additional activity, theatre productivity initiatives, waiting list validation, pathway redesign and enhanced operational oversight to support delivery of improvement trajectories.
- The committee received assurance regarding patient safety arrangements, including strengthening organisational learning and improving incident management processes. The committee welcomed evidence of cultural improvement and learning from incidents.
- Positive assurance was received regarding the National Cancer Patient Experience Survey, with strong patient feedback and overall patient experience outcomes. The report will be presented to the Board at its September meeting for assurance and oversight.
- Assurance was received regarding National Institute for Health and Care Excellence compliance, clinical audit governance, General Medical Council trainee oversight, Emergency Preparedness and resilience arrangements. Action plans are in place where improvements are required.
- Progress was noted against the Quality Priorities Programme, including work on health inequalities, ethnicity recording, patient outcomes measurement and improvement methodologies.
- The committee supported further development of outcome measures across quality priorities and encouraged greater use of patient outcomes and experience information to inform improvement activity.
- Strong patient experiences outcomes continue to be reported, including Friends and Family Test performance above target and continued focus on learning from patient feedback.

Advise

- The committee requested enhanced future reporting on performance trajectories to strengthen assurance regarding delivery of operational improvement programmes.
- Further work is required to strengthen oversight and governance arrangements relating to key service agreements and commissioned activity, with an update requested within three months.
- The committee discussed the need for continued focus on Mental Capacity Act compliance, training effectiveness and strengthening assurance regarding implementation of improvement plans.
- Following discussion of the Patient-Led Assessments of the Care Environment inspection outcomes, the committee requested a clearer assessment of the relative risk and prioritisation of outstanding actions, particularly regarding accessibility and wayfinding.
- The committee considered the outcome of its annual light-touch effectiveness review and concluded that it continues to operate effectively. The committee identified opportunities to further enhance communication of committee outcomes, strengthen engagement through work programme seminars and maintain strong operational participation and challenge.

Risks discussed and new risks identified

The committee discussed a range of operational, workforce, quality, digital and infrastructure risks relevant to the delivery of safe and effective services. The

committee reviewed the adequacy of existing controls, mitigating actions and assurance arrangements, and received assurance regarding ongoing monitoring and executive oversight of these risks.

The committee reviewed the Quality Board Assurance Framework risk score and discussed whether the current score remained appropriate in light of improvements in controls, actions and assurance mechanisms. The committee acknowledged areas requiring ongoing focus, including compliance, incident management and assurance maturity, whilst noting progress in strengthening governance arrangements and oversight.

Assurance was received regarding governance and risk management arrangements, including continued development of the Board Assurance Framework and strengthened executive ownership of strategic risks. The committee supported a proposal to reduce the quality risk score from 9 to 6, subject to Executive Team consideration and continued monitoring of key quality indicators, controls and assurance measures.

Recommendation

The Board is asked to:
Note the contents of this report and the assurance provided by the Quality & Safety Committee, whilst recognising the continued operational and strategic risks associated with elective recovery, diagnostics, cancer performance, workforce capacity, digital transformation and estates resilience

Report cover-page					
References					
Meeting title:	Board of Directors				
Meeting date:	16/09/2026	**Agenda reference:**	**66-26**		
Report title:	Financial, workforce and operational performance assurance				
Sponsor:	Nick Page, Non-executive Director, committee Chair				
Author:	Nick Page, Non-executive Director, committee Chair Katie Ally, Governance officer				
Appendices:	None				
Executive summary					
Purpose of report:	To alert, assure and advise the Board regarding matters considered at the last committee meeting.				
Summary of key issues	– Referral to Treatment (RTT), cancer and diagnostic performance remain below trajectory, with continued demand growth in Sleep, OMFS, Skin and Head & Neck services driving waiting list pressures. Whilst challenges remain, improvements were noted in long-wait performance and elective recovery activity. – The Trust delivered its planned Month 3 financial position; however, achievement of the full-year Better Value Programme remains challenging and a financial recovery plan is being developed to address the remaining efficiency gap and support long-term sustainability. – The committee received assurance on progress within the Digital Transformation Programme, whilst noting ongoing risks relating to PAS implementation timescales, operational readiness and programme funding beyond December 2026. – Waiting List Assurance Review – significant progress has been made, with strengthened governance, oversight and reporting arrangements. Delivery of remaining actions is dependent on increasing analytical capacity within the BIU, which remains a key risk, with additional support options being explored.				
Recommendation:	The Board is asked to **note** the contents of the report				
Action required	Approval	Information	Discussion	**Assurance**	Review
Link to key strategic objectives (KSOs):	**KSO1:** *To deliver outstanding care*	**KSO2:** *To innovate and improve*	**KSO3:** *To be an excellent employer*	**KSO4:** *To deliver sustainable services*	**KSO5:** *To collaborate with others*
Implications					
Board assurance framework:	The committee reviewed the BAF risk relevant to its remit at the meeting				
Organisational risk register:	The committee received the organisational risk register at the meeting.				
Regulation:	None				
Legal:	None				
Resources:	None				
Assurance route					
Previously considered by:					
	Date:		Decision:		
Next steps:					

Report to:	Board of Directors
Agenda item:	66-26
Date of meeting:	16 September 2026
Report from:	Nick Page, Non-executive Director, committee Chair
Report author:	Nick Page, Non-executive Director, committee Chair Katie Ally, Governance Officer
Date of report:	02 September 2026
Appendices:	None

Sub-committee assurance report
Finance and Performance Committee held on 1 September 2026

Key agenda items

- **Waiting List Assurance Action Plan update**
- **Integrated Quality & Performance Report – Month 3 and outlook**
- **Financial recovery options 2026/27**
- **Cost Improvement Programme (CIP) update**
- **Winter Plan – 2026/27**
- **Partnership Benefits realisation**
- **East Grinstead Community Diagnostic Centre (CDC)**
- **Digital Transformation including PAS and benefits realisation**
- **Premises Assurance Model 2026**
- **MRI Procurement and Refurbishment**
- **Estate assurance**
- **Review of Board Assurance Framework and Organisation risk register**
- **Review of committee's terms of reference**

Alert

- Operational performance recovery - the committee reviewed the Month 3 Integrated Quality and Performance Report and noted that RTT, cancer and diagnostic performance remain below trajectory. Sustained demand growth within Sleep, OMFS, Skin and Head & Neck services continues to drive waiting list growth and performance pressures. Whilst performance remains challenged, improvements were noted in clock-stop activity and reductions in the >65 week and >78 week cohorts. Recovery plans continue to be monitored through enhanced executive oversight arrangements.
- Financial sustainability - The committee noted that the Trust delivered its planned Month 3 financial position and remained in line with plan year to date. The committee discussed the continuing challenge of achieving the full-year Better Value Programme and noted that a detailed financial recovery plan is in development to meet the 2026/27 financial plan and address the underlying deficit to secure long-term sustainability.
- Digital Transformation Programme - the committee received an update on the Digital Transformation Programme and Patient Administration System (PAS) implementation. Risks remain relating to programme timelines, system readiness and programme funding beyond December 2026 and will be reviewed at the next meeting. National assurance support remains in place.

Assure

- Waiting List Assurance Review - The committee received assurance regarding waiting list governance arrangements and noted that improvement actions are being progressed and monitored.
- The committee received assurance regarding delivery of major strategic programmes, including:
    - Digital Transformation Programme - The committee received an update on the Digital Transformation Programme, including implementation of the new Patient

Administration System (PAS). The committee received assurance regarding progress of the Digital Transformation Committee and noted that risks and dependencies continue to be actively managed through established governance arrangements. The committee discussed operational readiness, software quality, implementation assurance arrangements and programme sustainability. Assurance was received that extensive oversight and assurance support is being provided through national programme teams and external specialists. The committee also noted continuing financial risks associated with sustaining programme resources beyond December 2026 and requested ongoing reporting regarding contingency arrangements and programme affordability.

- MRI Programme - The committee considered the MRI Programme as part of both the major projects update and the subsequent business case discussion. The committee noted that the programme represents a significant strategic investment that will improve patient experience, diagnostic resilience and service sustainability. Assurance was received regarding procurement arrangements, governance structures and programme planning. The committee discussed funding arrangements, estate dependencies, delivery timescales and residual risks and was satisfied that appropriate mitigation plans are being developed. The committee noted the work being carried out to firm-up the outline cost estimates. The risk of the programme slipping into the following financial year if procurement is delayed was discussed. The committee subsequently endorsed the preferred option, supported the progression of the scheme and recommended for approval the business case and contract award to the Board and Corporate Trustee.
- Research, Innovation and Education Centre - The committee noted continuing progress with development of the Research, Innovation and Education Centre, including establishment of dedicated task and finish arrangements and ongoing design and stakeholder engagement work. The programme remains aligned to the Trust's strategic ambition to strengthen research, innovation and education activity and that further updates will be presented as planning progresses.

- Estates assurance - the committee received assurance that progress continues against critical infrastructure priorities, including fire safety compliance, estate resilience programmes and backlog maintenance schemes. The committee noted positive engagement with regulators and ongoing risk-based prioritisation of capital investment.

Advise

- Partnership benefits realisation - The committee welcomed the partnership benefits realisation framework and noted progress in establishing the six partnership workstreams. The committee emphasised the importance of moving from a high-level framework to the identification, quantification and prioritisation of benefits to ensure focus is maintained on those areas delivering the greatest value across the Group. The committee requested future reports provide clearer information on expected financial, operational and clinical benefits, associated risks, delivery timescales and ownership arrangements. Emphasis was placed on distinguishing between local organisational benefits and wider Group benefits, with robust arrangements required to track delivery, demonstrate early wins and monitor long-term benefit realisation.
- Winter plan 2026/27 - The committee reviewed the Winter Plan and was advised that arrangements are in place to maintain elective, cancer and urgent care services whilst supporting wider system resilience and mutual aid requirements during periods of pressure. The committee supported submission of the Trust's Winter Plan to the ICB in accordance with the national planning timetable

- The committee reviewed the PAM submission and supporting action plan and having received assurance regarding the robustness of the assessment and identified improvements, recommends the submission to the Board for approval.

Risks discussed and new risks identified
The committee reviewed the Board Assurance Framework and Organisational Risk Register and received assurance regarding the continued development of alignment between risk, performance and assurance reporting.

The committee considered principal risks relating to operational performance, financial sustainability, major transformation programmes and strategic delivery. No new strategic risks were identified for escalation to the Board beyond those already captured within existing risk reporting arrangements.

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

Report cover-page					
References					
Meeting title:	Board of Directors				
Meeting date:	16/09/2026	**Agenda reference:**	**67-26**		
Report title:	Strategy and culture assurance				
Sponsor:	Angela McNab, Interim Trust Chair and committee Chair				
Author:	Ellie Simpkin, Governance manager				
Appendices:	None				
Executive summary					
Purpose of report:	To alert, assure and advise the Board regarding matters considered at the last committee meeting.				
Summary of key issues	- The key areas of deterioration in the 2025 NHS Staff Survey have been identified. Executive-led engagement sessions have informed targeted action plans to address concerns raised. Key themes include workforce capacity, communication, leadership visibility, wellbeing and recognition. Action plans are established across the majority of teams. - The strategic partnership has progressed into mobilisation following approval of the expanded Group arrangements and Memorandum of Understanding. Clinical and corporate collaboration is developing across priority areas. A Benefits Realisation Framework is being developed to support consistent identification, measurement and monitoring of partnership benefits. Oversight of the implementation and realisation the specific partnerships benefits will be reported to the relevant Board sub-committee. - Progress is being made across all priority areas of the Trust-wide Engagement Plan. Strategic partnership communications and engagement arrangements have been established across all three organisations and opportunities to increase patient and public involvement are being explored. - The committee is assured on the strong progress being made across all four strategic pillars of the Trust's Research & Innovation Strategy with the focus remaining on improving patient outcomes.				
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:	67-26
Date of meeting:	16 September 2026
Report from:	Angela McNab, Interim Trust Chair and committee Chair
Report author:	Ellie Simpkin, Governance manager
Date of report:	04 September 2026
Appendices:	None

Sub-committee assurance report
Strategy & culture committee meeting held on 3 September 2026

Key agenda items

- **Partnership update**
- **Trust-wide engagement plan – action plan implementation**
- **Research & Innovation update**
- **Staff survey update**
- **Pulse survey QVH findings report**
- **Culture Diagnostic Review**
- **Workforce Race Equality Standard annual report 2025/26 and Workforce Disability Equality Standard annual report 2025/26**
- **Gender pay gap report as at 31 March 2026**
- **Ethnicity pay gap report as at 31 March 2026**
- **Apprenticeship Levy annual report 2025/26**
- **Board Assurance Framework & Organisational risk register**
- **Committee Terms of Reference**

Alert

- The committee received a report on the key areas of deterioration identified in the 2025 NHS staff survey and the outcome from Executive-led engagement sessions with teams on resulting action plans developed to address concerns raised. This was considered alongside a thematic analysis of the Q4 2025/2026 and Q1 2026/2027 People Pulse findings. Key themes across service areas include workforce capacity, communication, leadership visibility, wellbeing and recognition. Action plans are now established across the majority of teams with clear improvement plans in place across most services. The committee welcomes the work done to identify teams with the largest decline in scores and the engagement being carried out with teams to develop specific action plans. Progress against the staff survey actions will be monitored through directorate governance arrangements and reviewed by the Executive Team. The committee will receive a further update in Quarter 3 2026/27.

Assure

- The strategic partnership has progressed into mobilisation following approval of the expanded Group arrangements and Memorandum of Understanding in July 2026. Initial leadership and governance arrangements are progressing. Clinical and corporate collaboration is developing across priority areas. A Benefits Realisation Framework is being developed to support identification, measurement and monitoring of partnership benefits, with work underway across the group to prioritise benefits. Oversight of the implementation and realisation of the specific partnerships benefits will be reported to the relevant Board sub-committee.
- Progress is being made across all priority areas of the Trust-wide Engagement Plan. Strategic partnership communications and engagement arrangements have been established across all three organisations and opportunities to increase patient and public involvement are being explored.

- The committee is assured on the strong progress being made across all four strategic pillars of the Trust's Research & Innovation Strategy with the focus remaining on improving patient outcomes. Research leadership is being strengthened through identified directorate leads and embedding research in Trust reporting. Work continues on the plans to develop the Trust's Research, Innovation and Education Centre. The Commercial Research Lead is now in post and will be key in building relationships and establishing industry links necessary to deliver our challenging commercial income targets. Future reporting will align to the recently published NHS England Framework for NHS boards: monitoring research activity.
- The Trust's Apprenticeship Levy annual report 2025/26 shows that apprenticeship levy utilisation increased from 76% to 88%. 11.29% of all apprentices declared ethnic diversity against a target of 12% and 11.29% of apprentices declared a disability against a target to maintain 9%. An action plan to improve access for underrepresented groups, including neurodiverse staff has been delivered. The committee has highlighted the importance of apprenticeships as a way to help reduce inequalities and widen participation.
- The committee has reviewed the workforce annual reports, which will be presented to the Board at its September meeting:
    - The Trust's gender pay gap improved in 2026. The pay gap continues to be driven by workforce composition rather than unequal employment practices. A Gender Pay Gap Deep Dive found no evidence of bias in recruitment, development or progression processes.
    - The Trust's Ethnicity pay gap continues to improve, remaining in favour of BME staff. Workforce diversity is increasing with workforce composition remaining the main driver of the pay gap.
    - The Workforce Race Equality Standard annual report 2025/26 and Workforce Disability Equality Standard annual report 2025/26 demonstrate improvement in BME and disabled staff representation. Reports of bullying and harassment have reduced among both BME and disabled staff. Career progression remains an area of challenge and will be an area of focus for 2026/27.
    - The committee discussed how the Culture Diagnostic Review can inform priorities for improving organisational culture, alongside the 2025 staff survey results and actions.

Advise
- An amendment has been made to the committee's Terms of Reference to reflect the reduction in Board Non-Executive Director membership and these are recommended 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, noting the key action being taken to address gaps in assurance. The scores for all of these BAF risks remain the same.

The committee highlighted the importance of questioning whether all available controls are being employed to mitigate the areas of most risk.

The partnership risk register continues to be reviewed through the QVH Partnership Steering Group as the programme moves into mobilisation.

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

Report cover-page					
References					
Meeting title:	Board of Directors				
Meeting date:	16/09/26	**Agenda reference:**	**68-26**		
Report title:	Research and Innovation update				
Sponsor:	Tamara Everington, Chief Medical Officer				
Author:	Mary Mason, Associate Director of Research, Innovation and Improvement				
Appendices:	Appendix 1 - Strategic Partnership Benefits – Deep Dive Appendix 2 – Pipeline document				
Executive summary					
Purpose of report:	To update the Board on Research and Innovation progress				
Summary of key issues	• Research leadership strengthened, with directorate leads identified and research embedded in Trust reporting. • Progress continues on the Research, Innovation and Education Centre, supported by strong staff engagement. • Governance and infrastructure have advanced through REDCap development, new innovation policies and key appointments. • Strategic projects have improved research delivery and strengthened primary care partnerships. • Additional funding secured to support growth despite reduced NIHR core funding. • A proactive research pipeline is improving prioritisation and delivery of opportunities. • Stronger academic, commercial and system partnerships are supporting sustainable growth. • Progress remains on track to increase research activity, innovation and patient access to research.				
Recommendation:	The Board is asked to **note** the update.				
Action required	Approval	Information	Discussion	**Assurance**	Review
Link to key strategic objectives (KSOs):	**KSO1:** ***To deliver outstanding care***	**KSO2:** ***To innovate and improve***	**KSO3:** ***To be an excellent employer***	**KSO4:** ***To deliver sustainable services***	**KSO5:** ***To collaborate with others***
Implications					
Board assurance framework:	None				
Organisational risk register:	None				
Regulation:	GMC Good Clinical Practice				
Legal:	None				
Resources:	In order to progress research & innovation, the Trust must match central NIHR funding with commitment of integrated resource				
Assurance route					
Previously considered by:	ELT, Strategy & Culture Committee				
	Date:	24/08/26 03/09/26	Decision:	N/A Update paper	
Next steps:					

Report to:	Board of Directors
Agenda item:	68-26
Date of meeting:	16 September 2026
Report from:	Tamara Everington, Chief Medical Officer
Report author:	Mary Mason, Associate Director of Research, Innovation and Improvement
Date of report:	07 August 2026
Appendices:	Appendix 1 - Strategic Partnership Benefits – Deep Dive Appendix 2 – Pipeline document

Research and Innovation update

Executive summary

Over the past six months, QVH has made strong progress against its Research and Innovation Strategy across all four strategic pillars. Key achievements include the appointment of a new Clinical Director of Research and Innovation, increased integration of research within Trust governance and performance reporting, and the identification of directorate research leads to strengthen research culture and leadership.

Significant advances have been made in developing the Research, Innovation and Education Centre, supported by extensive staff engagement and executive oversight, while research infrastructure and governance continue to mature through initiatives such as REDCap expansion, innovation policy development, and recruitment to key research roles.

NIHR Strategic funded projects have delivered measurable benefits, including improved research study set-up processes and strengthened partnerships with primary care, creating sustainable foundations for future collaborative research delivery.

Despite challenges relating to workforce capacity, infrastructure dependencies and reduced NIHR core funding, the Trust has secured additional strategic funding, established a proactive research pipeline, strengthened external partnerships with academic, commercial and system partners, and continues to focus on increasing research activity, commercial income and patient access to research.

Overall, progress remains on track with the strategic plan, and work continues to build a sustainable, research-active culture that supports innovation, improves patient outcomes and positions QVH for future growth.

Progress against Research Strategy

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

Pillar 1 – Develop Strategic leadership and culture of research

The New Clinical Director of Research and Innovation took up his post in May taking the Chair at the monthly Research Governance Group and with regular meetings scheduled to work through priorities within the Operational plan and Strategy. Initial discussions with many clinical colleagues have taken place affirming the intent to appoint research leads utilising the 0.25pa resource secured earlier via POAP with proposed leads in each directorate identified subject to confirmation meetings.

Research and Innovation section is now noted within the IQPR reporting structure further embedding research as a core part of the directorate service delivery and resulting in useful dialogue and sense of shared ownership between operational management and the R&I function. Discussions in progress to co-design a shared space where updated and 'live' information is held relating to research studies within each clinical specialty, updated activity and recruitment figures further supporting full and shared accountability.

Outreach to operational teams remains a priority for the Associate Director with the pilot of an interactive presentation designed and delivered at unit meeting within the OMFS Directorate with good engagement and interest. This will be extended across other unit meetings in the coming months outlining our strategic goals, encouraging colleagues to become involved in research and innovation, and importantly thanking those colleagues already supporting our team and patients already participating in research studies showing the impact this has on patient care and outcomes.

A new IP and Innovation policy has been developed going through final ratification which will encourage and support our teams to innovate and develop novel ideas. This will be socialised and shared through induction and the clinical learning forum further reinforcing our desire to actively support and promote innovation from our expert clinicians here at QVH.

Pillar 2: Workforce, Infrastructure and Governance

Significant progress has been made with development of the Research, Innovation and Education centre over the past 6 months. A successful engagement event was held with over 100 staff engaging on a series of questions relating to the centre name, resources available within the space and considerations that colleagues across the Trust have for utility of the area.

An executive led Task and Finish group continues with PMO and QVH Charity oversight incorporating key stakeholders who meet bi-weekly to drive this vital development forward. Limiting factors include interdependencies with other Trust estates priorities, however the group continues to progress with designers in place ready to provide plans once resource mapping and engagement is complete from stakeholder representatives. A co-design group is being developed using Experienced Based Co-design techniques to deliver the final inclusive centre wish list with 'The QVH Way' continuous improvement methodology utilised to deliver this important piece of the Trust development.

Our project in partnership with University of Sussex is nearing its conclusion with the final results being collated over the next 2 months. As such, some of the pump-prime funding has been drawn down against the original bid resulting in a successful and smooth delivery of this key project. The existing Laboratory infrastructure has been further developed and utilised successfully as part of this work with installation of existing resources previously stored elsewhere across the Trust along with required and agreed expenditure drawn down in line with the Charity bid.

An audit has concluded exploring potential wider use of REDCap (a research database with survey functionality) across the Trust to ensure that investment planned in the second phase of this deployment will realise wider benefits for example in recording and reporting patient outcomes of care. A paper will be delivered to the September Research Governance Group meeting for final approval of Phase 2 deployment which will enable use for all QVH sponsored studies.

Although delays remain in the establishment of an Innovation Forum, we remain committed to developing and learning from innovation as a Trust. One example of this is the 'Bleepa' platform offering asynchronous MDT functionality. This programme is part of a pilot evaluation for NHSE and learning following 2 independent evaluations will be shared in September at an NHSE event.

In support of the increased governance oversight, the workforce model remains a priority with discussions in place to optimise any opportunities across the partnership as we move forward. Synergies clearly exist from initial discussions with our colleagues / peers at RSC and ASPH and we look to developing these further over the coming 6 months. Please see the attached paper [***Appendix 1- 'Strategic Partnership Benefits – Deep Dive' – Chris Attoe***] which explores the art of the possible for research and innovation within the partnership model.

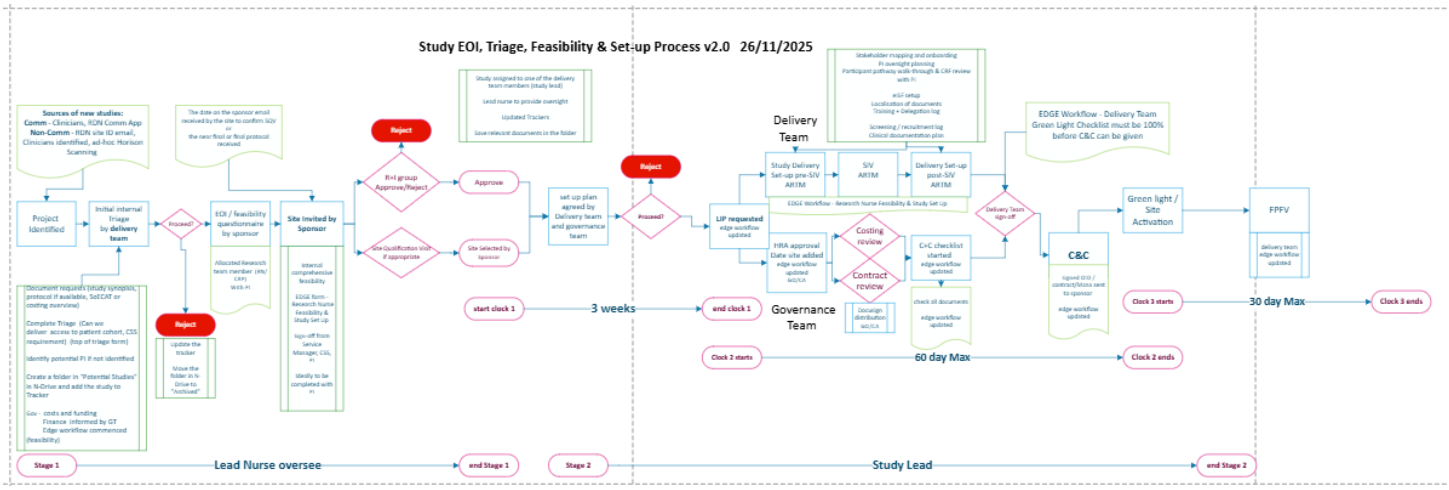
Following an extended period of recruitment, we have successfully recruited our new Commercial Research Lead who will commence post in September. Our Governance Officer is leaving the Trust in September having secured a promotion to a senior governance role within a university; recruitment is underway to minimise the gap with cover provided within existing resource.

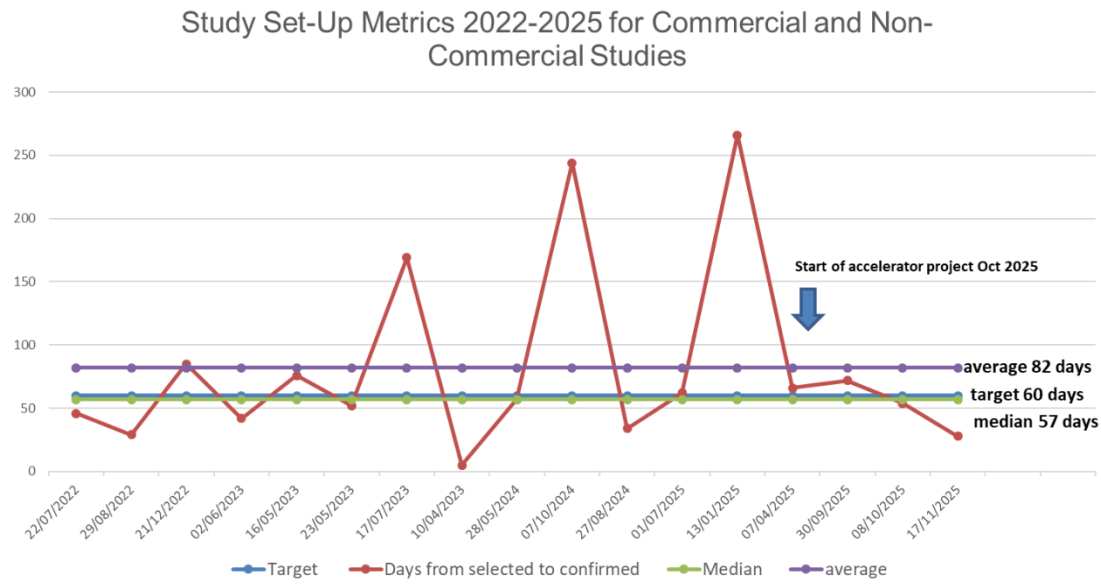
Pillar 3: Sustainable growth

Since the last report, 2025/6 Strategic funded projects have completed.

Research Accelerator programme – We successfully recruited our Research Governance Officer to this 6-month fixed term post joining research colleagues across the wider system to help improve and achieve the national 150 days research set up ambition. As part of this, using a Continuous Improvement approach, the end-to-end research process was mapped to ascertain potential barriers to achievement of this key metric and funding KPI.

At the end of the project, our team delivered a presentation to the wider national teams involved in this work and were congratulated on the results with a published standardisation process map clarifying responsibilities at each stage of the process ultimately demonstrating a reduction in variation of set up times of studies commencing following the work.





PCN project – The project successfully established a strong research partnership between QVH and the East Grinstead PCN, increasing research awareness, capability and engagement within primary care. Key successes included introducing research training for PCN staff, embedding research into regular leadership and Patient Participation Group discussions, developing sustainable processes for sharing study opportunities, and securing participation in the INDIGO Community study. The collaboration has also identified opportunities for future joint study delivery, supporting the longer-term ambition of providing more locally accessible research opportunities across primary and secondary care.

A key learning from the project was the significant challenge of delivering research within primary care, where workforce capacity, competing clinical priorities and limited dedicated research infrastructure can restrict participation. The programme demonstrated that building effective cross-sector research partnerships requires time, sustained engagement and tailored support.

Despite these challenges, the project has established strong foundations for ongoing collaboration, increased research visibility within the PCN, and created a platform to expand joint research activity through the Strategic Funding award for 2026/27 which is now in place as a ‘step-down’ project to ensure that we withdraw slowly enabling partners to continue benefitting from the gains.

Financial stability

As noted in previous reports, our funding income from the NIHR annual award has reduced this year to £194,301, a reduction of £14,625 from last year. Two strategic funding bids were successful securing an additional £38,763 resulting in an income total of £235,749 from the NIHR annual funding round.

We are focusing on plans already mentioned to increase our commercial income this year, this is supported by the new (and soon to be revised) commercial redistribution policy along with the commercialisation review commissioned in partnership with Mid Sussex Council which is being undertaken by Coast to Capital. We have shared initial opportunities to partner with other organisations where mutual benefit is anticipated, these discussions continue and will be reported as they progress.

In order to maximise our opportunities for NIHR funding in subsequent years we are working hard to optimise the performance element of the funding by increasing study portfolio, participants and delivery to time and target along with development of a proactive research pipeline and regular horizon scanning. The pipeline is reviewed at Research Governance Group meetings to help mobilise studies at pace within the new governance processes ensuring they are time and target focussed

Pillar 4: Collaboration and Partnerships

A new shared pipeline document (noted also above) has been developed which allows tracking of all opportunities for research and innovation from the point at which we identify them with updates and next steps planned right through to set up and delivery. Our 'live' visible and proactive pipeline of home-grown and portfolio / non portfolio studies is updated and will be visible to key stakeholders. This document ***[Appendix 2 –Pipeline Document]*** identifies those studies that are feasible to commence within 3 months, 6 months and 12 months along with home grown opportunities requiring funding applications with timelines expected and assessment of realistic expectation of successful award. Where options are not able to progress, rationale and feasibility challenges are noted so that we can regularly review potential barriers further optimising our opportunities for the future.

Strong links have been formed with partners at the Commercial Research Delivery Centre in Sussex. The Business Manager has recently been invited to be part of our Interview panel for the new Commercial Research Lead and will provide induction support and invite the role to key commercial / industry partner meetings to ensure from the outset that the role quickly builds relationships and develops these industry links necessary to deliver our challenging commercial income targets.

As the University of Sussex project comes to close, partners plan to develop a secondary bid following on the success of the pre-clinical trial and partnership nearing completion. This strong relationship is expected to further develop and will be reported as we progress.

Our PCN step down project funded by our bid to the NIHR Strategic Fund continues with our Senior Research Lead supporting the new research forward practices to develop their own research providing mentoring and training as required. As part of this our new annual programme of monthly Lunchtime Learning sessions has been developed and is due to commence in September with a hybrid model of face to face, Teams and recorded sessions to enable all staff across the Trust and our PCN partners to join together to participate and learn how to get involved in research.

Despite Innovation hub development moving slower than anticipated, internal innovative collaborations continue to be discussed and feasibility assessed, these are noted within the pipeline document.

Dependencies / Challenges

As part of our aim to support our directorates to embrace and increase research activity in line with our strategic objectives, we are continuing to monitor utilisation of research clinics in order to ensure resources are utilised appropriately in collaboration with our operational leaders.

In order to ensure that research leads in each directorate have job planned time to undertake research and that clinical support areas (eg. Pharmacy) are able to support research growth, we have secured funding to each of these areas to cover this important investment in research via POAP and this is evident already via budget

statements. It is expected that operational colleagues are therefore able to evidence the agreed utilisation of this funding via their IQPR reporting which will greatly contribute to the desired uplift in research activity.

Summary
Over the last 6 months we have made steady progress consistent with the strategic plan. Whilst it is too early to say if the investment approved in cost pressures is showing the necessary uplift in activity, the ambition remains to meet the strategic targets for this year with continued collaborative support, an increase in the number of research forward clinicians and our mutual desire to develop a stronger research culture. A paper planned for circulation to the partnership group outlines the opportunities and strategic ambitions that can help accelerate our progress towards this joint endeavour, and although also very early to say how this might work in terms of shared posts, we look to explore this further over the coming months.

We have heard the desire for a showcase event which remains a key objective which our teams and governance groups are developing to ensure that our successes and progress are shared whilst creating organisational hunger to offer more research led care to our patients and meet the organisational strategic goals.

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

STRATEGIC PARTNERSHIP BENEFITS - DEEP DIVE

This document presents a deep dive into 4 key benefits to Royal Surrey and Ashford & St Peter's relating to the strategic partnership with QVH. These benefits were primarily identified in the initial proposal and partnership scoping phase, and developed further during mutual planning and assurance work across the three partners (via a partnership benefits framework), and have been highlighted here based on Board discussions at Royal Surrey and Ashford & St Peter's. It is believed that these strategic risks are the most pertinent to demonstrate the case for the partnership at the current time and are more tangible that other strategic benefits such as system influence and positioning based on the scale and geography of an expanded group.

1. Patient benefit across specific services
2. Workforce development, resilience and corporate function alignment
3. Regional leader in research, development and innovation

The purpose of reviewing these benefits is to ensure that we are focusing on the right areas of collaboration for the partnership and that we can understand the potential in key areas, recognising that continued work will be required in these areas and that certain developments will only be possible in future as a partnership develops, subject to organisational governance.

Deep dive benefit 3: Regional leader in research, development and innovation

Regional leader in research, development and innovation						
Overall Confidence Rating (RAG)	**Q3- 2025/26**	**Q4- 2025/26**	**Q1- 2026/27**	**Q2- 2026/27**		
Deep Dive Benefit 3	**Benefit description** Establishing regional leadership in research, development and innovation through scale, breadth and pooled resources that drive improved patient outcomes, choice, and experience, enhanced staff development and satisfaction, and financial benefits through research and innovation. **Benefit type:** Quality / Workforce / Financial **Scope:** An expanded group incorporating QVH alongside RSFT and ASPH presents a significant strategic opportunity to establish a regionally leading centre of excellence for research, development and innovation (RDI) across the South East. By combining the scale, clinical breadth and population reach of RSFT, ASPH and QVH's research portfolios and established academic partnerships, the Group would be well positioned to extend both its research capability and translational impact. **Expanding Research Scale and Reach** The integration would enable a step-change in research scale by: • Extending access to specialist research programmes across a broader patient population and range of specialties • Increasing the volume, diversity and complexity of research activity, particularly in priority clinical areas such as surgical specialities, complex reconstruction, oncology, frailty, and certain medical specialties • Enhancing patient access to clinical trials and innovative treatments, ensuring more patients benefit from cutting-edge care closer to home • Aligning elements of research agendas around transformative policy shifts and their implementation – neighbourhoods, health inequalities, digital service delivery models, scaled services (e.g. single points of access) This creates the foundation for a networked research model, where expertise is concentrated but delivery is distributed across the Group. **Strengthening Academic and System Partnerships** An expanded group's established links with leading academic institutions (including University of Surrey, Royal Holloway, Imperial College, Brighton and Sussex Medical School, University of Sussex, University of Bath) provide a strong platform to: • Extend academic partnerships across all three organisations • Attract additional research funding, grant income and collaborative opportunities • Position the Group as a partner of choice for universities, life sciences organisations and industry (QVH member of Federation of Specialist Hospitals) At scale, the Group could play a more prominent role within regional academic health science systems, ICS-wide innovation agendas, and national research networks					

Accelerating Translation from Research to Clinical Practice
A key ambition would be to improve the translation of research into patient care by:

- Embedding innovation pathways across multiple trusts and care settings, including faster study setup times
- Enabling faster adoption of new techniques, technologies and treatment pathways, through both commercial research and home-grown trials
- Supporting a stronger pipeline from discovery research to first-in-human/early phase trials to implementation within services

This would move the Group beyond research participation to becoming a leader in applied clinical innovation

Building a Critical Mass of Research Capability and Talent
The combined group would create a larger, more attractive RDI environment, enabling:

- Recruitment and retention of high-calibre clinical academics and research staff
- Development of joint research roles, fellowships and academic career pathways
- Increased opportunities for clinicians across all sites to participate in research, including NMAHPs

Over time, this would drive a more embedded research culture across all three Trusts and stronger alignment between clinical excellence, education and innovation

Driving Innovation, Productivity and Service Transformation
RDI capability would not sit in isolation but act as a key enabler of transformation and innovation, supporting:

- Development and adoption of digital innovation, data analytics and AI-enabled pathways
- New models of care informed by evidence and evaluation, e.g. within neighbourhood health
- Improvements in productivity, quality and outcomes through innovation at scale

This aligns directly with wider workforce, digital and clinical transformation ambitions across the Group.

Creating a Recognised Regional Centre of Excellence
The long-term ambition is to position the Group as:

- A regionally leading centre for specialist research and innovation
- A recognised hub for complex clinical research and translational medicine
- A contributor to national research priorities, international, academic, and industry collaboration (with all partners investing NIHR funds in industry and commercial capability)

This would enhance organisational reputation, our ability to attract funding and partnerships, and contribute to economic growth and the life sciences ecosystem in the region

Scale: Our combined research activity, based on participant recruitment numbers, would position us in the top 30 trusts nationally. Regionally, this positions us second across Kent, Surrey, Sussex, a handful of participants fewer than Maidstone & Tunbridge in first, and considerably ahead of UHSx. This scale and benchmarking demonstrates the ability to deliver on the ambitions outlined above, as well as demonstrating how many patients research at scale can positively impact.

	Measure	FY2425	FY2526
Ashford and St Peter's Hospitals NHS Foundation Trust	Participants recruited	3799	3298
	National rank	61	69
	Studies recruiting	38	33
	National rank	107	113
Royal Surrey County Hospital NHS Foundation Trust	Participants recruited	4079	4112
	National rank	58	61
	Studies recruiting	66	62
	National rank	75	75
	Participants recruited	531	228

Queen Victoria Hospital NHS Foundation Trust	National rank	124	132
	Studies recruiting	14	10
	National rank	134	134
Combined	Participants recruited	8409	7638
	National rank	31	27
	Studies recruiting	118	105
	National rank	42	46

<u>Outcomes and measurement</u>: Building on the existing performance metrics of R&D activities (including participant and study numbers, commercial and grant income, evidence of translational impact of patients, and regulatory compliance), additional outcomes targeted would be major strategic partnership (e.g. with industry), major NIHR grants (e.g. infrastructure funding), and work towards University Hospital status.

<u>Timeline / milestones</u>: Further development of this collaborative proposition, understanding of the resources, assets, strengths, and opportunities across research and innovation, and building the relationships and knowledge across teams, departments and research active clinicians and our partners – by Apr-27.

Further alignment activities to be mapped out to begin from Apr-27, including sharing our processes and procedures, partnership collaborations, grant opportunities, industry engagement, and strategic alignment of our areas of research interest. Live collaborations on specific studies, grants, partner engagement to be sought specifically.

Responsible committee	Partnership Working Group (move to joint Sub-Co if partnership proceeds)	**Date Benefit added:**	Oct-25		
Principal Exec – Benefit Owner	Chris Attoe, Group Director of Strategy	**Date Benefit last reviewed:**	Jun-26	**Date next review:**	Jul-26
Benefit Handler(s)	Associate Directors of RD&I	**Date Benefit last formally discussed:**	Jun-26	**Date next formally discussed:**	Jul-26

Inherent Score

Maturity	Confidence 1	2	3	4	5
5					
4					
3					
2		X			
1					

Current Score

Maturity	Confidence 1	2	3	4	5
5					
4					
3			X		
2					
1					

Direction of travel since last review 

Target Score

Maturity	Confidence 1	2	3	4	5
5					X
4					
3					
2					
1					

Target date	Apr-28
Benefit value	High

Risks to delivery	**Mitigations**
Access to baseline and comparable data to understand each trust's R&D activity, identify and measure changes that can drive these benefits and map the strengths, weaknesses, assets	National benchmarking data already available, working within the same Regional Research Delivery Network, with teams already sharing information and connecting
Must ensure continued alignment from Executive to departmental leadership to leading research-active clinicians	Close working required between senior R&D leaders across the trusts, as well as with senior research active clinicians who shape the views of those around them. Must give clarity on the purpose, opportunities, and impact that this collaboration could have on patients, staff, and the organisations

Capacity and capability to increase our research activity	Due to the primarily self-funding nature of R&D activities the increased activity will have associated funding to drive growth, just requiring effective use of trust financial and HR support to navigate
Staff engagement in new R&D opportunities	Building on existing engagement work around R&D across the trusts, making the opportunity visible by comms linked to an expanded group, and demonstrating successes and our breadth of research already
Broader system pressures (financial to performance) preventing adequate focus and resources being dedicated to R&D activities	Strategic alignment across partners behind R&D, strong Executive leadership, robust business planning and working with finance business partners, as well as R&D governance to track our income, activity, spend and ring-fenced funding, e.g. for grants or clinical support services from commercial research

Actions / Milestones	**Timescale**	**Lead**	**Status** (complete, on track, off track, not yet started)
1. Complete an engagement and planning exercise with R&D leadership to understand the potential opportunities, benefits, risks, and workplan within an expanded R&D collaboration	Sep-26	Group DoS/QVH CMO/Dept Leads/ADs	On track
2. Develop a specific project within the corporate alignment workstream for R&D, feeding into the Partnership Working Group	Jul-26	Group DoS	On track
3. Build relationships and collaboration between existing departments, starting with senior colleagues	Jul-26	Group DoS/QVH CMO	On track
4. Review current research active areas to determine overlap and the potential to open up research in new sites that map to other organisations' areas of strength	Oct-26	Group DoS/QVH CMO/Dept Leads/ADs	On track
5. Review current academic and industry partners to determine overlap and opportunities for new engagement	Oct-26	Group DoS/QVH CMO/Dept Leads/ADs	On track
6. Jointly reach out to Health Innovation KSS to explore potential regional engagement	Sep-26	Group DoS/QVH CMO	On track

APPENDIX 2 – PIPELINE DOCUMENT (COPY) 07.08.26

Open Studies

Studies open to recruitment	Portfolio / Non-portfolio	Specialty	Studies total	Total Participants Recruited	Participant target
Elios Sterling - Commercial CTIMD	Portfolio	Corneo Plastics		6	open
RAPTOR - Non commercial interventional	Portfolio	Max fax		3	10
GRACE - Non-commercial interventional	Portfolio	Plastics		66	72
PQIP - Non-commercial observational	Portfolio	Plastics		1163	open
Genesis - Non-commercial observational	Portfolio	Cross-cutting		8	open
			5		

Studies currently in follow up	Portfolio / Non-portfolio	Specialty	Studies total	Total Participants Recruited
NAMInG - Non commercial CTIMP	Portfolio	Corneo Plastics		27
PETNECK-2 - Non commercial interventional	Portfolio	Max fax		10
D-MAPP - Non commercial interventional	Portfolio	Plastics (hands)		2
			3	

Study Pipeline

Studies likely to open in next 3 months				Current Actions / Barriers	PI	Delivery Lead
Potential non-Commercial next 3 months	**Portfolio / Non-portfolio**	**Specialty**				
Tesla Micron	Portfolio	Sleep		SIV set to 30/09/26	Susanna Ng	Sophie Holden
Bloom43	Portfolio	Plastics		Cost negotiation in progress - SB emailed Plexxa 30/07/2026	Lydia Ioannidi	Sophie Holden
HMV Home Vent UK - Start in Autumn	Portfolio	Sleep		Roles and responsibilities between the research team and the clinical team need to be agreed - meeting being arranged upon PI return 10/8/26	Susanna Ng	Sophie Holden
EVEREST-HN4	Portfolio	Max fax		Triage approval, service lead approval required	Sally Collins	Sally Collins
			4			
Potential Commercial next 3 months (EOI's submitted)	**Portfolio / Non-portfolio**	**Specialty**				
			0			

Studies likely to open in next 6 months				Current Actions / Barriers	PI	Delivery lead
Potential Non commercial	**Portfolio / Non-portfolio**	**Specialty**				
Paediatric partial-thickness burns audit study	Unknown	Burns / Plastics		Awaiting ethics approval from Stoke Mandeville (Sponsor) - TE approved 1/8/26 email		
			1			
Potential Commercial in next 6 months	**Portfolio / Non-portfolio**	**Specialty**				
Neutrophic Keratitis Trial	Unknown	Corneo Plastics		Site selected, ongoing feasibility	Silvana Madi	Tracey Shewan
AZD9550-OSA	Portfolio	Sleep		EOI submitted awaiting confirmation	Susanna Ng	Not known yet
VESPER-OSA (Pfizer)	Portfolio	Sleep		EOI submitted awaiting confirmation	Susanna Ng	Not known yet
			3			

Homegrown Study Pipeline

Homegrown studies - can be open within 3 months				Current Actions / Barriers	Current Lead
	Portfolio / Non-portfolio	**Specialty**			
BASICS	Portfolio	Plastics		Funding agreement with Polynovo (potential 150K)	Polynovo - Lauren neil (Polynovo) / Simon Booth
Clear Burn	Non-Portfolio	Burns		protocol being discussed with burns team	Simon Booth/ Burns team
			2		
Homegrown studies - can be open within 6 months				**Current Actions / Barriers**	**Current Lead**
	Portfolio / Non-portfolio	**Specialty**			
TRIAGE	Non-Portfolio	Radiology		Pilot work completed, grant funding; possible RCR funding	Simon Booth, Bruce Smith
Cryoneurolysis	Non-Portfolio	Plastics		scoping review	Franlkin Wou
CANAL study	Non-Portfolio	Corneo Plastics		protocol design MHRa celarence	Raman Malhotra
AI Smile	Non-Portfolio	Plastics	2	Initial discussion	
Homegrown studies - can be open within 12 months				**Current Actions / Barriers**	**Current Lead**
	Portfolio / Non-portfolio	**Specialty**			
PREVENT-PLP (Targeted muscle Reninnervation to Prevent Ph	Portfolio	Plastics	1	NIHR RFPB bid to be submitted in November 26 - final desision Sept 27 will need to be approved by R+I July and ELT before submission	Simon Booth Tania Cubison/ Rachael Harrison
Oxartis, Julian Dye created SmartMatrix					

Report cover-page					
References					
Meeting title:	Board of Directors				
Meeting date:	16/09/26	**Agenda reference:**	**69-26**		
Report title:	NHS Workforce Race Equality Standards (WRES) Report 2025/26 & NHS Workforce Disability Equality Standards (WRES) Report 2025/26				
Sponsor:	Helen Edmunds, Chief People Officer				
Author:	Helen Edmunds, Chief People Officer Lawrence Anderson, Deputy Chief People Officer				
Appendices:	Appendix 1 - Workforce Race Equality Standards (WRES) Report 2025/26 Appendix 2 - Workforce Disability Equality Standards (WDES) Report 2025/26				
Executive summary					
Purpose of report:	This paper sets out the 2025/26 WRES and WDES reports and associated actions that will be taken, based on data collected on 31 March 2026.				
Summary of key issues	• Workforce diversity continues to improve**,** with BME representation increasing from 21.98% to 24.98% and disabled staff representation increasing from 7.62% to 8.49% • Experiences of bullying and harassment have improved**,** with reductions reported by both BME and disabled staff, particularly in harassment from colleagues, managers and members of the public • Board diversity has improved for ethnicity, with BME Board representation increasing to 25%, now reflecting the overall workforce. There remains no Board representation from colleagues declaring a disability • Career progression remains a challenge, with 55.9% of BME staff and 51.4% of disabled staff believing the Trust provides equal opportunities for progression and promotion • Recruitment disparities continue, with white applicants remaining almost three times more likely to be appointed from shortlisting than BME applicants (2.99), and non-disabled applicants 1.28 times more likely to be appointed than disabled applicants • Focus for 2026/27 will be on reducing discrimination, improving recruitment and career progression outcomes, strengthening succession planning and talent management, and increasing senior representation				
Recommendation:	The Board are asked to **NOTE** the contents of the reports and actions being undertaken to address key priorities.				
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:	Workforce BAF				
Corporate risk register:	None				
Regulation:	None				
Legal:	None				
Resources:	None				
Assurance route					
Previously considered by:	Strategy and Culture Committee				
	Date:	3/09/2026	Decision:	Present the report to the Board of Directors	
Next steps:	Continue with actions as detailed and publish the WRES and WDES reports on the Trusts website				

Report to:	Board of Directors
Agenda item:	69-26
Date of meeting:	16 September 2026
Report from:	Lawrence Anderson, Deputy Chief People Officer
Report author:	Helen Edmunds, Chief People Officer Lawrence Anderson, Deputy Chief People Officer
Date of report:	05 August 2026
Appendices:	1. 2025/26 WRES Report 2. 2025/26 WDES Report

NHS Workforce Race Equality Standards (WRES) and NHS Workforce Disability Equality Standards (WDES) Report 2025/26

National context - WRES

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

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

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

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

In line with the categories taken from the 2001 Census:

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

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

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

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

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

Workforce Race Equality Standard (WRES)

The full details for the Workforce Race Equality Standard (WRES) and Workforce Disability Equality Standard (WDES) reports are detailed in Appendices 1 and 2, with summary highlights as follows:

Workforce & Board Representation
There has been a further increase in BME representation within the workforce, from 21.98% in 2024/25 to 24.98% in 2025/26, an increase of 3%. Representation within non-clinical roles increased by 1.5% and clinical roles by 4.03%.

Most BME staff remain clustered at Band 5 (32.93%), followed by Band 8b (28.57%) and Band 6 (25%). Representation at Band 8b has increased significantly from 6.67% to 28.57%. Representation remains low at Band 4 (9.94%) and there is no BME representation at Bands 8d and 9.

Board representation has improved significantly, with four Board members identifying as BME at the time of reporting, resulting in 25% Board representation and eliminating the previous gap between Board and workforce representation.

Recruitment
There has been a small increase in the relative likelihood of white applicants being appointed from shortlisting compared with BME applicants, from 2.94 in 2024/25 to 2.99 in 2025/26.

The data for this metric includes applicants who do not have the right to work in the UK and whom the Trust cannot legally sponsor due to immigration salary threshold requirements, which continues to have a significant impact on this indicator.

Disciplinary Processes
There has been an increase in the relative likelihood of BME staff entering the formal disciplinary process, from 1.15 in 2024/25 to 2.99 in 2025/26.

This increase is based on a small number of cases, with 12 cases recorded during 2025/26 (6 were BME staff and 6 were white staff), this compared to 3 disciplinary cases in 2024/25. Given the relatively low numbers, percentage differences should be interpreted with caution.

Access to CPD and Non-Mandatory Training
The Trust has continued to achieve equitable access to non-mandatory training and Continuing Professional Development opportunities, with a score of 0.99 in 2025/26.

Bullying and Harassment
There has been improvement in the experiences of BME staff:

- Harassment, bullying or abuse from patients, relatives or members of the public reduced from 28.1% in 2024/25 to15.1% in 2025/26, a reduction of 13% (36 respondents to 21 respondents).
- Harassment, bullying or abuse from colleagues reduced from 25.2% to 22.5%, a reduction of 2.7% (32 respondents to 30 respondents).

Both indicators compare favourably with national averages.

Career Progression
There has been a decrease in the proportion of BME staff who believe the Trust provides equal opportunities for career progression or promotion, decreasing from 55.1% to 50.4%. This remains above the national average of 49.7%.

Discrimination
The proportion of BME staff reporting discrimination from a manager, team leader or colleague increased slightly from 13.3% to 13.9% (27 BME respondents and 21 white respondents).

Whilst this remains significantly lower than the 21.8% reported in 2022/23, BME staff remain approximately three times more likely to experience discrimination than white staff (13.9% compared with 4.4%).

Workforce Disability Equality Standard (WDES)

Workforce & Board Representation
The proportion of staff declaring a disability has increased from 7.62% in 2024/25 to 8.49% in 2025/26, continuing the upward trend seen over recent years.

The highest levels of under-representation remain within Medical and Dental staff groups and senior leadership positions. There continues to be no Board members who have declared a disability.

Recruitment
The relative likelihood of non-disabled candidates being appointed from shortlisting compared with disabled candidates increased from 1.09 in 2024/25 to 1.28 in 2025/26.

Whilst this represents a deterioration on the previous year, the position remains significantly improved compared with 2022/23, when non-disabled candidates were more than twice as likely to be appointed.

Capability Processes
Disabled staff were no more likely than non-disabled staff to enter a formal capability process during 2025/26.

Feeling Valued
There has been a significant improvement in presenteeism, with disabled staff reporting feeling pressure to come to work despite being unwell reducing from 31.8% in 2024/25 to 18.3% in 2025/26, a reduction of 13.5% (28 respondents in 2024/25, reducing to 21 respondents in 2025/26).

There has also been a small increase in the proportion of disabled staff who feel the Trust values their work, increasing from 34.6% (57 respondents) to 35.4% (62 respondents).

Staff Engagement
Disabled staff engagement decreased slightly from 7 to 6.6, while engagement for non-disabled staff fell from 7.5 to 7.2.

Career Progression
The percentage of disabled staff who believe the Trust provides equal opportunities for career progression or promotion fell from 57.8% in 2024/25 to 51.4% in 2025/26. This is above the national average of 48.6%.

Reasonable Adjustments
A total of 82.3% of disabled staff reported that reasonable adjustments had been made to enable them to undertake their role.

Whilst this is a slight reduction from 83.5% in 2024/25, it remains significantly above the national average and demonstrates organisational commitment to supporting disabled colleagues.

Bullying and Harassment
There have been further improvements across all bullying and harassment indicators for disabled staff:

- Harassment, bullying or abuse from patients, service users, relatives and members of the public reduced from 24.2% to 23.3%.
- Harassment, bullying or abuse from managers reduced from 11.6% to 9.7% (19 respondents in 2024/25 to 17 respondents in 2025/26).
- Harassment, bullying or abuse from colleagues reduced from 20.1% to 19.2%.

There has also been an increase in reporting, with 51.7% (29 respondents) of disabled staff who experienced bullying or harassment indicating that they or a colleague reported it, compared with 44.4% (27 respondents) in 2024/25.

Conclusions
It is encouraging that BME workforce representation has increased further from 21.98% in 2024/25 to 24.98% in 2025/26, alongside an improvement in Board representation at the time of reporting.

There have been improvements in the experience of BME colleagues in relation to bullying, harassment and abuse, with reductions in incidents involving both members of the public and colleagues. BME staff remain approximately three times more likely than white staff to report discrimination at work, and recruitment and disciplinary indicators continue to show disproportionate outcomes (noting there are small numbers for the disciplinary indicator). Work will therefore continue through the Cultural Transformation Steering Group, EDI Improvement Plan, listening exercises, Freedom to Speak Up arrangements and leadership development programmes to address these disparities.

There has been a further increase in the proportion of staff declaring a disability, rising from 7.62% in 2024/25 to 8.49% in 2025/26, reflecting growing confidence in disclosure and the ongoing focus on inclusion and wellbeing.

Disabled staff continue to report positive outcomes in several areas, including reduced bullying and harassment, improved reporting of concerns, lower levels of presenteeism and higher staff engagement scores. The Trust continues to perform strongly in relation to workplace adjustments, with over 82% of disabled colleagues reporting that appropriate adjustments have been made to support them in their roles.

Challenges remain regarding career progression, recruitment outcomes and senior representation. Disabled staff continue to be underrepresented in senior roles and on the Board and are less likely than non-disabled colleagues to believe that the Trust provides equal opportunities for progression. Work during 2026/27 will therefore focus on recruitment processes, career development pathways, succession planning, talent management and ensuring disabled colleagues feel valued, supported and able to fulfil their potential.

As with previous years, caution should be exercised when interpreting percentage differences derived from small sample sizes, as relatively small changes in the number of individuals can produce significant percentage variations that may not necessarily reflect a substantial change in overall workforce experience.

Priorities for 2026/27
Within Appendices 1 and 2, details are provided on key areas of progress during 2025/26 together with ongoing actions for 2026/27.

Key priorities for 2026/27 include:

- Reducing experiences of discrimination among BME staff
- Improving recruitment outcomes for BME and disabled applicants
- Improving perceptions of equal career progression opportunities
- Supporting succession planning and talent management for underrepresented groups
- Continuing to reduce bullying, harassment and abuse
- Strengthening psychological safety and confidence in reporting concerns
- Increasing representation of disabled staff within senior leadership and Board-level roles

These actions will support the Trust's continued cultural transformation and commitment to creating an inclusive environment where all colleagues can thrive.

Recommendation

The Board are asked to **NOTE** the contents of the reports and actions being undertaken to address key priorities.

NHS
Queen Victoria Hospital
NHS Foundation Trust



WRES-Workforce Race Equality Standard

Report 2025-26

Slide Number	Content
3	Introduction
4	WDES Indicators
5	Data Limitations
6	Definitions
7	Year on Year Comparison
8	Executive Summary - Key Findings
9	**WRES indicator 1:** Percentage of staff in each of the AfC Bands 1-9 or Medical and Dental subgroups and VSM (Very Senior Manager) (including executive Board members) compared with the percentage of staff in the overall workforce disaggregated by: Non-Clinical staff and Clinical staff.
12	**WRES indicator 2:** Relative likelihood of staff being appointed from shortlisting across all posts (both external and internal posts).
13	**WRES indicator 3:** Relative likelihood of staff entering the formal disciplinary process, as measured by entry into a formal disciplinary investigation.
14	**WRES indicator 4:** Relative likelihood of staff accessing non-mandatory training and CPD
15	**WRES indicator 5:** Percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 months
16	**WRES indicator 6:** Percentage of staff experiencing harassment, bullying or abuse from staff in last 12 months
17	**WRES indicator 7:** Percentage of staff believing that the trust provides equal opportunities for career progression or promotion
18	**WRES indicator 8:** In the last 12 months have you personally experienced discrimination at work from any of the following? Manager/team leader or other colleagues
19	**WRES indicator 9:** Percentage difference between the organisations' Board membership and its overall workforce disaggregated, by voting membership of the Board and executive membership of the Board
20	Additional Insights
21	Key Areas of Progress and Actions for next 12 months
23	Actions for next 12 months

Introduction

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

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

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

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

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

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

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

The information in this report details key findings from the data collated for 2025/2026, comparisons of data from previous years, the progress made and actions we will be put in place to address the findings.

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

Queen Victoria Hospital
NHS Foundation Trust

WRES Metrics

There are nine WRES indicators. Four of the indicators focus on **workforce data**, four are based on data from the **national NHS Staff Survey** questions, and one indicator focuses upon **BME representation on boards**. Based on the requirement from the National team, the Trust submitted the WRES data for Indicators 1 -4 and indicator 9 on the National Data Collection Framework (DCF) on **31st May 2026**.The staff survey results for Indicators 5 to 8, are taken directly from the WRES publications available on the NHS Staff Survey website.

Workforce Indicators:

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

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

Data Sourced from ESR

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

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

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

National NHS Staff Survey indicators (or equivalent):

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

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

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

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

b) Manager/team leader or other colleagues

Data Sourced from NHSS

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

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

Data Sourced from ESR

Data Limitations

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

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

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

Definitions

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

Queen Victoria Hospital
NHS Foundation Trust

Yearly comparison 2019-2026

	WDES Metrics		Year								Trend	Difference between 2025 & 2026	
			2018-2019	2019-2020	2020-2021	2021-2022	2022-2023	2023-2024	2024-2025	2025-2026			
1	Percentage of black and minority ethnic (BME) staff	Overall	14.68%	15.91%	18.81%	19.33%	19.57%	21.20%	21.98%	24.98%		3.00%	↑
		Non-Clinical	7.06%	7.61%	8.83%	8.50%	9.36%	10.00%	11.30%	12.80%		1.50%	↑
		Clinical (inc M&D)	18.93%	20.39%	24.19%	25.17%	25.03%	27.06%	27.82%	31.85%		4.03%	↑
2	Relative likelihood of staff being appointed from shortlisting across all posts (both external and internal posts).		1.32	1.47	1.79	1.27	2.31	2.72	2.94	2.97		0.03	↑
3	Relative likelihood of staff entering the formal disciplinary process, as measured by entry into a formal disciplinary investigation		0.00	1.27	0.00	0.00	0.00	1.82	1.15	2.99		1.84	↑
4	Relative likelihood of staff accessing non-mandatory training and CPD		0.65	1.04	0.90	0.89	1.04	1.00	0.96	0.99		0.03	↑
5	Percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 months	BME	27.6%	27.4%	18.3%	15.4%	28.0%	27.0%	28.1%	15.1%		-12.99%	↑
		Non-BME	24.6%	25.3%	16.0%	20.0%	19.2%	21.8%	19.1%	20.2%		1.13%	↑
6	Percentage of staff experiencing harassment, bullying or abuse from staff in last 12 months	BME	22.8%	34.3%	34.9%	36.0%	30.0%	21.7%	25.2%	22.5%		-2.74%	↑
		Non-BME	24.5%	21.2%	21.4%	19.5%	18.0%	21.1%	20.2%	17.6%		-2.62%	↑
7	Percentage of staff believing that the trust provides equal opportunities for career progression or promotion	BME	51.8%	52.8%	48.2%	48.9%	47.0%	58.8%	55.1%	50.4%		-4.74%	↑
		Non-BME	61.2%	58.1%	60.2%	60.8%	59.1%	62.5%	63.1%	55.9%		-7.17%	↑
8	In the last 12 months have you personally experienced discrimination at work from a manager, team leader or other colleague?	BME	13.0%	14.5%	23.2%	18.3%	21.8%	17.5%	13.3%	13.9%		0.57%	↑
		Non-BME	4.1%	5.8%	5.6%	5.3%	5.5%	4.0%	6.9%	4.4%		-2.54%	↑
9	Percentage difference between the organisations' Board membership and its overall workforce disaggregated	Voting Membership	N/A	N/A	N/A	N/A	N/A	-21.0%	3.0%	-5.0%		-8.00%	↑
		Executive Membership	N/A	N/A	N/A	N/A	N/A	-21.0%	-5.0%	-12.0%		-7.00%	↑
		Overall Board	-6.5%	-7.6%	-18.8%	-10.9%	-11.8%	-21.0%	-2.0%	0.0%		2.00%	↑

Executive Summary

Queen Victoria Hospital NHS Foundation Trust

Workforce Representation

There is an increase of 3% BME staff, from 21.98% 24/25 to **24.98%** in 25/26 (an additional 44 people in total). Our non clinical staff rose by 1.5% and clinical staff by 4.03%

Most BME staff are still clustered at **Band 5** (32.93%), closely followed by **Band 8b** (28.57%) and **Band 6** (25%). Representation at **Band 8b** has grown from 6.67% to 28.57%. There is still low representation at **Band 4** (9.94%) and none from **Band 8d and Band 9** (0%).

Discrimination

BME staff that have personally experienced discrimination at work from a manager/team leader or other colleagues has slightly increased from **13.3%** in 24/25 to **13.9%** in 25/26. This remains a significant reduction from **21.8**% in 22/23.

BME staff are three times more likely to experience discrimination compared to white staff, **13.9%** (27 BME respondents)compared to **4.4%** (21 White Respondents).

As per the NHS national Staff Survey, the Trust performed comparatively with the national average of 13.9%.

Career Progression

There is a decrease of **4.7%** in BME staff that believe there is equal opportunity for career progression or promotion, in comparison to white staff, from **55.1%** in 24/25 to **50.4%** in 25/26. The Trust performed better than the national average of 49.70%

Disciplinary Processes

There is an increase in the relative likelihood of BME staff entering the formal disciplinary process from **1.15** in 24/25 to **2.99** in 25/26.

In 25/26 there were a total of 12 cases. The difference in disparity is 0.019 vs 0.006 however this is auto calculated to 2.99. in 24/25 we had 3 employee relations cases which auto calculates at 0.0032 vs 0.0036

Board Representation

The difference between the board's membership and the Trust Workforce has increased to 25% in 25/26 and now mirrors the Trust's over all representation

As per the national WRES Summary for the 2024/2025 reporting year, The Trust performed better than the national average of 17.3%.

Accessing CPD and Non-Mandatory Training

The Trust has continued to achieve equal access to non-mandatory training and CPD for 25/26 (0.99)

Recruitment

There is an increase of **0.05** in the relative likelihood of white applicants being appointed from shortlisting compared to BME applicants, from **2.94** in 24/25 to **2.99** in 25/26.

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

Bullying and Harassment

There is significant progress in this area with **a decrease of 13%** of BME staff experiencing harassment, bullying or abuse from patients, relatives or the public, from 28.1% to 15.1% in 25/26 (36 to 21 respondents)

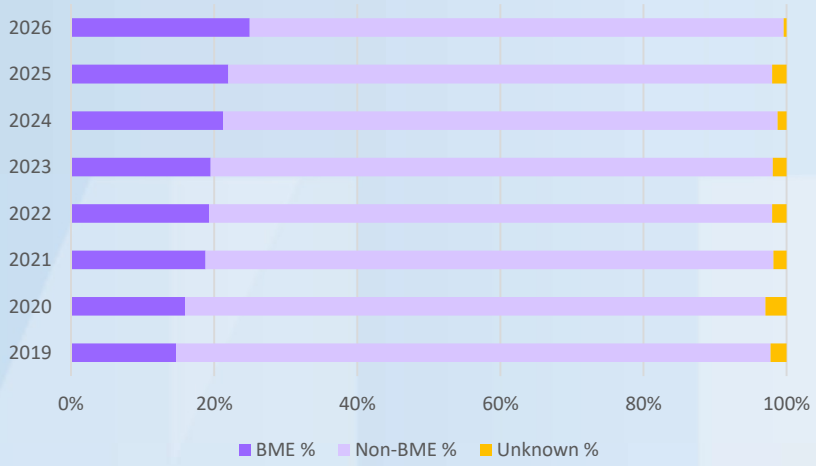
There is **a decrease of 2.7%** of BME staff experiencing harassment, bullying or abuse from staff, **from 25.2% in 24/25 to 22.5%** (32 to 30 respondents)in **25/26**. This is below the national average of 23.29%

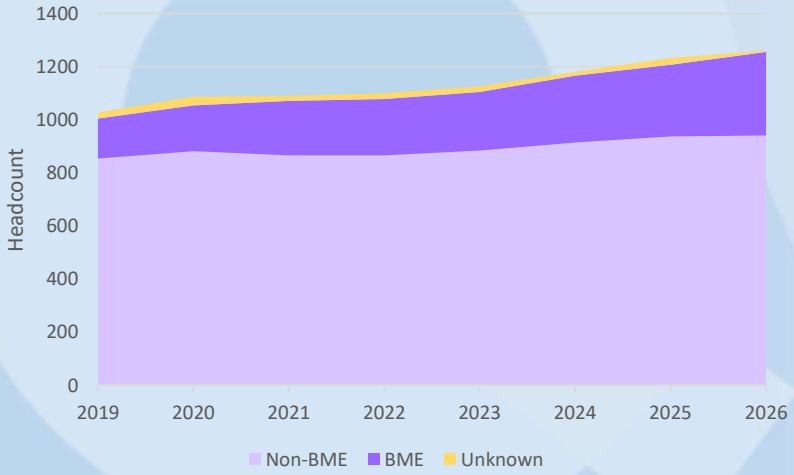
Queen Victoria Hospital
NHS Foundation Trust

WRES Indicator 1

Workforce Representation

	Headcount				Percentage		
	Non-BME	BME	Unknown	Total	Non-BME %	BME %	Unknown %
2019	854	151	23	1028	83.1%	14.7%	2.24%
2020	882	173	32	1087	81.1%	15.9%	2.94%
2021	866	205	20	1091	79.4%	18.8%	1.83%
2022	866	212	22	1100	78.7%	19.3%	2.00%
2023	885	220	22	1127	78.5%	19.5%	1.95%
2024	915	251	15	1181	77.48%	21.25%	1.27%
2025	937	271	25	1233	75.99%	21.98%	2.03%
2026	941	315	5	1261	74.62%	24.98%	0.40%





The overall headcount for the Trust is **1261**. This has increased between 2025 and 2026 with the number of staff declaring as BME increasing to **315 (24.98%),** an additional **44** people. The Data shows the percentage of BME staff at the Trust continues to increase, growing by 3% in the last year.

There has also been a marked decrease in the proportion of staff who have not declared their ethnicity (unknown), which is now 5 (0.4%) which is down from **25 (2.03%)** last year.

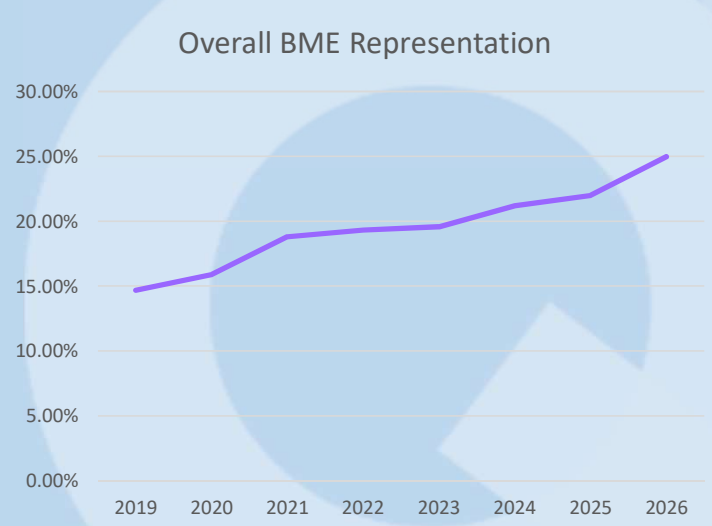
NHS Workforce Race Equality Standard 2025

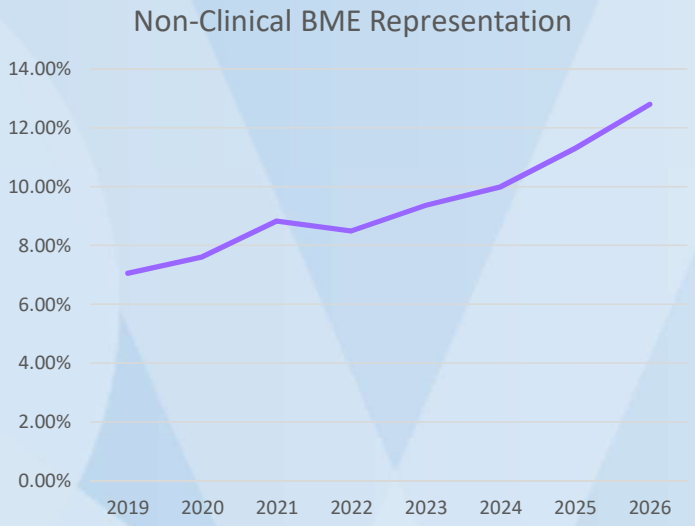
National Average
BME: 30.7%
Non-BME: 65.4%

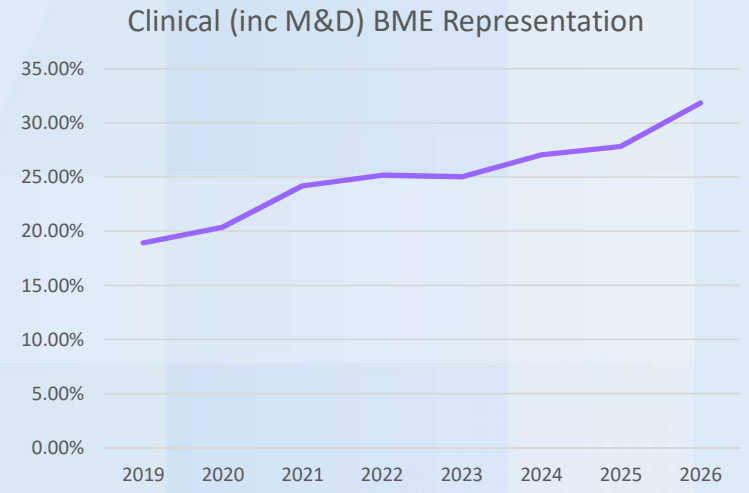
WRES Indicator 1

Workforce Representation

	Year							
	2019	2020	2021	2022	2023	2024	2025	2026
Overall	14.68%	15.91%	18.81%	19.33%	19.57%	21.20%	21.98%	24.98%
Non-Clinical	7.06%	7.61%	8.83%	8.50%	9.36%	10.00%	11.30%	12.80%
Clinical (inc M&D)	18.93%	20.39%	24.19%	25.17%	25.03%	27.06%	27.82%	31.85%



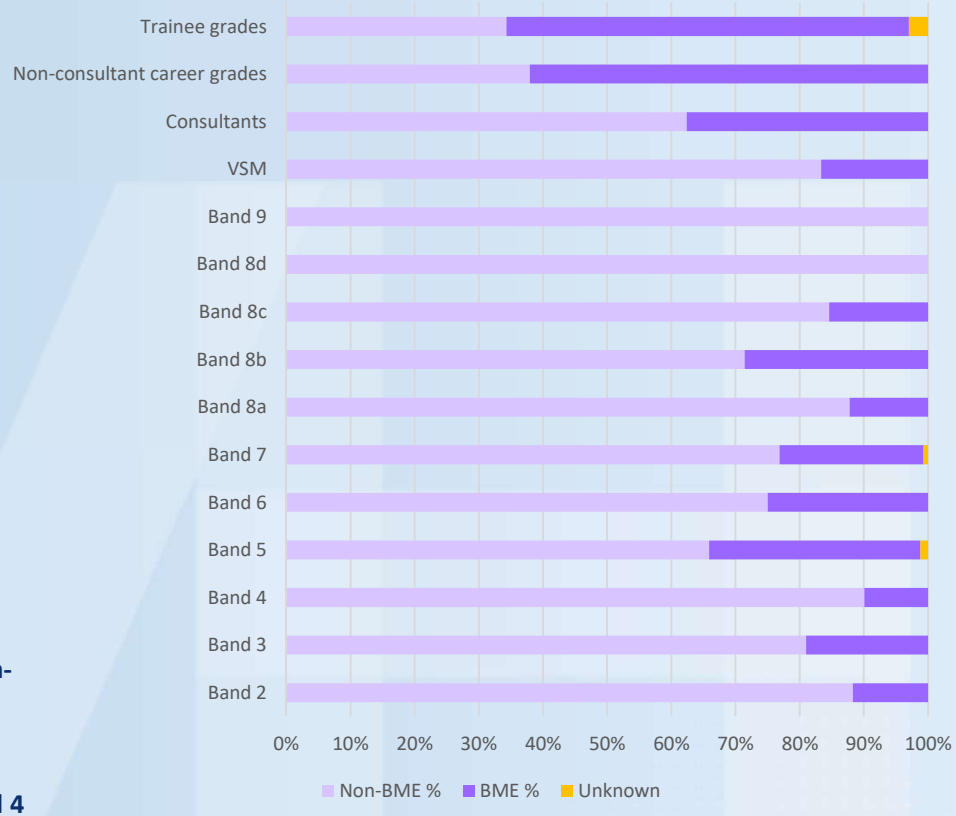




WRES Indicator 1

Workforce Representation

Pay banding	White	BME	Unknown	Total	White %	BME %	Unknown
Band 2	83	11	0	94	88.30%	11.70%	0.00%
Band 3	175	41	0	216	81.02%	18.98%	0.00%
Band 4	145	16	0	161	90.06%	9.94%	0.00%
Band 5	110	55	2	167	65.87%	32.93%	1.20%
Band 6	132	44	0	176	75.00%	25.00%	0.00%
Band 7	113	33	1	147	76.87%	22.45%	0.68%
Band 8a	36	5	0	41	87.80%	12.20%	0.00%
Band 8b	15	6	0	21	71.43%	28.57%	0.00%
Band 8c	11	2	0	13	84.62%	15.38%	0.00%
Band 8d	6	0	0	6	100.00%	0.00%	0.00%
Band 9	8	0	0	8	100.00%	0.00%	0.00%
VSM	5	1	0	6	83.33%	16.67%	0.00%
Consultants	68	41	0	109	62.39%	37.61%	0.00%
Non-consultant career grades	11	18	0	29	37.93%	62.07%	0.00%
Trainee grades	23	42	2	67	34.33%	62.69%	2.99%



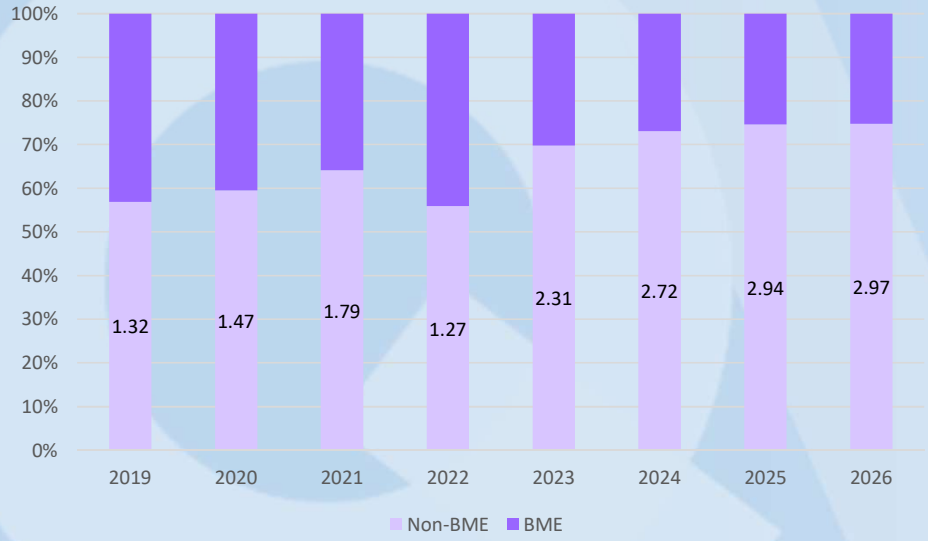
The majority of BME representation in the workforce are remain clustered at **Consultant** (37.61%) **Non-Consultant Career Grade** (62.07%) and **medical trainees** (62.69%) Of our Agenda for Change staff representation mainly falls within **Band 5** (32.93%), closely followed by **Band 8b** (28.57%).

Representation at Band 8b has grown from 6.67% to 28.57%. There is still low representation at **Band 4** (9.94%) and none from **Band 8d and Band 9** (0%).

WRES Indicator 2

Recruitment

	Year							
	2019	2020	2021	2022	2023	2024	2025	2026
Relative likelihood of staff being appointed from shortlisting across all posts (both external and internal posts).	1.32	1.47	1.79	1.27	2.31	2.72	2.94	2.97



The relative likelihood of white applicants being appointed from shortlisting compared to BME applicants has increased since last year by **0.05**.

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

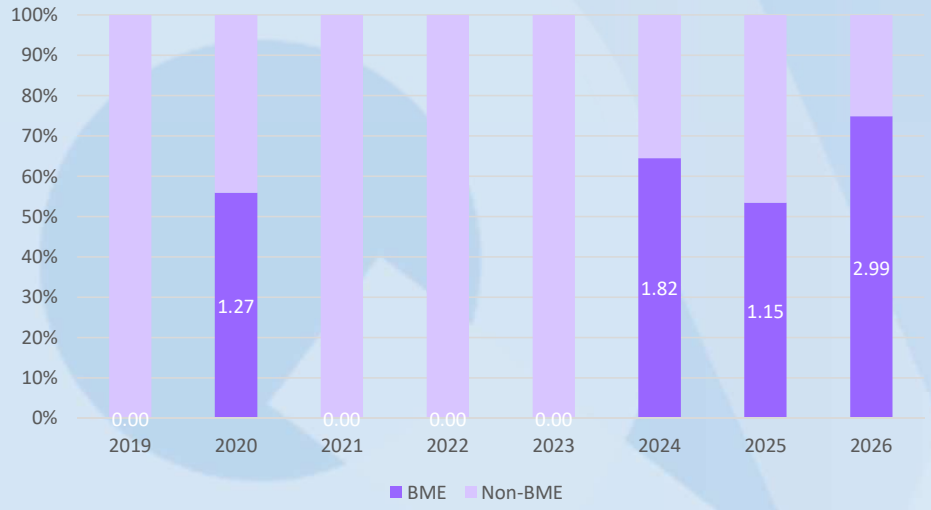
This issue has a significant impact upon this metric as these are not excluded from the data

NHS Workforce Race Equality Standard 2025
National Average 1.77

WRES Indicator 3

Disciplinary

	Year							
	2019	2020	2021	2022	2023	2024	2025	2026
Relative likelihood of staff entering the formal disciplinary process, as measured by entry into a formal disciplinary investigation	0.00	1.27	0.00	0.00	0.00	1.82	1.15	2.99



There is an increase in the relative likelihood of BME staff entering the formal disciplinary process from **1.15** in 24/25 to **2.99** in 25/26.

In 25/26 there were a total of 12 cases. The difference in disparity is 0.019 vs 0.006 however this was auto calculated to 2.99. In 24/25 we had 3 employee relations cases which auto calculates at 0.0032 vs 0.0036

NHS Workforce Race Equality Standard 2025
National Average 1.11

WRES Indicator 4

Training and Continual Professional Development

	Year							
	2019	2020	2021	2022	2023	2024	2025	2026
Relative likelihood of staff accessing non-mandatory training and CPD	0.65	1.04	0.90	0.89	1.04	1.00	0.96	0.99



The Trust has continued to achieve equal access to non mandatory training and CPD for 25/26 **(0.99)**

NHS Workforce Race Equality Standard 2025

National Average
1.02

WRES Indicator 5

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

		Year							
		2019	2020	2021	2022	2023	2024	2025	2026
Percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 months	BME	27.6%	27.4%	18.3%	15.4%	28.0%	27.0%	28.1%	15.1%
	Non-BME	24.6%	25.3%	16.0%	20.0%	19.2%	21.8%	19.1%	20.2%



This data is from the National Staff Survey results.

Over 15% of BME staff experience harassment, bullying or abuse from patients, relatives or the public

There is a **significant decrease of 13%** of BME staff experiencing harassment, bullying or abuse from patients, relatives or the public, from 28.1% to 15.1% (36 to 21 respondents) in 25/26.

NHS Staff Survey Data 2025

National Average
BME: 29.16%
Non-BME: 23.54%

Queen Victoria Hospital
NHS Foundation Trust

WRES Indicator 6

Bullying, harassment or abuse from colleagues

		Year							
		2019	2020	2021	2022	2023	2024	2025	2026
Percentage of staff experiencing harassment, bullying or abuse from staff in last 12 months	BME	22.8%	34.3%	34.9%	36.0%	30.0%	21.7%	25.2%	22.5%
	Non-BME	24.5%	21.2%	21.4%	19.5%	18.0%	21.1%	20.2%	17.6%



This data is from the National Staff Survey results.

There is a **decrease of 2.7%** of BME staff experiencing harassment, bullying or abuse from staff, from 25.2% in 24/25 to 22.5% (32 to 30 respondents) in 25/26.

NHS Staff Survey Data 2025

National Average
BME: 23.39%
Non-BME: 19.58%

Queen Victoria Hospital
NHS Foundation Trust

WRES Indicator 7

Career Progression

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

	Year							
	2019	2020	2021	2022	2023	2024	2025	2026
BME	51.8%	52.8%	48.2%	48.9%	47.0%	58.8%	55.1%	50.4%
Non-BME	61.2%	58.1%	60.2%	60.8%	59.1%	62.5%	63.1%	55.9%



This data is from the National Staff Survey results.

There has been a decrease of **4.7%** in the number BME staff that believe the Trust provides equal opportunities for career progression or promotion. This is alongside a decreased percentage of staff who believe that the Trust provided equal opportunities for career progression or promotion for non-BME staff.

NHS Staff Survey Data 2025

National Average
BME: 49.70%
Non-BME: 55.85%

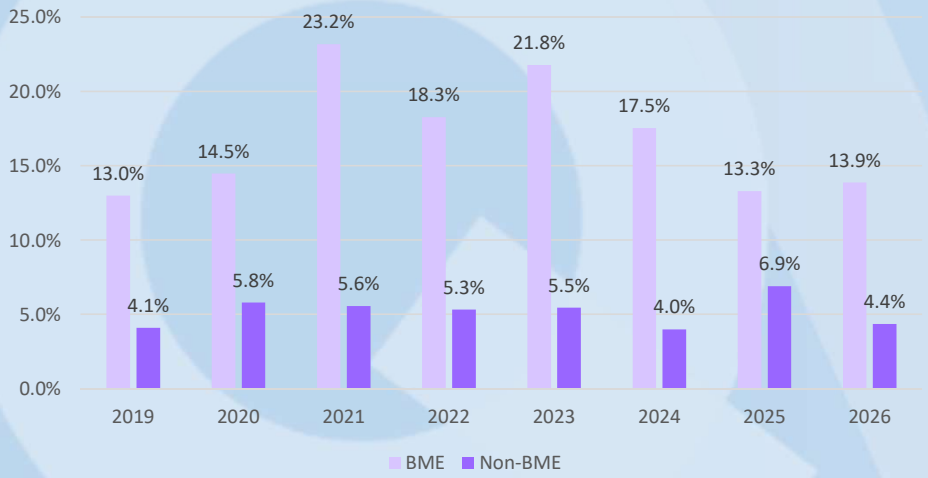
Queen Victoria Hospital
NHS Foundation Trust

WRES Indicator 8

Discrimination at work

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

	Year							
	2019	2020	2021	2022	2023	2024	2025	2026
BME	13.0%	14.5%	23.2%	18.3%	21.8%	17.5%	13.3%	13.9%
Non-BME	4.1%	5.8%	5.6%	5.3%	5.5%	4.0%	6.9%	4.4%



This data is from the National Staff Survey results.

There is a slight increase in BME staff that have personally experienced discrimination at work from manager/team leader or other colleagues, from **13.3%** in 24/25 to **13.9%** in 25/26.

The overall percentage of staff who personally experienced discrimination from manager/team leader or other colleague is significantly higher for BME staff, being three times as likely to experience discrimination compared to white staff, **(13.9%** (27 BME Respondents) compared to **4.4%** (21 White respondents)**).**

As per the NHS England Staff Survey results, the Trust performed comparatively with the national average of 13.93%.

NHS Staff Survey Data 2025

National Average
BME: 13.93%
Non-BME: 6.51%

WRES Indicator 9

Board Representation

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

	2019	2020	2021	2022	2023	2024	2025	2026
Overall Board	-6.5%	-7.6%	-18.8%	-10.9%	-11.8%	-21.0%	-2.0%	0.0%



The number of BME board members has increased in 25/26 to 4 members. There is now a 25% representation

Since 2019 the Trust board representation has been below the workforce representation and has fluctuated each year . In 25/26 this has increased to reduce the gap to 0.

100% of the board have declared their ethnicity.

As per the summary for the 2024/2025 reporting year, the Trust is above the national average of 17.3%

NHS Workforce Race Equality Standard 2025

National Average 17.3%

Additional Insights

- BME staff represent 24.44% of the Trust's voluntary resignations in 2025-26.

- Analysis of retention data shows BME staff cite the following as the reason for their resignation:
  - Work-life balance
  - Relocation
  - Other/not known
  - To undertake further education and training

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

  This may also be linked to our 2025 Staff Survey results around career progression –this year has seen a decrease (4.7%) in the number of BME colleagues reporting a belief that the Trust provides equal opportunities for career progression, the overall percentage also remains comparatively low at approximately 55% of BME staff.

  The relative likelihood of white candidates being appointed from shortlisting compared to BME peers has grown year on year and remains high at 2.99 - this may also contribute to the perception that opportunities for progression are not provided equally.

  It is worth noting that by using the Trac reports the Equal Opportunities data is not available for any new starters manually added to Trac, such as Trainee Doctor rotations, therefore incorrectly presenting these as 'undisclosed'. The data is collected during recruitment and added to ESR at hire stage.

Key Areas of Progress

Culture Change	1. **Refreshed Vision and Values & Behavioral Framework -** These were launched in late 2024, with a behaviour framework to support an inclusive learning culture, increasing psychological safety of staff and supporting the embedding of an enhanced speak up process for staff. 2. **Workforce Belonging & Value** – The Trust has in place a comprehensive action plan aligned with NHS England's EDI Improvement Plan to to create an environment that eliminates the conditions in which bullying, discrimination, harassment and physical violence at work occur. 3. **Inclusive Behaviours** – The Trust has implemented a Cultural Transformation Steering Group, with the aim to embed inclusion into business-as-usual practices. This group is attended by the Trust's CEO and CMO. A module on EDI and inclusive management (including reasonable adjustments) was added to the mandatory line manager's training offer in 2025-26. 4. **Freedom to Speak Up** – The Freedom to Speak Up Guardian for QVH meets with the Chief Executive and Chief Nurse on a regular basis. 5. **Cultural Listening Exercises** – The Wellbeing & Inclusion team have supported cultural listening exercises across several teams to understand and tackle behaviours than contribute to a more inclusive environment for our BME staff.
Recruitment	1. **Inclusive Recruitment Process & Practice –** The relative likelihood of being appointed from shortlisting has increased slightly. 55.9% of our BME colleagues have reported feeling that opportunities for career development and/or promotion are equal, which is an increase against last year. There was a significant decrease in the number of non-BME colleagues who felt opportunities for career development are equal. It might be valuable to look at the internal candidate experience. 2. **Career development through Apprenticeships -**Apprenticeships support career development across all staff groups. In 2025/26, the Trust recorded its highest number of apprentices to date (62), though overall numbers remain low due to organisational size. Representation of BME apprentices increased slightly from 10.9% in 2024/25 to 11.29% in 2025/26. Further work continues in 2026/27 to improve diversity and maximise levy use. 3. Work experience access has broadened through the introduction of targeted events alongside traditional placements. In 25/26 ' 62.07% of attendees at work experience events and 57.89% of placement students under 18 where from a BME background .
Career Development	1. **Appraisal Process Revised with a focus on Wellbeing and career development-** As part of the revised process, we ask for feedback and monitor effectiveness of appraisal alongside our National Staff Survey results. Any areas of concern are raised at the appropriate level to address concerns. 2. **Developing a management and leadership strategic framework-** In light of the new Management and Leadership Framework that is being co-developed by NHS England in response to the Messenger (2022) and Kark (2019) reviews, QVH is awaiting the publication of the framework before launching a local version. The purpose of this framework is to equip NHS managers – both clinical and non-clinical - with a code of practice, defined set of standards and competencies, a national development curriculum, and practical, accessible learning resources to enable them to lead and manage with confidence, care, and consistency and elevate NHS management and leadership as a recognised professional discipline. We have launched a QVH Managers' Essential Programme which includes inclusive and compassionate leadership, which is publicized to all staff . 3. **Leadership through Education for Excellent Patient Care Programme (LEEP) -** The Trust continues to deliver our LEEP programme with a focus on multidisciplinary teamwork, increasing opportunities for staff from BME backgrounds both from a clinical and non-clinical staff groups.

Key Areas of Progress

Bullying and Harassment	1. **Violence, Aggression & Abuse -** The Trust's Violence Prevention and Reduction group has increased compliance against the national standards to 98% in 25/26. The Trust has implemented a Formal VPR group that meets monthly, along with collaborating with other Sussex Trusts on national VPR initiatives. 2. **Sexual Safety –** the Trust reached 98% compliance with the principles of NHS England's Sexual Safety Charter, with key achievements including the publication of our first Sexual Safet Policy, the addition of sexual safety to both AfC and Medical & Dental Induction programmes and to the line manager's training offer. 3. **NHS England High Impact Actions -** The Trust has in place a comprehensive action plan aligned with NHS England's EDI Improvement Plan, to address High Impact Action 6, which is to 'Create an environment that eliminates the conditions in which bullying, discrimination, harassment and physical violence at work occur. 4. **Restorative Just Culture** – The Employee Relations team have incorporated a Restorative Just and Learning Culture approach into their key policies and processes and Managing Essentials Programme.
Staff Engagement	1. **Engagement of BME staff** – The Wellbeing & Inclusion team have worked to engage our diverse staff and amplify their voices, including launching the Trust's Wellbeing and Inclusion Survey to drive engagement. 2. **Wellbeing & Inclusion Resources** – The Wellbeing & Inclusion team have introduced a monthly bulletin and all-staff email to promote inclusive activities and initiatives. 3. **Recognition –** a QVH EDI Champion sat on the judging panel of our annual Star Awards to encourage a balanced and inclusive approach to recognition. 4. **Wellbeing & Inclusion Resources** – The Wellbeing & Inclusion team have introduced a monthly bulletin and all-staff email to promote inclusive activities and initiatives.
Board Sponsorship	1. **Board Accountability –** As work continues towards partnership with RSH and ASPH we will continue to work with them to utilise their network resources. Executive colleagues continue to develop relationships with their peers to review culture and workforce to align across the group drawing upon areas of progress and excellent practice 2. **Workforce Committee –** This has been embedded and highlights areas of challenge to the Executive Leadership Team and Strategy and Culture Committee relating to our BME colleagues.

Actions for next 12 months

Action	By When	Lead
Collaborate and engage on a flexible working toolkit for staff and managers	Q4 2026-27	Employee Relations team
Collaborate and engage on Restorative Just and Learning Culture framework to further embed the approach into policy, process and culture of people management	Q4 2026-27	Employee Relations Team
Triangulate Employee Relations case work, Freedom to Speak Up reports, Occupational Health data, Staff Survey and Pulse Survey results and Wellbeing & Inclusion insights to capture and act on themes highlighted by our BME colleagues on a quarterly basis.	Q2 2026-27	Wellbeing & Inclusion Manager
Apply an EDI lens through lived experience to an ongoing end-to-end review of our current internal and external recruitment processes, with an EDI representative available for interview panels to support the de-biasing of the recruitment process.	Q3 2026-27	Resourcing Business Partner
Conduct an EDI audit of all applications for career development, including apprenticeships and external learning, to establish how our BME colleagues can be better supported to develop their careers and tackle any potential barriers.	Q3 2026-27	DCPO
Mapping of senior roles has been undertaken in 2026. Succession planning and talent management from Band 8a to VSM will be explored in line with Partnership working.	Q4 2026/27	CPO, supported by Head of OD & L
Implementation of a reciprocal mentoring programme to support career progression. Working group established to take forward in 2026/2027.	Ongoing through 2026/27	CPO, supported by OD&L Manager
Development and implementation of a shadow board programme to develop future leaders, build board level experience and confidence to support succession planning and talent management	Q4 2026/27	CPO
Continue to monitor Violence Prevention and Reduction data to monitor of number staff who are affected by Violence in the workplace.	Q3 2026-27	VPR Operational Lead

NHS
Queen Victoria Hospital
NHS Foundation Trust



WDES-Workforce Disability Equality Standard

Report 2025-26

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Introduction

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

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

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

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

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

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

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

The following information in the report details key findings from the data collated for 2025/2026, comparisons of data from previous years, the progress made and actions that will be implemented to address the findings.

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

Queen Victoria Hospital
NHS Foundation Trust

WDES Metrics

There are ten (10) WDES metrics. Three (3) metrics focus on **workforce data**; Five (5) are based on questions from the **NHS Staff Survey**; One (1) metric focuses on disability representation on boards; One (1) metric (metric 9b) focuses on the voices of Disabled staff. Based on the requirement from the National team, the Trust submitted the WDES data for Metrics 1 –3, and Metric 9b and Metric 10 on the National Data Collection Framework (DCF) on 31st May 2026. The staff survey results for the Metrics 4 –9a, are taken directly from the WDES publications available on the NHS Staff Survey website.

Workforce Metrics:

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

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

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

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

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

a) Patients/service users, their relatives or other members of the public
b) Managers
c) Other colleagues,
d) Percentage of disabled staff compared to non-disabled staff saying that the last time they experienced harassment, bullying or abuse at work, they or a colleague reported it.

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

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

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

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

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

9. NHS Staff Survey and the engagement of disabled staff For part a)compare the staff engagement scores for Disabled, non-disabled staff.
a)The staff engagement score for Disabled staff, compared to nondisabled staff. b) Have you taken action to facilitate the voices of disabled staff in your organisation to be heard (Yes or No)?

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

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

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

Data Limitations

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

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

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

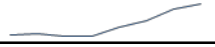
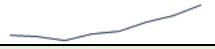
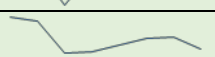
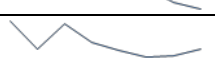
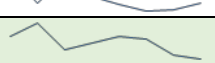
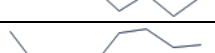
Benchmarking groups
NHS organisations vary in the services they provide and relatedly, the challenges they face. Organisations are assigned to a benchmarking group based on the services they offer. This means that comparisons are only made between organisations of a similar type and ensures comparisons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

Data from ESR is provided based on those staff who had declared their disability to the Trust. Staff survey data is not on this basis and is provided anonymously by the individual carrying out the survey a disability recorded if they self identify. In 25/26 figures 8.49% of staff declared a disability, however in the staff survey 25.7% of respondents identified as disabled (178 out of 693 respondents).

Definitions

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

Yearly comparison 2019-2026

	WDES Metrics		Year								Trend	Difference between 2023 & 2024	
			2018-2019	2019-2020	2020-2021	2021-2022	2022-2023	2023-2024	2024-2025	2025-2026			
1	Percentage of staff in AfC (Agenda for Change) paybands or medical and dental subgroups and very senior managers (including Executive Board members) compared with the percentage of staff in the overall workforce	Overall	5.23%	5.02%	4.70%	5.36%	5.77%	6.67%	7.62%	8.49%		0.87%	↑
		Non-Clinical	6.20%	6.30%	6.00%	5.90%	7.30%	8.30%	9.90%	10.80%		0.90%	↑
		Clinical	5.50%	5.30%	4.90%	5.60%	5.90%	6.80%	7.50%	8.70%		1.20%	↑
2	Relative likelihood of non-disabled staff compared to disabled staff being appointed from shortlisting across all posts		2.18	1.71	2.41	0.68	2.05	1.11	1.09	1.28		0.19	↑
3	Relative likelihood of disabled staff compared to non-disabled staff entering the formal capability process as measured by entry into the formal capability procedure		0.00	5.78	0.00	0.00	0.00	4.49	2.93	0.00		-2.93	↑
4a	Percentage of disabled staff compared to non-disabled staff experiencing harassment, bullying or abuse from Patient/Service users, their relatives or other members of the public	Disabled	24.7%	31.0%	18.6%	30.1%	28.5%	28.1%	24.2%	23.3%		-0.94%	↑
		Non-disabled	24.9%	23.8%	16.2%	16.6%	18.3%	19.8%	19.9%	17.4%		-2.53%	↑
4b	Percentage of disabled staff compared to non-disabled staff experiencing harassment, bullying or abuse from managers	Disabled	19.5%	12.8%	20.0%	13.5%	14.6%	15.7%	11.6%	9.7%		-1.93%	↑
		Non-disabled	10.2%	7.3%	9.9%	7.9%	7.1%	6.4%	6.6%	7.2%		0.63%	↑
4c	Percentage of disabled staff compared to non-disabled staff experiencing harassment, bullying or abuse from other colleagues	Disabled	24.1%	27.2%	21.4%	22.6%	24.3%	23.7%	20.1%	19.2%		-0.91%	↑
		Non-disabled	16.0%	15.4%	18.5%	15.6%	14.1%	14.1%	15.2%	14.2%		-1.00%	↑
4d	Percentage of disabled staff compared to non-disabled staff experiencing harassment, bullying or abuse at work and they or a colleague reported it	Disabled	57.9%	53.4%	53.7%	55.8%	46.3%	52.8%	44.4%	51.7%		7.28%	↑
		Non-disabled	59.6%	47.5%	52.1%	47.3%	59.5%	61.0%	54.1%	55.4%		1.26%	↑

Yearly comparison 2019-2026

5	Percentage of disabled staff compared to non-disabled staff believing that the organisation provides equal opportunities for career progression or promotion	Disabled	53.4%	61.3%	54.8%	57.8%	55.4%	61.1%	57.8%	51.4%		-6.42%	↑
		Non-disabled	61.6%	56.1%	58.1%	58.9%	57.4%	60.7%	62.3%	54.2%		-8.10%	↑
6	Percentage of disabled staff compared to non-disabled staff saying that they have felt pressure from their manager to come to work, despite not feeling well enough to perform their duties	Disabled	29.3%	33.3%	38.0%	31.8%	22.0%	22.7%	31.8%	18.3%		-13.49%	↑
		Non-disabled	25.3%	27.8%	25.5%	17.7%	20.0%	17.5%	12.3%	18.3%		6.01%	↑
7	Percentage of disabled staff compared to non-disabled staff saying that they are satisfied with the extent to which their organisation values their work	Disabled	39.3%	43.2%	41.9%	40.7%	42.0%	45.3%	34.6%	35.4%		0.84%	↑
		Non-disabled	52.0%	57.1%	55.9%	51.8%	54.1%	57.1%	53.6%	48.3%		-5.32%	↑
8	Percentage of disabled staff saying that their employer has made reasonable adjustment(s) to enable them to carry out their work	Disabled	77.4%	73.7%	82.4%	80.7%	84.8%	84.6%	83.5%	82.3%		-1.24%	↑
9	NHS Staff Survey and the engagement of disabled staff For part a)compare the staff engagement scores for Disabled, non-disabled staff	Disabled	6.8	7.3	6.9	7.1	7.0	7.2	7.0	6.6		-0.4	↑
		Non-disabled	7.4	7.6	7.5	7.4	7.5	7.6	7.5	7.2		-0.3	↑
10	Percentage difference between the organisation's Board voting membership and its organisation's overall workforce, disaggregated		5%	5%	5.00%	5%	5%	3%	0%	0%		0.00%	

Executive Summary

Queen Victoria Hospital NHS Foundation Trust

Workforce & Board Representation

There has been an increase in the proportion of disabled staff, from **7.62%** in 24/25 to **8.49%** in 25/26. The highest reported under representation is in Medical and Dental roles.

Feeling Valued

There is a **significant decrease of 13.5%** in disabled staff who felt pressure to come to work, from **31.8%** in 24/25 (28 respondents) to **18.3%** in 25/26 (21 respondents)

35.4% of disabled staff feel the Trust values their work compared to **48.3%** of non-disabled staff – this represents an increase of **0.8%** or 5 respondents (from 57 to 62)

Staff Engagement

Engagement amongst disabled staff remains below that of non-disabled staff.

There is a slight decrease of 0.4 points(out of 10) in the staff engagement score for disabled staff and a 0.3 decline for non-disabled staff.

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

Career Progression

There is a decrease of **6.4%** in the number of disabled staff believing that the Trust provides equal opportunities for career progression or promotion, from **57.8%** in 24/25 to **51.4%** in 25/26.

Recruitment

There has been a further decline in the likelihood of disabled candidates being appointed into roles from **1.09** in 24/25 to **1.28** 25/26. This is still significantly lower than the 2.05 reported in 23/24

The national average in the 2025 WDES Report is 0.95

Reasonable Adjustments

82.3 % of disabled staff say that the Trust has made reasonable adjustments, which is significantly above the national average.

This has reduced very slightly since 2025, however has remained consistently over the current national average since 2019

Bullying and Harassment

There is a **decrease of 0.9%** in bullying and harassment towards disabled staff from patients, service users, relatives and members of public, from 23.3% in 25/26 to 28.1% in 25/26.

There has been **decrease of 1.9%** in the number of disabled staff experiencing bullying, harassment or abuse from managers, from 11.6% in 24/25 (19 respondents) to 9.7% (17 respondents) in 25/26.

There has been a **decrease of 0.9%** in the number of disabled staff that have experienced harassment, bullying or abuse from colleagues

There has been an increase of 7.3% in the number of disabled staff that have experienced harassment, bullying or abuse from colleagues and have reported it – from 44.4% in 24/25 (27 respondents) to 51.7% in 25/26 (29 respondents)

Capability

Disabled staff are no more likely to enter into a formal capability process than their non-disabled colleagues

Board Representation

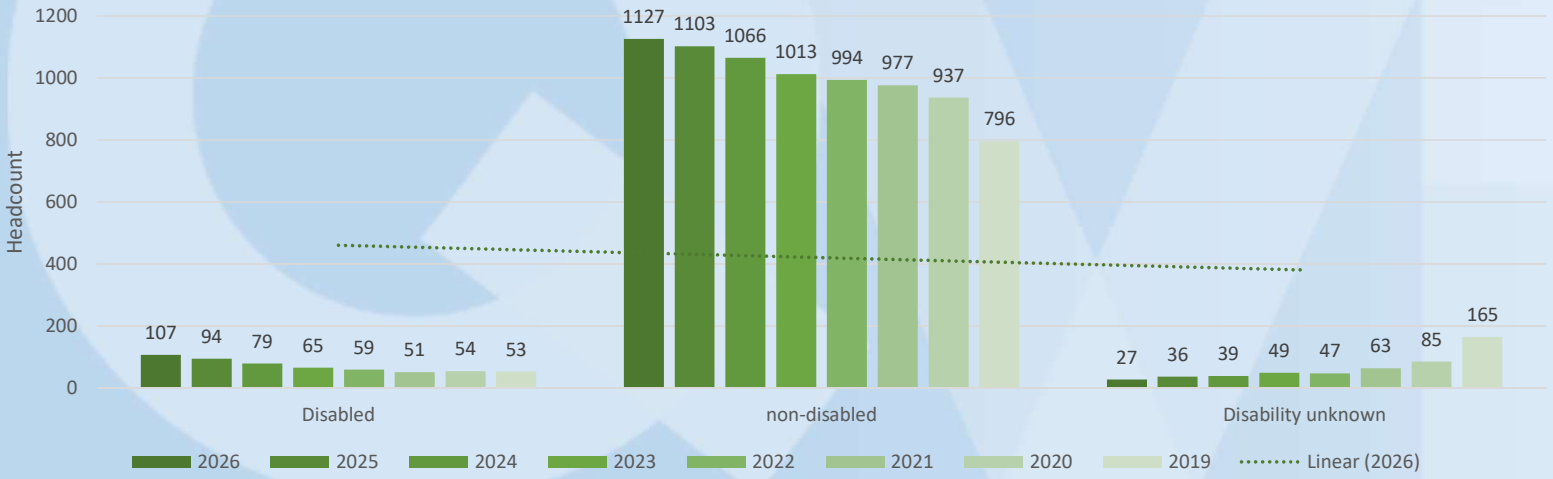
In 25/26 Board representation remained at **0**% from a previous high of 6.7% in 23/24.

WDES Metric 1

Workforce Representation

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

Staff Group	2026	2025	2024	2023	2022	2021	2020	2019
Disabled	107	94	79	65	59	51	54	53
non-disabled	1127	1103	1066	1013	994	977	937	796
Disability unknown	27	36	39	49	47	63	85	165
Total headcount	1261	1233	1184	1127	1100	1091	1076	1014
Percentages								
Disabled	8.49%	7.62%	6.67%	5.80%	5.40%	4.70%	5.00%	5.20%
non-disabled	89.37%	89.46%	90.03%	89.90%	90.40%	89.60%	87.10%	78.50%
Disability unknown	2.14%	2.92%	3.29%	4.30%	4.30%	5.80%	7.90%	16.30%



QVH has 107 individuals with a recorded disability amongst its workforce (8.49%) which is an increased from 97 (7.62%) in 2025.

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

NHS Workforce Disability Equality Standard 2025

National Average
Disabled: 6.7%
Non-Disabled: 81.4%

WDES Metric 1

Workforce Representation

	Pay banding	Disabled	non-disabled	Unknown	Total	Disabled %	non-disabled %
Non-Clinical	Cluster 1 (Bands 1-4)	31	264	6	301	10.3%	87.7%
	Cluster 2 (Bands 5-7)	12	88	0	100	12.0%	88.0%
	Cluster 3 (Bands 8a-8b)	2	20	0	22	9.1%	90.9%
	Cluster 4 (Bands 8c-9 & VSM)	3	19	1	23	13.0%	82.6%
	All non-clinical roles	**48**	**391**	**7**	**446**	**10.8%**	**87.7%**
Clinical	Cluster 1 (Bands 1-4)	16	151	3	170	9.4%	88.8%
	Cluster 2 (Bands 5-7)	36	346	8	390	9.2%	88.7%
	Cluster 3 (Bands 8a-8b)	1	39	0	40	2.5%	97.5%
	Cluster 4 (Bands 8c-9 & VSM)	0	10	0	10	0.0%	100.0%
	Total clinical	**53**	**546**	**11**	**610**	**8.7%**	**89.5%**
Medical and Dental	Cluster 5 (M&D: Consultants)	3	103	3	109	2.8%	94.5%
	Cluster 6 (M&D: Non-Consultant career grades)	0	29	0	29	0.0%	100.0%
	Cluster 7 (M&D: trainee grades)	3	58	6	67	4.5%	86.6%
	Total Medical and Dental	**6**	**190**	**9**	**205**	**2.9%**	**92.7%**

The overall headcount for QVH is 1261 which includes:

- 107 disabled staff
- 1127 non-disabled staff
- 27 who have not provided monitoring information to the Trust

Non-Clinical staff in Cluster 1 (Bands 1-4) have the highest headcount of workforce with a recorded disability (31)

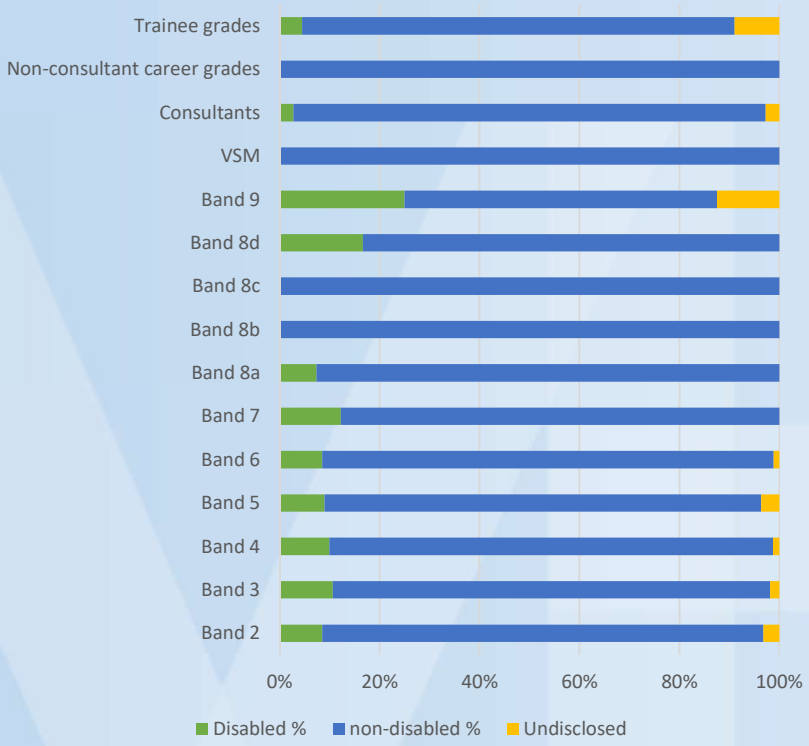
Clinical staff in Cluster 2 (Band 5-7) have the highest headcount of workforce who have recorded a disability (36)

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

WDES Metric 1

Workforce Representation

Pay banding	Disabled	non-disabled	Unknown	Total	Disabled %	non-disabled %
Band 2	8	83	3	94	8.51%	88.30%
Band 3	23	189	4	216	10.65%	87.50%
Band 4	16	143	2	161	9.94%	88.82%
Band 5	15	146	6	167	8.98%	87.43%
Band 6	15	159	2	176	8.52%	90.34%
Band 7	18	129	0	147	12.24%	87.76%
Band 8a	3	38	0	41	7.32%	92.68%
Band 8b	0	21	0	21	0.00%	100.00%
Band 8c	0	13	0	13	0.00%	100.00%
Band 8d	1	5	0	6	16.67%	83.33%
Band 9	2	5	1	8	25.00%	62.50%
VSM	0	6	0	6	0.00%	100.00%
Consultant	3	103	3	109	2.75%	94.50%
Non-consultant career grades	0	29	0	29	0.00%	100.00%
Trainee grades	3	58	6	67	4.48%	86.57%



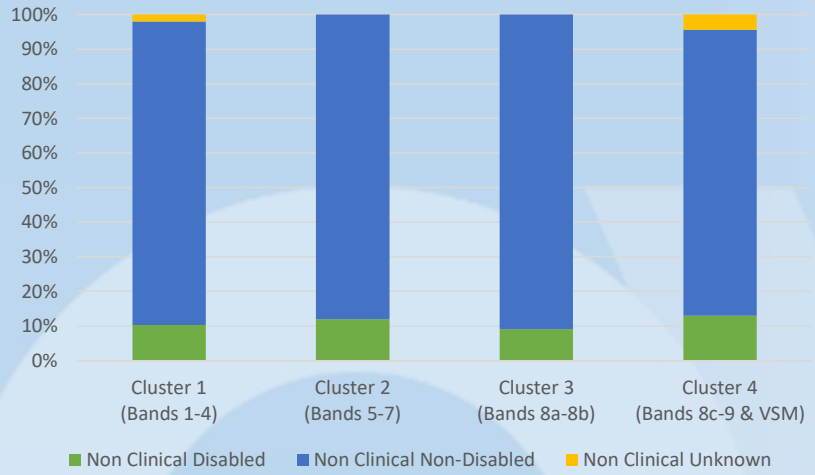
Data shows that we have no disabled staff in senior banded positions 8b, 8c VSM and non-consultant career grades. The highest declaration of disability is amongst Band 9 although this only affects 6 staff for context

WDES Metric 1

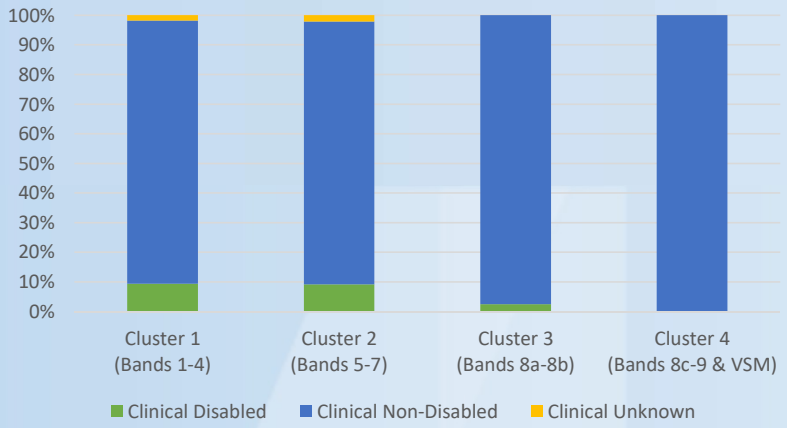
Workforce Representation

Queen Victoria Hospital
NHS Foundation Trust

Non-Clinical



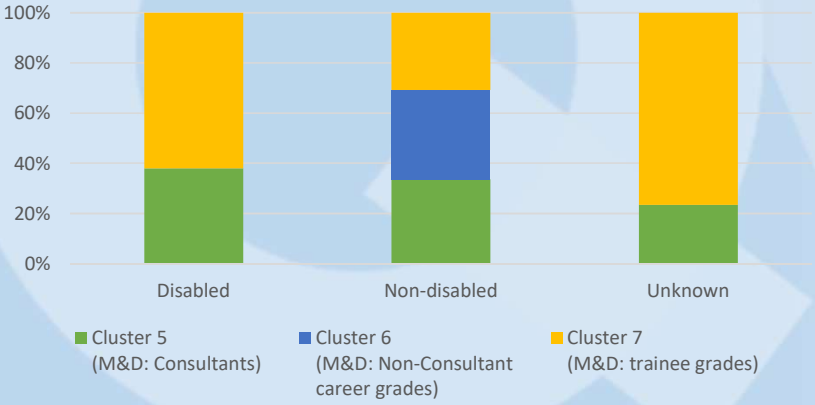
Clinical



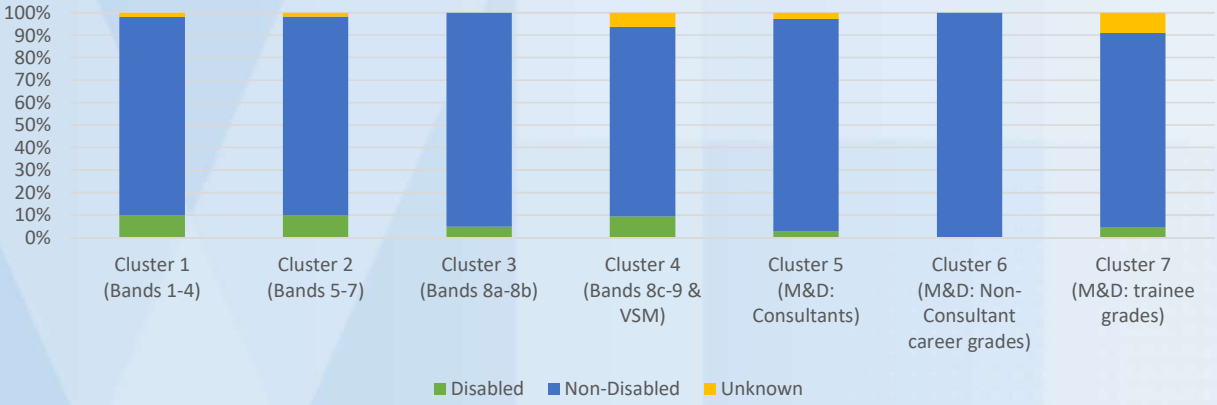
This metric demonstrates the proportion of declaration reduces as pay banding increases.

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

Medical and Dental



Overall Workforce

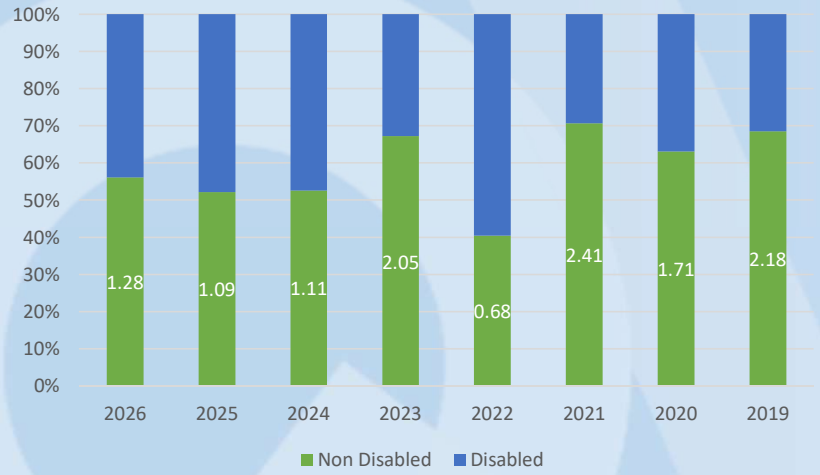


Queen Victoria Hospital
NHS Foundation Trust

WDES Metric 2

Recruitment

	2026	2025	2024	2023	2022	2021	2020	2019
Non Disabled	1.28	1.09	1.11	2.05	0.68	2.41	1.71	2.18



This metric shows non-disabled candidates are 1.28 times more likely to be appointed from shortlisting to Disabled candidates

This demonstrates a significant progress from 2023 where candidates were more than 2 times likely to be appointed but is a slight increase from 2025 of 0.19.

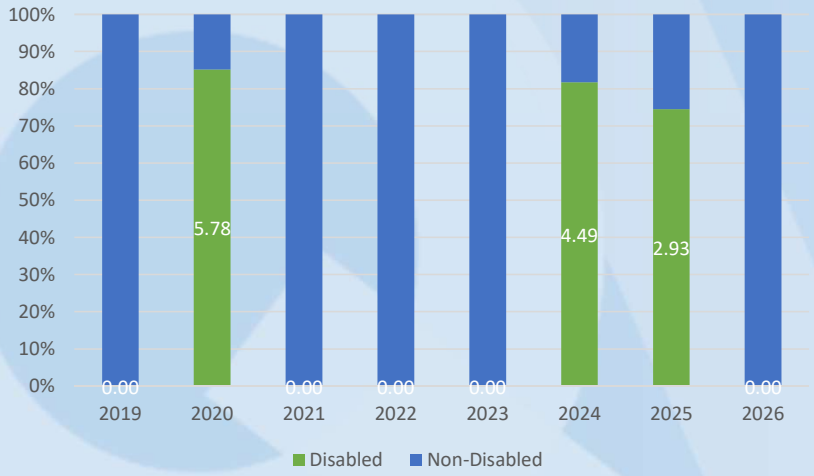
NHS Workforce Disability Equality Standard 2025

National Average
0.95

WDES Metric 3

Capability

	Year to March							
	2019	2020	2021	2022	2023	2024	2025	2026
Relative likelihood of disabled staff compared to non-disabled staff entering the formal capability process as measured by entry into the formal capability procedure	0.00	5.78	0.00	0.00	0.00	4.49	2.93	0.00



Data shows that disabled staff are no more likely to enter into a formal capability process than their non-disabled colleagues.

For the past 2 years (2024 and 2025) the Trust has had an average of 1 disabled, 4 Non-disabled and 0 unknown (5 cases in total) enter into a formal capability process. The difference in disparity is 0.010 vs 0.0036 however this is auto calculated to 2.29.

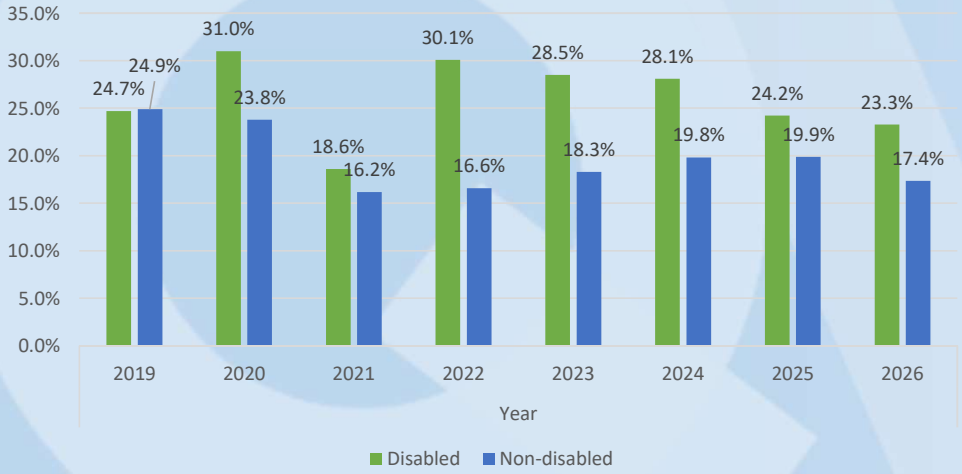
Queen Victoria Hospital
NHS Foundation Trust

WDES Metric 4a

Harassment, bullying or abuse

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

	Year							
	2019	2020	2021	2022	2023	2024	2025	2026
Disabled	24.7%	31.0%	18.6%	30.1%	28.5%	28.1%	24.2%	23.3%
Non-disabled	24.9%	23.8%	16.2%	16.6%	18.3%	19.8%	19.9%	17.4%



There is a **decrease of 0.9%** in bullying and harassment towards disabled staff from patients, service users, relatives and members of public, from **24.2%** 24/25 to **23.3%** in 25/26 (39 respondents in 24/25 to 41 in 25/26 – while this appears as an increase, the number of disabled respondents was higher in 25/26 than 24/25, resulting in a higher number but a decrease overall).

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

These results are below the national average.

NHS Staff Survey report 2025

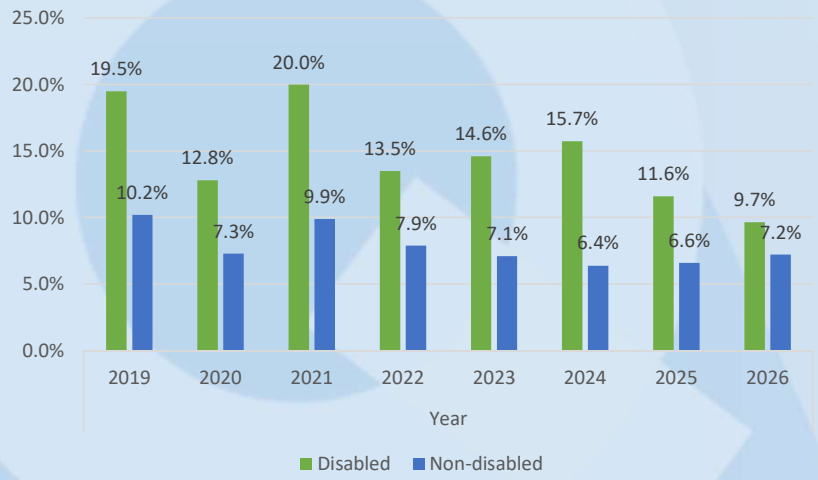
National Average
Disabled: 29.68%
Non-Disabled: 23.44%

WDES Metric 4b

Harassment, bullying or abuse

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

	Year							
	2019	2020	2021	2022	2023	2024	2025	2026
Disabled	19.5%	12.8%	20.0%	13.5%	14.6%	15.7%	11.6%	9.7%
Non-disabled	10.2%	7.3%	9.9%	7.9%	7.1%	6.4%	6.6%	7.2%



There has been **decrease of 1.9%** in the number of disabled staff experiencing bullying, harassment or abuse from managers, from **11.6%** in 24/25 to **9.7%** in 25/26 (19 to 17 respondents).

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

QVH are below the national benchmark.

NHS Staff Survey report 2025

National Average
Disabled: 13.62%
Non-Disabled: 7.38%

WDES Metric 4c

Harassment, bullying or abuse

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

	Year							
	2019	2020	2021	2022	2023	2024	2025	2026
Disabled	24.1%	27.2%	21.4%	22.6%	24.3%	23.7%	20.1%	19.2%
Non-disabled	16.0%	15.4%	18.5%	15.6%	14.1%	14.1%	15.2%	14.2%



There has been a **decrease of 0.9%** in the number of disabled staff that have experienced harassment, bullying or abuse from colleagues, from **20.1%** in 24/25 to **19.2%** in 25/26 (32 to 34 respondents – while this appears as an increase, the number of disabled respondents was higher in 25/26 than 24/25, resulting in a higher number but a decrease overall).

QVH are below the national benchmark.

NHS Staff Survey report 2025

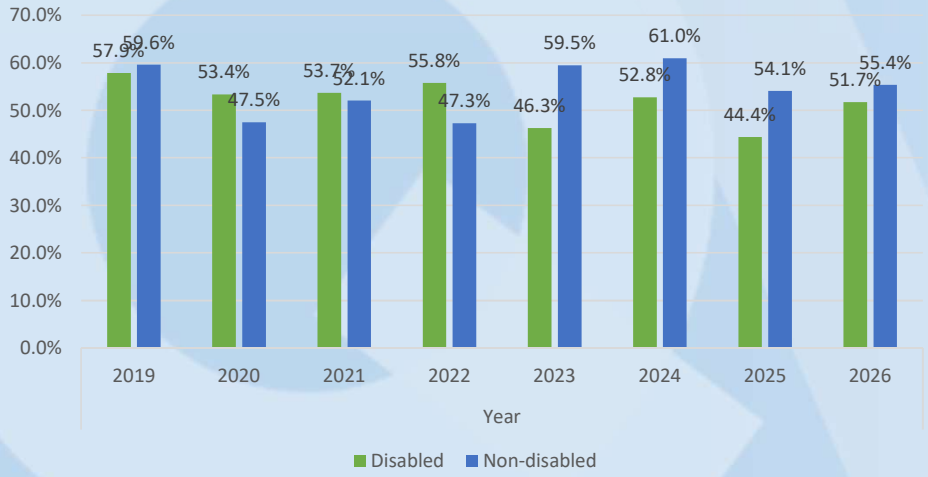
National Average
Disabled: 22.94%
Non-Disabled: 14.76%

WDES Metric 4d

Harassment, bullying or abuse

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

	Year							
	2019	2020	2021	2022	2023	2024	2025	2026
Disabled	57.9%	53.4%	53.7%	55.8%	46.3%	52.8%	44.4%	51.7%
Non-disabled	59.6%	47.5%	52.1%	47.3%	59.5%	61.0%	54.1%	55.4%



There has been an increase of **7.3%** in the number of disabled staff that have experienced harassment, bullying or abuse from colleagues and have reported it – from **44.4%** in 24/25 to **51.7%** in 25/26 (27 to 29 respondents).

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

NHS Staff Survey report 2025

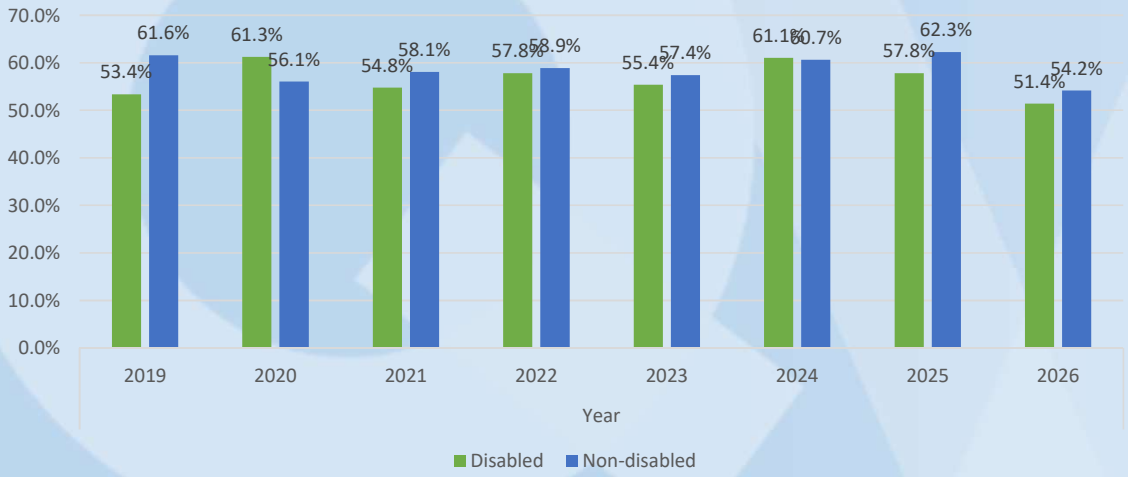
National Average
Disabled: 54.89%
Non-Disabled: 54.93%

WDES Metric 5

Career Progression

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

	Year							
	2019	2020	2021	2022	2023	2024	2025	2026
Disabled	53.4%	61.3%	54.8%	57.8%	55.4%	61.1%	57.8%	51.4%
Non-disabled	61.6%	56.1%	58.1%	58.9%	57.4%	60.7%	62.3%	54.2%



51.4% of disabled staff believe the Trust provides equal opportunities compared to **54.2%** of non-disabled staff.

There is a decrease of **6.4%** in the number of disabled staff believing that the trust provides equal opportunities for career progression or promotion, from **57.8%** in 24/25.

QVH are above the national average for disabled staff.

NHS Staff Survey report 2025

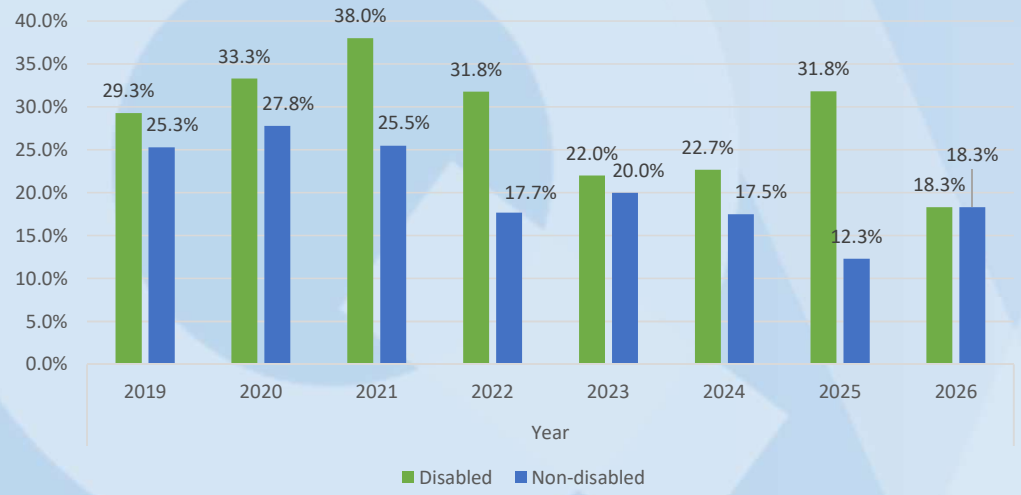
National Average
Disabled: 48.58%
Non-Disabled: 55.74%

WDES Metric 6

Presenteeism

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

	Year							
	2019	2020	2021	2022	2023	2024	2025	2026
Disabled	29.3%	33.3%	38.0%	31.8%	22.0%	22.7%	31.8%	18.3%
Non-disabled	25.3%	27.8%	25.5%	17.7%	20.0%	17.5%	12.3%	18.3%



There is a **significant decrease of 13.5%** in disabled staff who felt pressure to come to work, from **31.8%** in 24/25 to **18.3%** in 25/26 (28 to 21 respondents).

18.3% (1 in 5) of QVH disabled staff have felt pressure from their manager to come to work when not feeling well enough to perform their duties.

This has decreased to the lowest level since reporting started in 2019

QVH is 7.26% below the national average for disabled staff

NHS Staff Survey report 2025

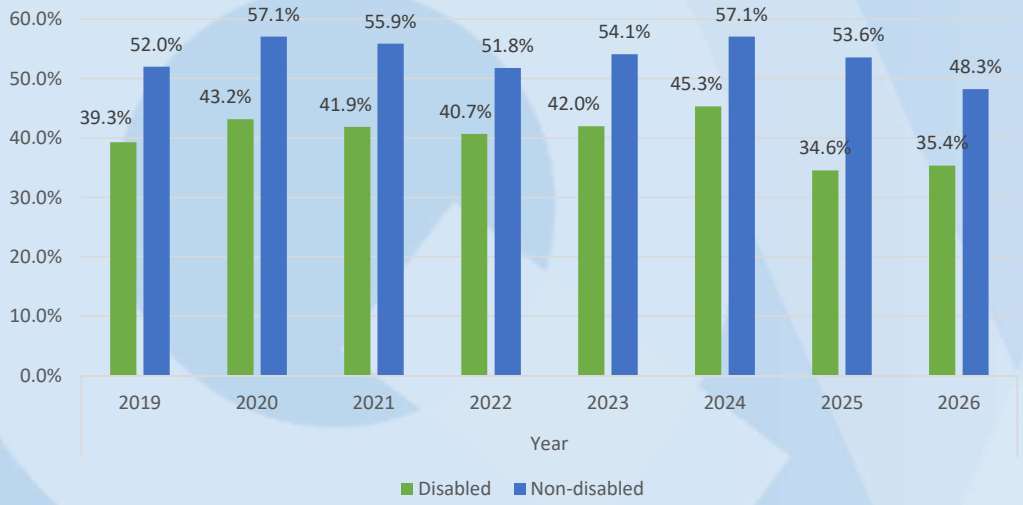
National Average
Disabled: 25.56%
Non-Disabled: 17.49%

WDES Metric 7

Feeling Valued

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

	Year							
	2019	2020	2021	2022	2023	2024	2025	2026
Disabled	39.3%	43.2%	41.9%	40.7%	42.0%	45.3%	34.6%	35.4%
Non-disabled	52.0%	57.1%	55.9%	51.8%	54.1%	57.1%	53.6%	48.3%



35.4% of disabled staff feel the Trust values their work compared to **48.3%** of non-disabled staff – this represents an increase of **0.8%, or 5 respondents** (from 57 to 62).

This was improving year on year between 2019 and 2024 when 2025 took a significant decline. Some recover has been seen in 2026. For non-disabled staff this has remained fairly consistent since 2019 however in 2026 has seen a significant decline.

QVH is below the national average for disabled staff.

NHS Staff Survey report 2025

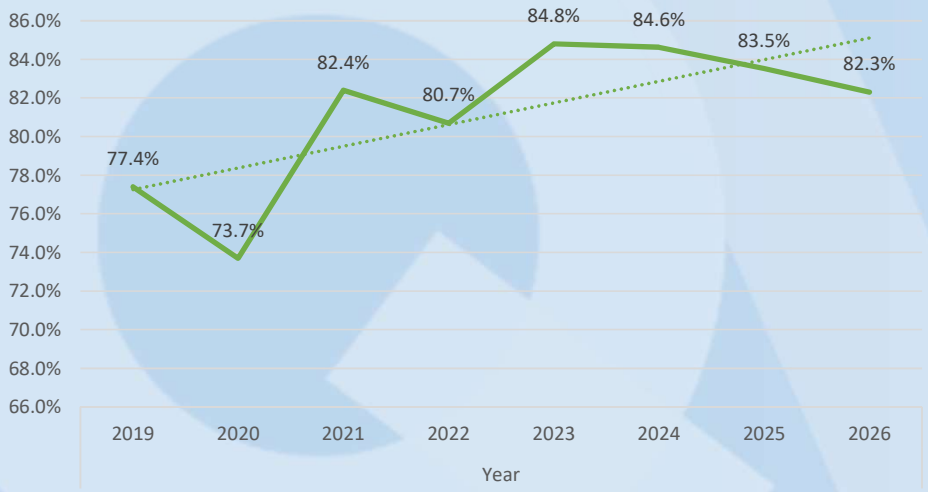
National Average
Disabled: 38.50%
Non-Disabled: 50.51%

WDES Metric 8

Workplace Adjustments

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

Year							
2019	2020	2021	2022	2023	2024	2025	2026
77.4%	73.7%	82.4%	80.7%	84.8%	84.6%	83.5%	82.3%



82.3 % of disabled staff say that the Trust has made reasonable adjustments, which is significantly above the national average.

This has reduced very slightly since 2025 (from 71 to 78 respondents – while this appears as an increase, the number of disabled respondents was higher in 25/26 than 24/25, resulting in a higher number but a decrease overall) , however has remained consistently over the current national average since 2019

NHS Staff Survey report 2025

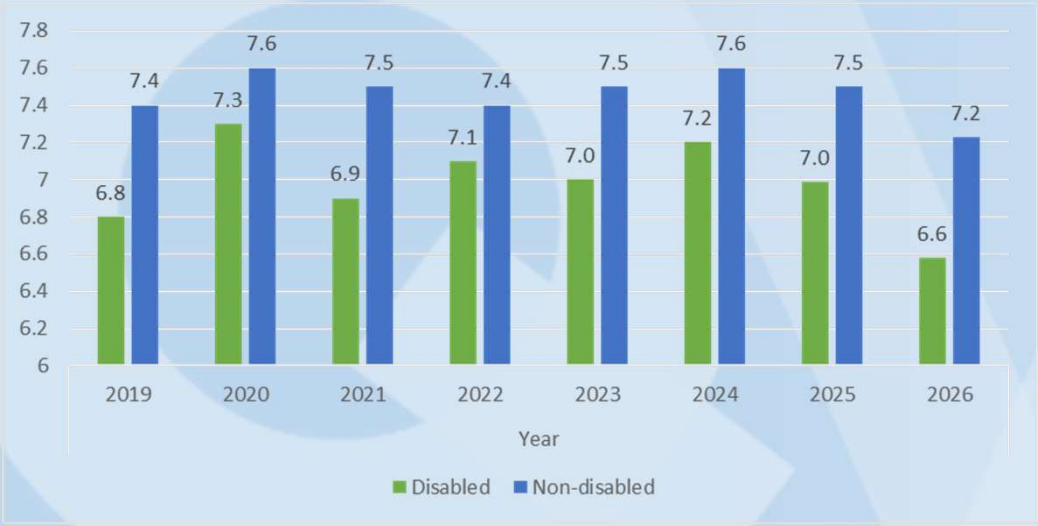
National Average
74.89%

WDES Metric 9

Staff Engagement

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

	Year							
	2019	2020	2021	2022	2023	2024	2025	2026
Disabled	6.8	7.3	6.9	7.1	7.0	7.2	7.0	6.6
Non-disabled	7.4	7.6	7.5	7.4	7.5	7.6	7.5	7.2



Engagement amongst disabled staff remains below that of non-disabled staff.

There is a slight decrease of 0.4 points (out of 10) in the staff engagement score for disabled staff and a 0.3 decline for non-disabled staff.

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

NHS Staff Survey Benchmark report 2024

National Average
Disabled: 6.44
Non-Disabled: 6.99

Queen Victoria Hospital
NHS Foundation Trust

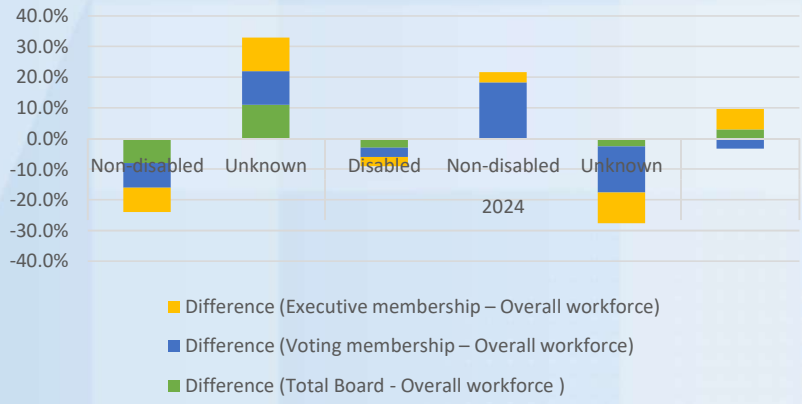
WDES Metric 10

Board Representation

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

	2026				2025				2024				2023			
	Disabled	Non-disabled	Unknown	Total	Disabled	Non-disabled	Unknown	Total	Disabled	Non-disabled	Unknown	Total	Disabled	Non-disabled	Unknown	Total
Total Board members	0	16	0	16	0	15	0	15	1	14	1	16	2	10	1	13
of which voting	0	5	0	5	0	4	0	5	1	3	0	4	1	2	1	4
of which non-voting	0	11	0	11	0	11	0	11	0	11	1	12	1	8	0	9
Total Board members	0	16	0	0	0	15	0	15	1	14	1	16	1	9	2	13
of which Executive	0	8	0	0	0	6	0	6	1	8	1	10	1	6	1	8
of which Non-Executive	0	8	0	0	0	9	0	9	0	6	0	6	1	4	0	5

	2026				2025			
	Disabled	Non-disabled	Unknown	Total	Disabled	Non-disabled	Unknown	Total
Number of staff in overall workforce	107	1127	27	1261	94	1103	36	1233
Total Board members - % by Disability	0.0%	100.0%	0.0%		0.0%	100.0%	0.0%	
Voting Board Member - % by Disability	0.0%	100.0%	0.0%		0.0%	100.0%	0.0%	
Non-Voting Board Member - % by Disability	0.0%	100.0%	0.0%		0.0%	100.0%	0.0%	
Executive Board Member - % by Disability	0.0%	100.0%	0.0%		0.0%	100.0%	0.0%	
Non-Executive Board Member - % by Disability	0.0%	100.0%	0.0%		0.0%	100.0%	0.0%	
Overall workforce - % by Disability	8.7%	89.5%	1.8%		7.6%	89.5%	2.9%	
Difference (Total Board - Overall workforce)	-8.0%	11.0%	-2.0%		-8.0%	11.0%	-3.0%	
Difference (Voting membership – Overall workforce)	-8.0%	11.0%	-2.0%		-8.0%	11.0%	-3.0%	
Difference (Executive membership – Overall workforce)	-8.0%	11.0%	-2.0%		-8.0%	11.0%	-3.0%	



0% of Trust board membership has a declaration of a disability, which is not broadly reflective of the overall workforce of 8.7%.

Additional Insights

The increase in our overall Trust representation of disabled staff (8.49%) may be due to the improvements seen in our staff experience indicators, as fewer disabled staff are experiencing bullying and harassment from the public or colleagues, and those who have experienced it are more likely to report it, suggesting improved psychological safety among this group.

The number of disabled staff who feel that QVH values their work has increased, and disabled staff report a higher average engagement score than last year. While the percentage of disabled staff saying that we have made reasonable adjustments has dropped slightly, this still remains high at over 82%.

A significant improvement is also seen in the percentage of disabled staff who felt pressure from their manager to come to work when not well enough to do so, with a reduction of over 13%.

The percentage of leavers with a declared disability (7.45%) is lower than the overall Trust representation

- Disabled staff are most likely to cite the following as the reason for their resignation (29% of total voluntary resignations for this group respectively):
  - Promotion
  - Work-life balance

This suggests that while the Trust has taken positive steps to improve the experience and retention of our disabled workforce, there is work to be done to improve access to career development – this is supported by our 2025 Staff Survey results, which show that our disabled colleagues are less likely to agree that the Trust offers equal opportunities for career development and progression. Our data also shows that non-disabled candidates are 28% more likely to be appointed from shortlisting than disabled candidates.

It is worth noting that by using the Trac reports the Equal Opportunities data is not available for any new starters manually added to Trac, such as Trainee Doctor rotations, therefore incorrectly presenting these as 'undisclosed'. The data is collected during recruitment and added to ESR at hire stage.

Key Areas of Progress

Culture Change	1. **Promotion of Vision and Values & Behavioural Framework -** These were launched in late 2024, with a behaviour framework to support an inclusive learning culture, increasing psychological safety of staff and supporting the embedding of an enhanced speak up process for staff. Workshops for managers, Session at Corporate of induction including cups/lanyard cards given out. 2. **Workforce Belonging & Value** – The Trust has in place a comprehensive action plan aligned with NHS England's EDI Improvement Plan to to create an environment that eliminates the conditions in which bullying, discrimination, harassment and physical violence at work occur. 3. **Inclusive Behaviours** – A module on EDI and inclusive management (including reasonable adjustments) has been added to the mandatory line manager's training offer in 2025-26. 4. **Freedom to Speak Up** – The Freedom to Speak Up Guardian for QVH meets with the Chief Executive and Chief Nurse on a regular basis. 5. **Cultural Listening Exercises** – The Wellbeing & Inclusion team have supported cultural listening exercises across several teams to understand and tackle behaviours than contribute to a more inclusive environment for our disabled staff. 6. **Wellbeing Culture –** the Wellbeing & Inclusion team published the Trust's first staff wellbeing policy to document responsibilities and actions to be taken to support and enhance wellbeing at work. The team also produced a checklist and guidance document for managers to use when staff call in to report a sickness absence, detailing how to manage sickness absence compassionately and sensitively to reduce presenteeism among our disabled colleagues.
Recruitment & Career Development	1. **Inclusive Recruitment Process & Practice –** There has been a decrease in the likelihood of disabled candidates being appointed to positions in the Trust. There is also a further decrease in the number of disabled staffing feeling that the trust provides equal opportunities for career progression or promotion. For those who do not disclose their Equal Opportunities information perhaps this is due to fear of it being available to recruiting managers. It would be worth exploring the possibility of an amended Trac application form to ensure reassurance is built into this part of the application form. 2. **Appraisal Process Continually Reviewed with a focus on Wellbeing and career development -** Continue to monitor effectiveness of appraisal alongside our National Staff Survey & NQPS results. Any areas of concern are raised at the appropriate level to address concerns. Future potential to move to a national appraisal linked to NHS Management & Leadership Framework. 3. **Career development through Apprenticeships** – Apprenticeships are key to support career development across all staffing areas. There was a significant increase of apprentices declaring a disability from 9.1% in 24/25 to 11.29% in 25/26. However, ongoing work is needed to ensure diversity of staff accessing apprentice opportunities is maintained and the use of the levy continues to increase. Work experience opportunities have been offered to a more diverse range of students due to the introduction of work experience events to complement traditional work experience placements. The Wellbeing & Inclusion team have produced the Trust's Neurodiversity Support for Apprenticeships guide, with the aim of encouraging more disabled staff into ongoing development.
Staff Engagement	1. **Staff Engagement** – Scores for our staff with disabilities have steadily increased since 2023-24, suggesting that good work has been achieved in this area. This is likely underpinned by activities to support these colleagues, such as publishing policy and process documents that embed a culture of inclusion and wellbeing, working with line managers to raise awareness of disabilities and the reasonable adjustments that can be offered and launching the Trust's Wellbeing and Inclusion Survey to drive engagement. 2. **Reasonable Adjustments –** Throughout 2024-25, the Wellbeing & Inclusion team supported 4 applications to the government's Access to Work scheme. The new Managing Sickness policy provides greater detail around reasonable adjustments and supporting staff. Flexible Working requests continue to be reviewed, and rejected requests for flexible working are reviewed by the EIA team to ensure that impacts to equality at QVH are minimised. These actions have aided in the reduction of presenteeism. 3. **Recognition –** a QVH EDI Champion sat on the judging panel of our annual Star Awards to encourage a balanced and inclusive approach to recognition. 4. **Wellbeing & Inclusion Resources** – The Wellbeing & Inclusion team have introduced a monthly bulletin and all-staff email to promote inclusive activities and initiatives.

Key Areas of Progress

Bullying and Harassment	1. **Violence, Aggression & Abuse -** The Trust's Violence Prevention and Reduction group has increased compliance against the national standards to 98% in 25/26. The Trust has implemented a Formal VPR group that meets monthly, along with collaborating with other Sussex Trusts on national VPR initiatives. 2. **Sexual Safety –** the Trust reached 98% compliance with the principles of NHS England's Sexual Safety Charter, with key achievements including the publication of our first Sexual Safety Policy, the addition of sexual safety to both AfC and Medical & Dental Induction programmes and to the line manager's training offer. 3. **NHS England High Impact Actions -** The Trust has in place a comprehensive action plan aligned with NHS England's EDI Improvement Plan, to address High Impact Action 6, which is to 'Create an environment that eliminates the conditions in which bullying, discrimination, harassment and physical violence at work occur. 4. **Restorative Just Culture** – The Employee Relations team have incorporated a Restorative Just and Learning Culture approach into their key policies and processes and Managing Essentials Programme.
Board Sponsorship	1. **Board Accountability** – As work continues towards partnership with RSH and ASPH we will continue to work with them to utilise their network resources. Exec Colleagues continue to develop relationships with their peers to review culture and workforce to align across the group drawing upon areas of progress and excellent practice 2. **People Committee** – This has been embedded and highlights areas of challenge to the Trust Board relating to our disabled colleagues.

Actions for next 12 months

Action	By When	Lead
Collaborate and engage on a flexible working tool kit for staff and managers	Q4 2026-27	Employee Relations Team
Collaborate and engage on Restorative Just and Learning Culture framework to further embed the approach into policy, process and culture of people management	Q4 2026-27	Employee Relations Team
Triangulate Employee Relations case work, Freedom to Speak Up reports, Occupational Health data, Staff Survey and Pulse Survey results and Wellbeing & Inclusion insights to capture and act on themes highlighted by our colleagues with disabilities or long-term health conditions on a quarterly basis.	Q4 2026-27	Wellbeing & Inclusion Manager
Apply an EDI lens through lived experience to an end-to-end review of our current internal and external recruitment processes, with an EDI representative available for interview panels to support the de-biasing of the recruitment process.	Q3 2026-27	Resourcing Business Partner
Conduct an EDI audit of all applications for career development, including apprenticeships and external learning, to establish how our disabled colleagues can be better supported to develop their careers and tackle any potential barriers.	Q4 2026-27	DCPO
Demonstrate recognition and value of our disabled colleagues through inclusion events and resources that challenge assumptions and stereotypes, reinforcing the strengths and capabilities our diverse workforce bring to QVH.	Q4 2026-27	Wellbeing & Inclusion Manager
Continue to monitor Violence Prevention and Reduction data to monitor number of disabled staff vs non disabled staff who are affected by Violence in the workplace.	Ongoing through 2026-27	VPR Operational lead

Report cover-page					
References					
Meeting title:	Board of Directors				
Meeting date:	16/09/26		**Agenda reference:**	**70-26**	
Report title:	Gender Pay Gap Report 2026				
Sponsor:	Helen Edmunds, Chief People Officer				
Author:	Helen Edmunds, Chief People Officer Lawrence Anderson, Deputy Chief People Officer				
Appendices:	1. Gender Pay Gap report 2026				
Executive summary					
Purpose of report:	To provide the position of the QVH Gender Pay Gap for QVH as of 31 March 2026, the reasons behind our gender pay gap and actions on how QVH are planning to continue work to reduce the Gender Pay Gap.				
Summary of key issues	• The Trust's gender pay gap improved in 2026, with the mean pay gap reducing from 36.86% to 33.07% and the median pay gap reducing from 35.07% to 31.01%, demonstrating progress compared to the previous year. • The pay gap continues to be driven by workforce composition rather than unequal employment practices, with men remaining more represented in senior administrative and consultant roles, whilst women are concentrated in several lower-paid occupational groups. The Gender Pay Gap Deep Dive found no evidence of bias in recruitment, development or progression processes. • Agenda for Change pay gaps improve year-on-year, reducing to 10.97% (mean) and 12.69% (median), while the Medical and Dental mean pay gap remained broadly stable at 10.73%, although the median pay gap increased to 17.01%. • Bonus pay disparities reduced, with the mean bonus pay gap reducing from 73.57% to 47.68%. The remaining gap continues to be influenced by the legacy impact of historic Clinical Excellence Awards and the higher proportion of men in consultant posts.				
Recommendation:	The Board are asked to **NOTE** the contents of the reports and actions being undertaken.				
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:	People BAF				
Corporate risk register:	None				
Regulation:	None				
Legal:	None				
Resources:	None				
Assurance route					
Previously considered by:	Strategy and Culture Committee				
	Date:	3/09/2026	Decision:	To present report to the Board of Directors	
Next steps:	Continue with actions as detailed to continue to improve gender pay gap.				

Report to:	Board of Directors
Agenda item:	70-26
Date of meeting:	16 September 2026
Report from:	Helen Edmunds, Chief People Officer
Report author:	Helen Edmunds, Chief People Officer Lawrence Anderson, Deputy Chief People Officer
Date of report:	5 August 2026
Appendices:	1. Gender Pay Gap report 2026

Gender Pay Gap Report 2026

Executive Summary

Our overall workforce remains predominantly female at 74.7%, representing a small increase from 2025 (74.66%). The majority of Medical and Dental (M&D) staff continue to fall within the upper pay quartile, where men remain proportionately more represented than women.

QVH's gender pay gap continues to be influenced by structural workforce patterns, including a greater proportion of men in senior administrative and managerial roles, a higher proportion of male consultants in the most senior medical grades, and the legacy impact of historic Clinical Excellence Awards. Findings from the Trust's Gender Pay Gap Deep Dive report (Appendix 2) concluded that the pay gap is not driven by inequitable recruitment, promotion or development practices, but by workforce composition and occupational segregation.

The Trust's overall gender pay gap has improved during 2026. The mean gender pay gap reduced from 36.86% in 2025 to 33.07% in 2026, while the median pay gap reduced from 35.07% to 31.01%. This represents a reduction of 3.79 percentage points and 4.06 percentage points respectively.

The Agenda for Change (AfC) gender pay gap has also improved, reducing from 13.54% to 10.97% (mean) and from 14.56% to 12.69% (median). The Medical and Dental gender pay gap remain broadly stable, with a mean gap of 10.73%, although the median gap increased to 17.01% in 2026.

The Trust has also seen a reduction in the bonus pay gap. The mean bonus pay gap reduced from 73.57% to 47.68%, while the median bonus pay gap reduced from 80.94% to 75.24%.

1. Introduction

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

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

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

The gender pay gap report is a snapshot as at 31 March 2026.

As at 31 March 2026, QVH employed 1269 employees who were included within the scope of gender pay reporting, comprising 940 women (74.7%) and 329 men (25.3%). The analysis

has been undertaken using data extracted from the Electronic Staff Record (ESR). There were no gaps in gender reporting within ESR data.

2. Data Used to Calculate Gender Pay Gap Figures

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

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

3. Definitions

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

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

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

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

4. Methodology

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

5. Data Analysis- Gender

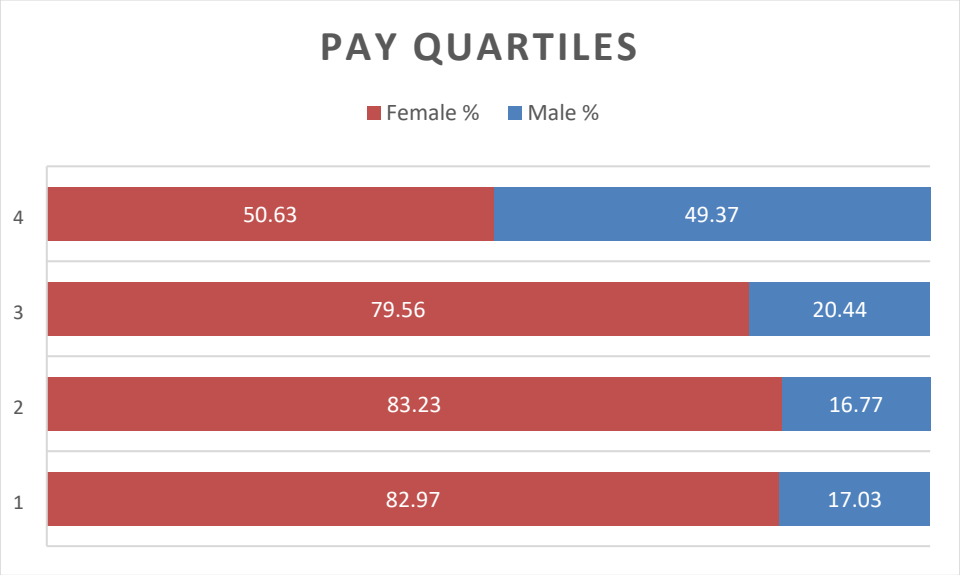
5.1 Gender Profiles

Our workforce remains predominantly female, with women representing 74.7% of employees included within the gender pay gap calculations. This has remained broadly consistent over recent years and mirrors the wider NHS workforce profile.

Gender Distribution Pay Quartiles

The distribution of staff across the four pay quartiles demonstrates that women continue to be concentrated within the lower and middle pay quartiles, while men remain proportionately more represented within the upper quartile

Quartile	Female	Male	Female %	Male %
1	263.00	54.00	82.97	17.03
2	263.00	53.00	83.23	16.77
3	253.00	65.00	79.56	20.44
4	161.00	157.00	50.63	49.37



Compared to 2025, there has been a positive increase in female representation within both the lower and upper-middle quartiles. The movement observed during 2025/26 demonstrates some improvement in representation across pay bands, contributing to reductions in the overall mean and median pay gaps.

The Deep Dive report (Appendix 2) identified that pay quartile distribution is influenced not only by substantive pay band but also by workforce composition and occupational clustering. Women remain overrepresented in nursing, administrative and support roles, while men remain proportionately more represented in senior administrative and consultant positions.

The majority of Medical and Dental staff continue to fall within the upper quartile, where men remain the larger proportion of the workforce. This remains a significant contributor to the Trust's overall gender pay gap

5.2 Mean and Median Hourly Rate

The mean pay gap compares the average hourly pay of all male and female staff. The median pay gap compares the middle value of hourly pay for male and female staff and is less influenced by extreme values at either end of the pay distribution.

The 2026 data demonstrates that, while a significant gender pay gap remains, the Trust has achieved a year-on-year improvement.

Overall Workforce

	2025		2026	
Gender	**Mean average hourly rate**	**Median average hourly rate**	**Mean average hourly rate**	**Median average hourly rate**
Male	£34.22	£28.37	£34.17	£28.01
Female	£21.61	£18.42	£22.87	£19.32
Difference	£12.61	£9.95	£11.30	£8.69
Pay Gap %	**36.9%**	**35.1%**	**33.08%**	**31.01%**

The mean gender pay gap reduced by 3.79 percentage points and the median gender pay gap reduced by 4.06 percentage points compared to 2025. This improvement reflects changes in workforce distribution across quartiles and improvements in the AfC pay gap.

Gender pay gap – Agenda for Change (AfC) workforce

Agenda for Change Staff				
	2025	**2025**	**2026**	**2026**
Gender	**Mean average hourly rate**	**Median average hourly rate**	**Mean average hourly rate**	**Median average hourly rate**
Male	£22.07	£19.09	£22.30	£19.62
Female	£19.08	£16.31	£19.85	£17.13
Difference	£2.99	£2.78	£2.44	£2.49
Pay Gap %	**13.5%**	**14.6%**	**10.98%**	**12.69%**

In respect of Agenda for Change staff (excluding Medical & Dental staff and Very Senior Managers), the mean pay gap reduced from 13.54% in 2025 to 10.97% in 2026, while the median pay gap reduced from 14.56% to 12.69%. This represents a positive movement in pay equity across the AfC workforce.

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

Medical & Dental Staff				
	2025	**2025**	**2026**	**2026**
Gender	**Mean average hourly rate**	**Median average hourly rate**	**Mean average hourly rate**	**Median average hourly rate**
Male	£52.69	£51.55	£52.10	£54.19
Female	£47.06	£46.52	£46.51	£44.98
Difference	£5.63	£5.03	£5.59	£9.22
Pay Gap	**10.7%**	**9.75%**	**10.74%**	**17.01%**

For Medical and Dental staff, the mean gender pay gap remained relatively stable at 10.73% compared to 10.69% in 2025. However, the median pay gap increased from 9.75% to 17.01% in 2026. Given the relatively small size of the Medical and Dental workforce and the impact of consultant pay, additional earnings and legacy Clinical Excellence Awards, year-on-year fluctuations can be more pronounced within this staff group

5.3 Staff Groups

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

	2025				2026			
Staff Group	**Female**	**Male**	**Difference**	**Pay Gap %**	**Female**	**Male**	**Difference**	**Pay Gap %**
Add Prof Scientific and Technic	£26.79	£24.31	-£2.48	-10.20	£26.93	£24.70	-2.24	-9.06
Additional Clinical Services	£13.76	£13.62	-£0.13	-0.98	£14.62	£14.01	-0.60	-4.30
Administrative and Clerical	£17.94	£26.66	£8.72	32.71	£18.34	£28.27	9.93	35.12
Allied Health Professionals	£23.82	£21.72	-£2.10	-9.66	£24.40	£23.60	-0.80	-3.39
Estates and Ancillary	£13.88	£14.96	£1.08	7.22	£14.45	£15.42	0.96	6.24
Healthcare Scientists	£26.45	£29.58	£3.13	10.58	£26.07	£29.48	3.41	11.56
Medical and Dental	£45.51	£49.75	£4.24	8.52	£45.88	£50.77	4.90	9.64
Nursing and Midwifery Registered	£22.67	£26.43	£3.76	14.23	£23.73	£26.67	2.94	11.01
Students	£13.43	£12.31	-£1.12	-9.07	£14.01	£13.85	-0.17	-1.21

Administrative and Clerical staff remain the largest contributor to the Trust's overall pay gap, with a gender pay gap of 35.12% in 2026 compared to 32.71% in 2025. This continues to reflect the greater proportion of men occupying senior administrative and leadership positions.

The Medical and Dental workforce recorded a pay gap of 9.64%, which remains broadly comparable to previous years and continues to reflect the gender profile of the consultant workforce and the influence of historic Clinical Excellence Awards.

The Nursing and Midwifery workforce recorded a pay gap of 11.01%, while Healthcare Scientists recorded a pay gap of 11.56%. Several staff groups continue to demonstrate pay differentials in favour of female staff, including Allied Health Professionals, Additional Clinical Services and Additional Professional Scientific and Technical roles.

5.4 Bonus Pay

Bonus payments - overall workforce
During 2025/26, bonus payments continued to comprise primarily legacy Clinical Excellence Award payments and other qualifying bonus arrangements.

The proportion of staff receiving a bonus payment was:

- Female: 1.68%

- Male: 6.06%

The Trust's mean bonus pay gap reduced significantly from 73.57% in 2025 to 47.68% in 2026, while the median bonus pay gap reduced from 80.94% to 75.24%. This represents a substantial improvement in bonus pay outcomes compared with the previous reporting year.

Gender	Avg. Pay	Median Pay
Male	£9,488.73	£6,057.97
Female	£4,964.87	£1,500.00
Difference	£4,523.86	£4,557.97
Pay Gap %	47.68	75.24

Despite this improvement, bonus pay continues to be influenced by the historic allocation of Clinical Excellence Awards and the higher proportion of men in consultant roles who remain eligible for legacy payments.

Pro-rata bonus payments are not adjusted for part-time working within the statutory gender pay gap methodology and therefore continue to influence bonus pay calculations.

Bonus payments - Consultant workforce

Consultant bonus payments continue to be influenced by the legacy impact of Clinical Excellence Awards (CEAs). Although CEAs are no longer awarded nationally, historic awards remain pensionable and continue to be paid to eligible consultants, contributing to differences in bonus payments and overall pay between male and female consultants.

The Trust's Gender Pay Gap Deep Dive identified historic Clinical Excellence Awards as a significant contributor to the sustained gender pay gap within the Medical and Dental workforce. Historically, fewer female consultants received CEAs and, in some cases, awards were of a lower value than those received by male colleagues. As these awards remain payable for the duration of a consultant's career, they continue to influence both the consultant and overall Trust gender pay gap.

Bonus payments - Agenda for Change workforce

Agenda for Change bonus payments continue to represent a relatively small proportion of overall earnings across the workforce. During 2025/26, bonus payments primarily related to local recruitment and retention initiatives, employee referral schemes and other qualifying payments made in accordance with Trust policies.

The overall Trust bonus pay gap reduced significantly during 2025/26, with the mean bonus pay gap reducing from 73.57% to 47.68% and the median bonus pay gap reducing from 80.94% to 75.24%.

Analysis undertaken through the Gender Pay Gap Deep Dive identified no evidence of inequitable access to bonus payments or additional earnings opportunities for Agenda for Change staff. Female staff received the majority of additional roster payments, including enhancements, allowances and call-out payments, broadly reflecting the Trust's workforce profile.

6. Priorities for 2026/2027

Action	By When	Lead
Collaborate and engage on a flexible working toolkit for staff and managers	Q4 2026-27	Employee Relations team
Collaborate and engage on a Restorative Just and Learning Culture framework to further embed the approach into policy, process and culture of people management.	Q4 2026-27	Employee Relations team
Triangulate Employee Relations case work, Freedom to Speak Up reports, Occupational Health data, Staff Survey and Pulse Survey results and Wellbeing & Inclusion insights to capture and act on themes highlighted on a quarterly basis.	Q4 2025-26	Wellbeing & Inclusion Manager
Apply an EDI lens through lived experience to an end-to-end review of our current internal and external recruitment processes, with an EDI representative available for interview panels to support the de-biasing of the recruitment process.	Q4 2026-27	Resourcing Business Partner
Introduce intersectionality data analysis on monthly IQPR reports to identify any high risk specialities or grades with wider gaps relating to gender and pay.	Ongoing through 2026-27	Head of Medical Workforce

Conclusion

QVH's 2026 Gender Pay Gap Report demonstrates a positive improvement in the Trust's overall gender pay gap position. The mean gender pay gap reduced from 36.86% to 33.07%, whilst the median pay gap reduced from 35.07% to 31.01%, representing the first significant reduction in a number of years.

The findings from the Gender Pay Gap Deep Dive provide assurance that the pay gap is not driven by inequitable recruitment, promotion or development practices. Women continue to be well represented across recruitment, learning and development opportunities and internal progression processes. The Trust's gender pay gap continues to be primarily influenced by workforce composition, including occupational segregation, the concentration of male staff within senior administrative and consultant roles, and the ongoing impact of historic Clinical Excellence Awards.

Although progress has been made during 2025/26, further work is required to address the structural factors that contribute to pay inequality. The Trust will continue to focus on improving access to flexible working, supporting progression into senior roles, applying an equality lens to recruitment and workforce processes, and monitoring workforce data to identify any emerging disparities.

Recommendation

The Board are asked to **NOTE** the contents of the reports and actions being undertaken.

NHS
Queen Victoria Hospital
NHS Foundation Trust

Gender Pay Report 2026



Executive Summary

Queen Victoria Hospital NHS Foundation Trust's mean gender pay gap has decreased by 3.79% from 36.86% in 2025 to 33.07% in 2026. The median gap has also decreased 4.06% from 35.07% to 31.01%.

The Agenda for Change gender pay gap for 2026 is 10.97% (Mean) down from 13.5% 2025 and 12.69% (Median) Down from 14.6% in 2025. The Medical & Dental gender pay gap for 2026 is maintained at 10.7% (Mean) but has increased from 9.75% (Median) in 2025 to 17.01% in 2026. Our gender pay gap continues to be driven in part by a greater number of men in more senior admin roles among our Agenda for Change (AfC) workforce and senior male clinicians earning top of grade and bonus payments relative to our total workforce.

In relation to the bonus pay gap, the Trust's pay gap for Bonus pay has significantly decreased in 2026. The mean gap has reduced by 25.89% and the median gap by 5.70%.

Our workforce profile is 74.7% female as at 31 March 2026, which represents a 0.04% increase against our 2025 data. 2026 saw a positive movement of female staff in both the Lower and Upper Middle pay quartiles, with an increase in males in the Lower Middle and Upper Quartiles

Reporting Requirements

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

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

"Pay" includes;

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

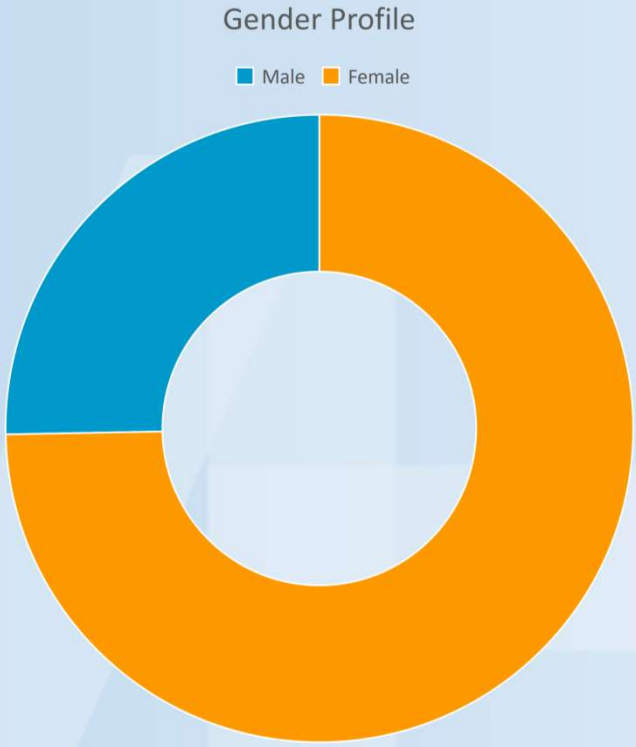
It does not include;

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

Our Gender Profile

Snapshot Date-31st March 2026

This chart provides details of the Trust gender profile. There were a total of 1269 employees who fell under the requirements to report the gender pay gap. 940 (74.7%) were female and 329 (25.3%) were male



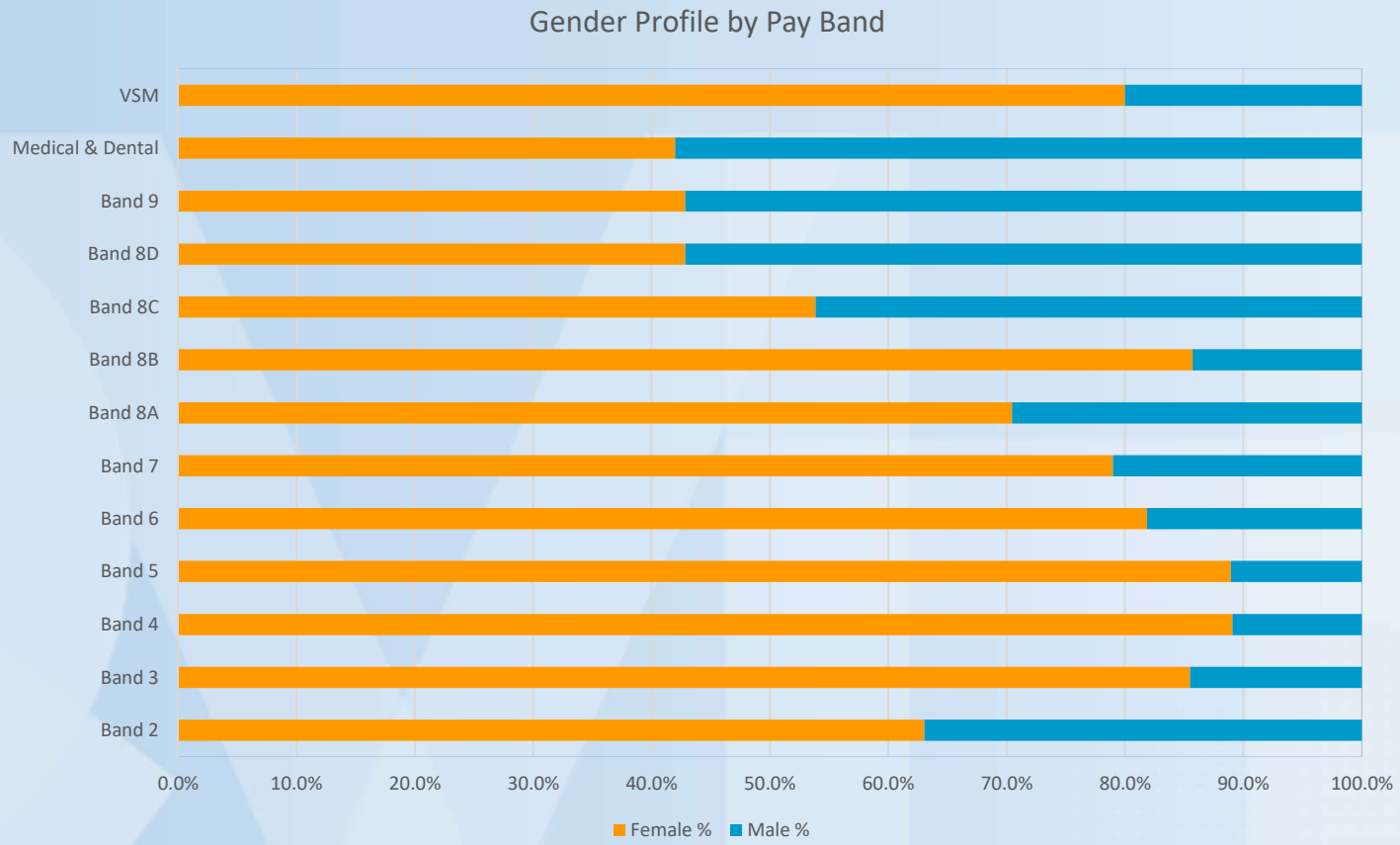
Our Gender Profile by Staff Group

Pay structure

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

Profile across bands

This chart details the percentage of female and male staff within each pay bands as of 31 March 2026. While band 8a is largely reflective of the organisation's profile, there continues to be a trend in employing proportionally more female staff in bands 3 to 7. Pay band 8D and 9 are representative of 7 individuals each but close to a 50:50 gender split.



Queen Victoria Hospital
NHS Foundation Trust

Our Gender Pay Gap Data

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

Ordinary Pay	2026	2025	Difference
Mean Gender Pay Gap	33.07%	36.86%	-3.79%
Median Gender Pay Gap	31.01%	35.07%	-4.06%

Bonus Pay	2026	2025	Difference
Mean Gender Pay Gap-bonus pay	47.68%	73.57%	-25.89%
Median Gender Pay Gap-bonus pay	75.24%	80.94%	-5.70%

	2026		2025		Year on Year Change	
	Female %	Male %	Female %	Male %	Female %	Male %
Lower quartile	50.63	49.37	49.2	50.8	1.43	-1.43
Lower middle quartile	79.56	20.44	82.05	17.95	-2.49	2.49
Upper middle quartile	83.23	16.77	82.75	17.25	0.48	-0.48
Upper quartile	82.97	17.03	84.62	15.38	-1.65	1.65

Proportion of staff paid a bonus	
Female	Male
1.68%	6.06%

Average Hourly Rate		Difference	Pay Gap %
Male	£33.74	£10.99	32.56
Female	£22.76		

Queen Victoria Hospital
NHS Foundation Trust

Our Gender Pay Gap Data

Hourly Rate of Pay-by Band

AfC Pay Grade	Female	Male	Difference	Pay Gap %
Band 2	£13.17	£14.35	£1.18	8.24
Band 3	£13.74	£13.40	-£0.35	-2.59
Band 4	£14.94	£14.97	£0.03	0.19
Band 5	£18.52	£18.43	-£0.08	-0.44
Band 6	£23.14	£22.68	-£0.46	-2.02
Band 7	£26.57	£26.99	£0.42	1.56
Band 8 - Range A	£29.65	£24.39	-£5.26	-21.56
Band 8 - Range B	£35.40	£37.66	£2.26	5.99
Band 8 - Range C	£42.24	£43.35	£1.11	2.55
Band 8 - Range D	£48.98	£51.71	£2.73	5.28
Band 9	£56.52	£63.59	£7.07	11.11
Other	£47.02	£51.29	£4.26	8.31

Hourly Rate of Pay-by Staff Group

Staff Group	Female	Male	Difference	Pay Gap %
Add Prof Scientific and Technic	£26.93	£24.70	-£2.24	-9.06
Additional Clinical Services	£14.62	£14.01	-£0.60	-4.30
Administrative and Clerical	£18.34	£28.27	£9.93	35.12
Allied Health Professionals	£24.40	£23.60	-£0.80	-3.39
Estates and Ancillary	£14.45	£15.42	£0.96	6.24
Healthcare Scientists	£26.07	£29.48	£3.41	11.56
Medical and Dental	£45.88	£50.77	£4.90	9.64
Nursing and Midwifery Registered	£23.73	£26.67	£2.94	11.01
Students	£14.01	£13.85	-£0.17	-1.21

Our Gender Pay Gap Data

Agenda For Change Staff

Gender	Mean Hourly Rate	Median Hourly Rate
Male	£22.30	£19.62
Female	£19.85	£17.13
2026 Gap%	10.97%	12.69%
2025 Gap %	13.54%	14.56%
Difference	-2.57%	-1.87%

Medical and Dental Staff

Gender	Mean Hourly Rate	Median Hourly Rate
Male	£52.10	£54.19
Female	£46.51	£44.97
2026 Gap%	10.73%	17.01%
2025 Gap %	10.69%	9.75%
Difference	-0.04%	7.26%

Very Senior Managers

Gender	Mean Hourly Rate	Median Hourly Rate
Male	£77.71	£77.65
Female	£70.26	£68.10
2026 Gap%	9.57%	12.30%
2025 Gap %	-4.55%	7.27%
Difference	14.12%	5.03%

Impacts upon our Gender Pay Gap

Lower numbers of male staff in lower bands

At QVH we have considerably less males in lower banded roles compared to other Trusts which impacts negatively upon our pay gap reporting. We only have 78 men in Band 2 or Band 3 roles across the Trust who fall within the scope of the gender pay report compared to 288 women. This accounts for only 5.3% of the workforce subject to the pay gap reporting.

We have a higher proportion of senior Admin & Clerical roles at QVH than clinical

As a small specialist NHS Trust, we have a higher proportion of higher banded non-clinical roles across the Trust compared to larger Trusts who will have a higher number of clinical roles. This negatively impacts upon the Trust's pay gap as there are fewer lower banded roles across both clinical and non-clinical roles to help reduce the average pay overall and the gaps we see between men and women. Coupled with this, in 2025/26 QVH have employed a number of men in senior roles replacing female staff that have left the Trust. This has also had a significant impact upon our pay gap this year.

Female staff are more likely to resign due to promotion than male counterparts, representing approximately 64% of all resignations due to promotion. Work-life balance, child dependants and lack of opportunities were also key reasons given by our female leavers.

Our Commitment

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

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

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

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

Key Areas of Progress and Ongoing Actions for Next 12 Months

Culture Change	1. **Promotion of Vision and Values & Behavioural Framework -** These were launched in late 2024, with a behaviour framework to support an inclusive learning culture, increasing psychological safety of staff and supporting the embedding of an enhanced speak up process for staff. Workshops for managers, Session at Corporate of induction including cups/lanyard cards given out. 2. **Workforce Belonging & Value** – The Trust has in place a comprehensive action plan aligned with NHS England's EDI Improvement Plan to to create an environment that eliminates the conditions in which bullying, discrimination, harassment and physical violence at work occur. 3. **Inclusive Behaviours** – A module on EDI and inclusive management (including reasonable adjustments) has been added to the mandatory line manager's training offer in 2025-26. 4. **Freedom to Speak Up** – The Freedom to Speak Up Guardian for QVH meets with the Chief Executive Officer and Chief Nurse on a regular basis.. 5. **Cultural Listening Exercises** – The Wellbeing & Inclusion team have supported cultural listening exercises across several teams to understand and tackle behaviours than contribute to a more inclusive environment for our staff. 6. **Wellbeing Culture –** the Wellbeing & Inclusion team published the Trust's first staff wellbeing policy to document responsibilities and actions to be taken to support and enhance wellbeing at work.
Staff Engagement	1. **Experience –** the Wellbeing & Inclusion Manager conducted a deep dive into the experience of women at QVH across the employee lifecycle in line with our 2024-2025 Gender Pay Gap action plan, with the aim to identify potential contributors to pay disparities. 2. **Recognition –** a QVH EDI Champion sat on the judging panel of our annual Star Awards to encourage a balanced and inclusive approach to recognition. 3. **Wellbeing & Inclusion Resources** – The Wellbeing & Inclusion team have introduced a monthly bulletin and all-staff email to promote inclusive activities and initiatives.
Bullying & Harassment	1. **Violence, Aggression & Abuse -** The Trust's Violence Prevention and Reduction group has increased compliance against the national standards to 98% in 25/26. The Trust has implemented a Formal VPR group that meets monthly, along with collaborating with other Sussex Trusts on national VPR initiatives. 2. **Sexual Safety –** the Trust reached 98% compliance with the principles of NHS England's Sexual Safety Charter, with key achievements including the publication of our first Sexual Safety Policy, the addition of sexual safety to both AfC and Medical & Dental Induction programmes and to the line manager's training offer. 3. **NHS England High Impact Actions -** The Trust has in place a comprehensive action plan aligned with NHS England's EDI Improvement Plan, to address High Impact Action 6, which is to 'Create an environment that eliminates the conditions in which bullying, discrimination, harassment and physical violence at work occur. 4. **Restorative Just Culture** – The Employee Relations team have incorporated a Restorative Just and Learning Culture approach into their key policies and processes and Managing Essentials Programme.

Our Actions

Action	By When	Lead
Collaborate and engage on a flexible working toolkit for staff and managers	Q4 2026-27	Employee Relations team
Collaborate and engage on a Restorative Just and Learning Culture framework to further embed the approach into policy, process and culture of people management.	Q4 2026-27	Employee Relations team
Triangulate Employee Relations case work, Freedom to Speak Up reports, Occupational Health data, Staff Survey and Pulse Survey results and Wellbeing & Inclusion insights to capture and act on themes highlighted on a quarterly basis.	Q3 2025-26	Wellbeing & Inclusion Man ager
Apply an EDI lens through lived experience to an end-to-end review of our current internal and external recruitment processes, with an EDI representative available for interview panels to support the de-biasing of the recruitment process.	Q3 2026-27	Resourcing Business Partner
Introduce intersectionality data analysis on monthly IQPR reports to identify any high risk specialities or grades with wider gaps relating to gender and pay.	Ongoing through 2026-27	Head of Medical Workforce

Report cover-page					
References					
Meeting title:	Board of Directors				
Meeting date:	16/09/2026		**Agenda reference:**	**71-26**	
Report title:	Ethnicity Pay Gap Report 2026				
Sponsor:	Helen Edmunds, Chief People Officer				
Author:	Helen Edmunds, Chief People Officer Lawrence Anderson, Deputy Chief People Officer				
Appendices:	Ethnicity Pay Gap report 2026				
Executive summary					
Purpose of report:	To provide the position of the QVH Ethnicity Pay Gap as at 31 March 2026, the reasons behind our ethnicity pay gap and actions as a result of the pay gap.				
Summary of key issues	• Ethnicity pay gap continues to improve – The Trust's mean ethnicity pay gap improved from -22.95% in 2025 to -22.46% in 2026, whilst the median pay gap improved from -27.53% to -26.50%, both remaining in favour of BME staff. • Workforce diversity is increasing – BME workforce representation has increased to 24.98% of the workforce in 2026, continuing a positive trend from 14.69% in 2019, demonstrating sustained progress in attracting and retaining a diverse workforce. • Workforce composition remains the main driver of the pay gap – The Trust has a higher proportion of BME colleagues employed within senior clinical, scientific and medical roles, resulting in greater representation within higher pay quartiles and influencing the overall ethnicity pay gap.				
Recommendation:	The Board is asked to **NOTE** the content of the report and actions being undertaken.				
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				
Corporate risk register:	None				
Regulation:	None				
Legal:	None				
Resources:	None at this stage				
Assurance route					
Previously considered by:	Strategy and Culture Committee				
	Date:	3/09/2026	Decision:	Present the report to the Board of Directors	
Next steps:	Continue with actions as detailed.				

Report to:	Board of Directors
Agenda item:	71-26
Date of meeting:	16 September 2026
Report from:	Helen Edmunds, Chief People Officer
Report author:	Helen Edmunds, Chief People Officer Lawrence Anderson, Deputy Chief People Officer
Date of report:	5 August 2026
Appendices:	Ethnicity Pay Gap report 2026

Ethnicity Pay Gap Report 2026

1. Introduction

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

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

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

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

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

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

The ethnicity pay gap report is a snapshot as at 31 March 2026.

2. Data Used to Calculate Ethnicity Pay Gap Figures

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

- **Mean ethnicity pay gap** – The difference between the mean hourly rate of pay of white full-pay relevant employees and that of BME full-pay relevant employees.
- **Median ethnicity pay gap** – The difference between median hourly rate of pay of white full-pay relevant employees and that of BME full-pay relevant employees.

- **Bonus proportions** – The proportion of White and BME staff receiving a bonus payment.
- **Quartile pay bands** – The proportion of White and BME in each of the four pay quartiles

3. Definitions

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

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

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

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

4. Methodology

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

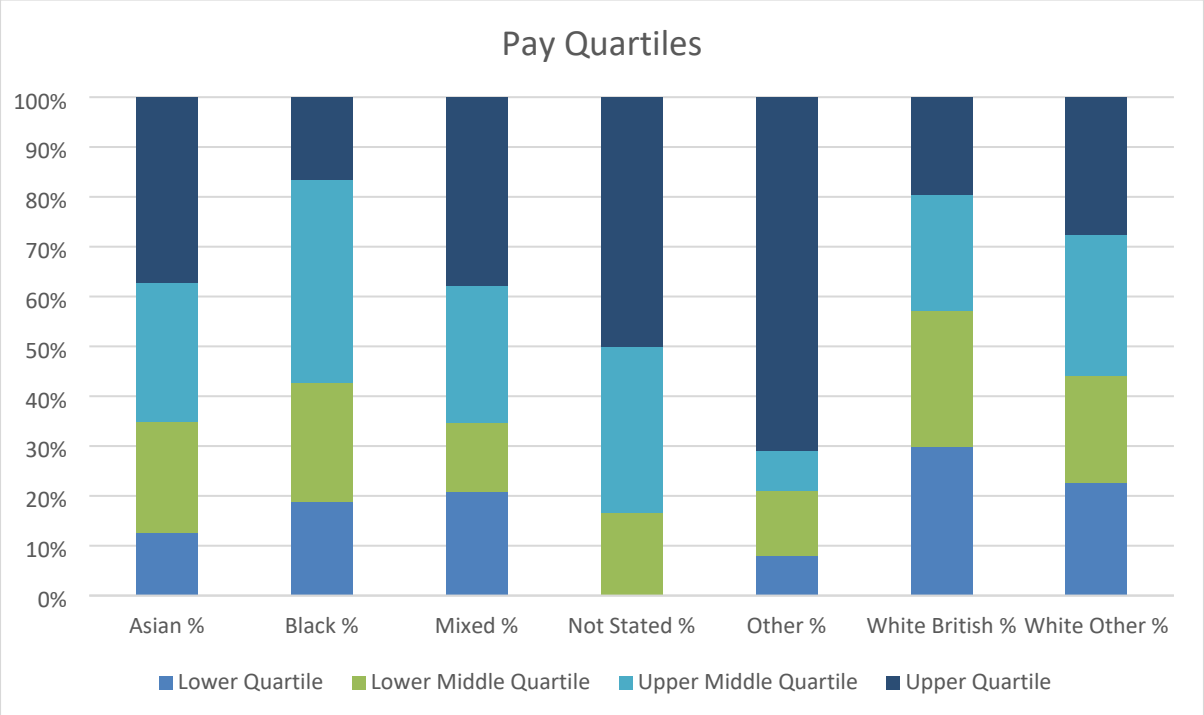
5. Data Analysis-Race

Colleagues from Black and Minority Ethnic (BME) backgrounds represent 24.98% of the Trust's workforce, an increase from 21.12% in 2025 and continuing the positive trend observed since ethnicity pay gap reporting commenced

	BME %	Non-BME %	Unknown %
2019	14.69%	83.07%	2.24%
2020	15.92%	81.14%	2.94%
2021	18.79%	79.38%	1.83%
2022	19.27%	78.73%	2.00%
2023	19.52%	78.53%	1.95%
2024	21.25%	77.48%	1.27%
2025	21.98%	75.99%	2.03%
2026	24.98%	74.62%	0.40%

5.1 Ethnicity Distribution Pay Quartiles

Quartile	Asian	Black	Mixed	Not Stated	Other	White British	White Other
1	25	10	6	0	3	244	26
2	44	13	4	1	5	226	25
3	56	22	8	2	3	195	33
4	74	9	11	3	27	162	32



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

5.2 Mean and Median Hourly Rate

The mean pay gap measures the difference between the average hourly earnings of White and BME employees across the Trust. The median pay gap measures the difference between the midpoint hourly earnings for both groups and is less affected by exceptionally high or low salaries.

As at 31 March 2026, the mean hourly rate for BME employees was £29.15, compared to £24.12 for white employees. The median hourly pay rate was £24.45 for BME employees and £19.33 for white employees. This results in a mean ethnicity pay gap of -22.46% and a median ethnicity pay gap of -26.50%, both in favour of BME employees.

The Trust's ethnicity pay gap has improved slightly when compared with 2025, where the mean pay gap was -22.95% and the median pay gap was -27.53%.

Consistent with previous years, this pay gap is driven predominantly by the concentration of BME colleagues within higher-paid clinical and specialist roles, rather than differences in pay

for equivalent work. All staff are remunerated according to nationally agreed contractual arrangements, either through Agenda for Change or Medical and Dental terms and conditions

Overall Workforce

	2026 Mean Hourly Rate	202 Median Hourly Rate	2025 Mean Hourly Rate	2025 Median Hourly Rate
BME	£29.15	£24.45	£29.13	£23.80
Not Known	£35.28	£30.04	£23.46	£19.21
White	£24.12	£19.33	£23.69	£18.66
Pay Gap - BME	**-20.88%**	**-26.50%**	**-22.95%**	**-27.53%**

6. Bonus Pay

Bonus payments - overall workforce

In 2026, the Trust reported a mean bonus pay gap of -24.96% and a median bonus pay gap of -34.22%, both in favour of BME staff. A total of 4.48% of BME employees received a bonus payment, compared with 2.33% of White employees.

The average bonus payment received by BME staff was £6,112.94, compared with £5,205.23 for White staff. Median bonus payments were £3,009.17 for BME staff and £1,979.48 for White staff.

The principal driver of the bonus pay gap continues to be historical Clinical Excellence Award payments within the consultant workforce together with other local bonus arrangements. As these payments relate to legacy arrangements awarded over a number of years, they continue to influence annual reporting despite no new national awards being made.

Ethnicity	2026 Mean Total Bonus	2026 Median Total Bonus	2025 Mean Total Bonus	2025 Median Total Bonus
BME	£8,643.48	£3,009.17	£6,617.23	£1,500.00
White	£6,491.37	!1,979.48	£5,205.23	£1,500.00
Pay Gap - BME	**-24.96%**	**-34.22%**	**-14.84%**	**0.00%**

7. Priorities for 2025/2026

Action	By When	Lead
Collaborate and engage on a flexible working toolkit for staff and managers	Q4 2026-27	Employee Relations team
Collaborate and engage on a Restorative Just and Learning Culture framework to further embed the approach into policy, process and culture of people management.	Q4 2026-27	Employee Relations team
Triangulate Employee Relations case work, Freedom to Speak Up reports, Occupational Health data, Staff Survey and Pulse Survey results and Wellbeing & Inclusion insights to capture and act on themes highlighted on a quarterly basis.	Q4 2025-26	Wellbeing & Inclusion Manager
Apply an EDI lens through lived experience to an end-to-end review of our current internal and external recruitment processes, with an EDI representative available for interview panels to support the de-biasing of the recruitment process.	Q4 2026-27	Resourcing Business Partner
Introduce intersectionality data analysis on monthly IQPR reports to identify any high risk specialities or grades with wider gaps relating to gender and pay.	Ongoing through 2026-27	Head of Medical Workforce

Conclusion

The Trust's ethnicity pay gap remains in favour of BME colleagues, with both the mean and median pay gaps showing a modest improvement during 2025/26. The mean gap reduced from -22.95% to -22.46%, whilst the median gap reduced from -27.53% to -26.50%.

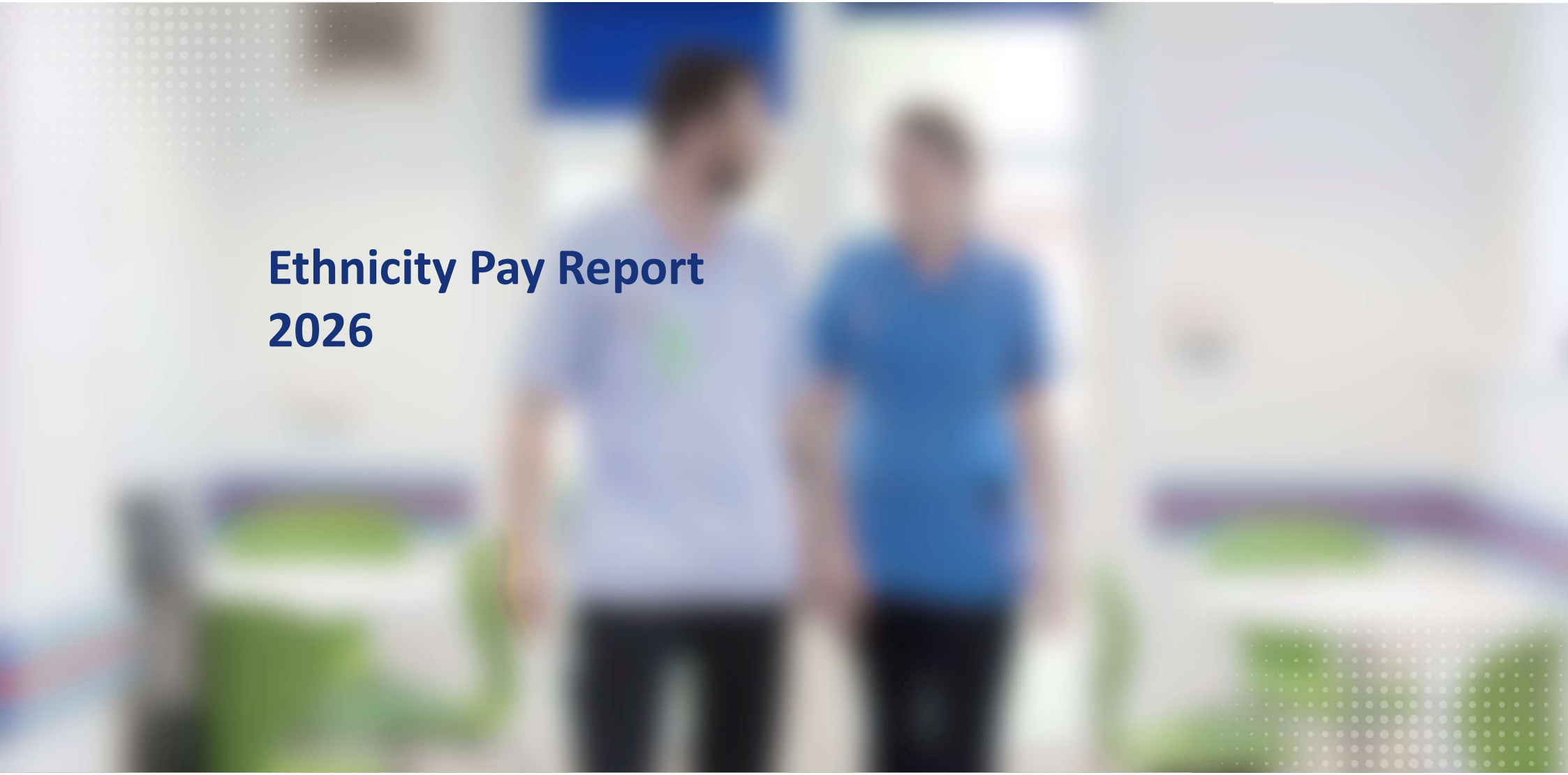
This position continues to be driven primarily by workforce composition. BME colleagues are strongly represented within higher-paid clinical, scientific and medical roles and are increasingly represented within the upper pay quartiles of the organisation. The Trust's pay arrangements remain governed by nationally agreed pay frameworks which support consistency, transparency and equal pay for work of equal value.

The Trust has achieved further progress in workforce diversity, with BME representation increasing to 24.98% of the workforce, the highest level recorded since reporting commenced. This reflects the positive impact of ongoing recruitment, inclusion and workforce development initiatives.

QVH remains committed to creating an inclusive workplace where all colleagues have equitable access to recruitment, development and career progression opportunities. Through delivery of the People and Culture Strategy and the actions outlined within this report, the Trust will continue to monitor workforce data, address inequalities and support a positive experience for all colleagues.

Recommendation
The Board are asked to **NOTE** the content of the report and actions being undertaken.

NHS
Queen Victoria Hospital
NHS Foundation Trust



Ethnicity Pay Report 2026

Executive Summary

Queen Victoria Hospital NHS Foundation Trust's mean ethnicity pay gap has decreased from -22.95% in 2025 to -22.49% in 2026 in favour of BME staff. The median gap has decreased from -27.53% to -26.50%.

Our ethnicity pay gap continues to be driven in part by a disproportionate number of BME colleagues in more senior clinical posts among our Agenda for Change (AfC) workforce and senior white clinicians earning top of grade and bonus payments relative to our total workforce.

In relation to the bonus pay gap, BME employees received a higher amount of bonus pay compared to white employees. The pay gap for bonus pay is -24.96% which has increased significantly since 2025 where the gap was -14.84% This is mainly attributed to Consultant medical staff receiving historical Clinical Excellence Awards which ceased to be awarded in 2018.

Our workforce profile is 24.98% BME staff as at 31 March 2026, which represents a 3.86% increase against our 2025 data.

Reporting Requirements

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

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

"Pay" includes;

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

It does not include;

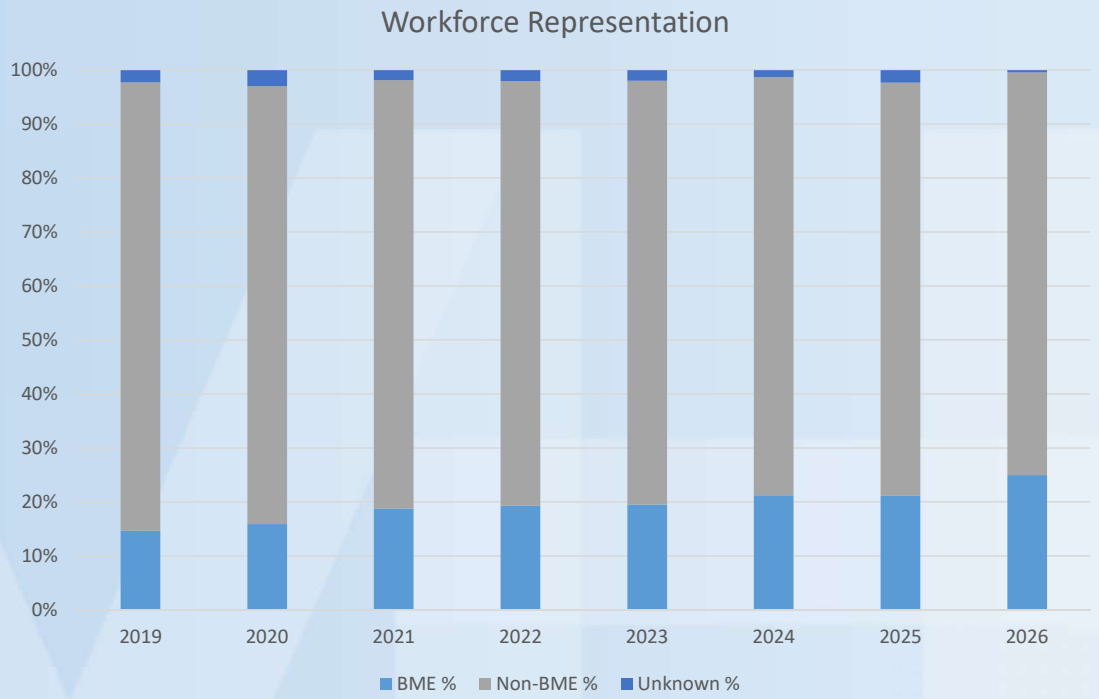
- overtime pay
- expenses (payments made to reimburse expenditure wholly and necessarily incurred in the course of employment, for example, mileage for use of vehicle)
- remuneration in lieu of leave
- benefits in kind (for example, child care vouchers)
- redundancy pay and tax credits.

Queen Victoria Hospital
NHS Foundation Trust

Our Workforce Profile

Snapshot Date-31st March 2026

This chart provides details of the Trust ethnicity profile. There were a total of 1269 employees who fell under the requirements to report the ethnicity pay gap. 943 were from a White background, 320 from a BME background and only 6 had not disclosed their ethnic origin to the Trust



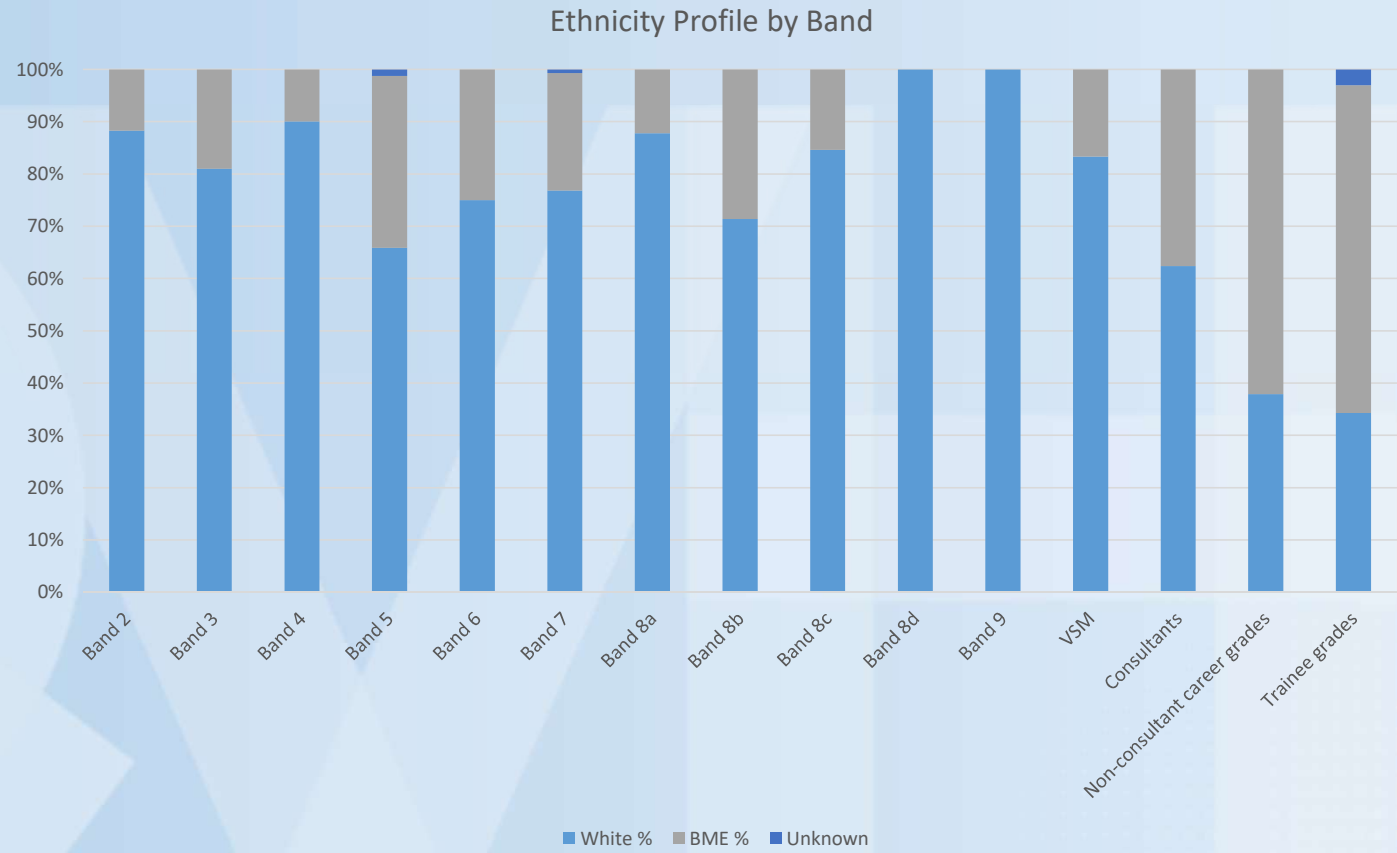
Our Ethnicity Profile by Band

Pay structure

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

Profile across bands

This chart details the number and percentage of BME staff within each pay bands as of 31 March 2026. While bands 2 to 8b are largely reflective of the organisation's profile, there is proportionally less BME particularly at Band 8D and 9.Pay bands 8D & 9 are representative of just 6 individuals. Our M&D workforce show a greater ethnic diversity amongst their workforce



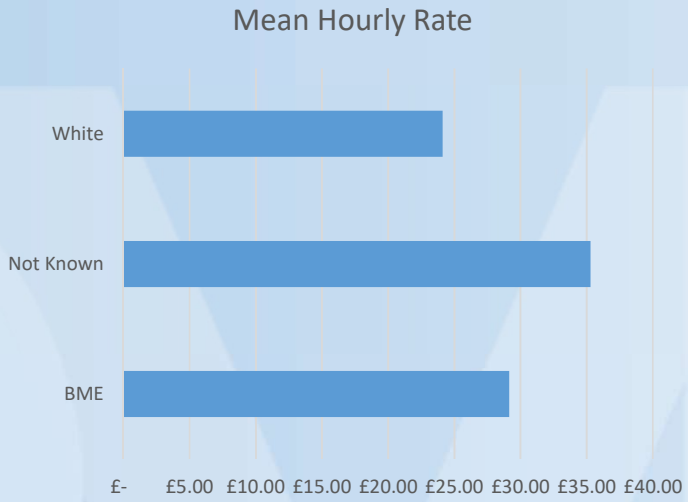
Queen Victoria Hospital
NHS Foundation Trust

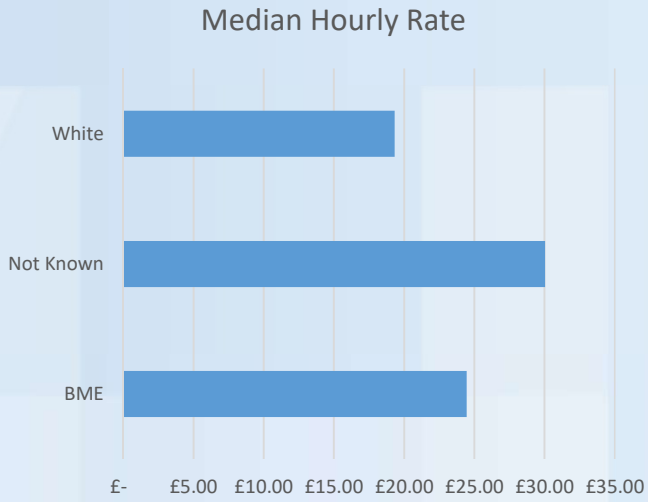
Our Ethnicity Pay Gap Data

Ordinary Pay	2026	2025
Mean Ethnicity Pay Gap	-22.46%	-22.95%
Median Ethnicity Pay Gap	-26.50%	-27.53%

Bonus Pay	2026	2025
Mean Ethnicity Pay Gap	-24.96%	-14.84%
Median Ethnicity Pay Gap	-34.22%	0.00%

Proportion of staff paid a bonus		
BME	White	Not Stated
4.48%	2.33%	0.00%



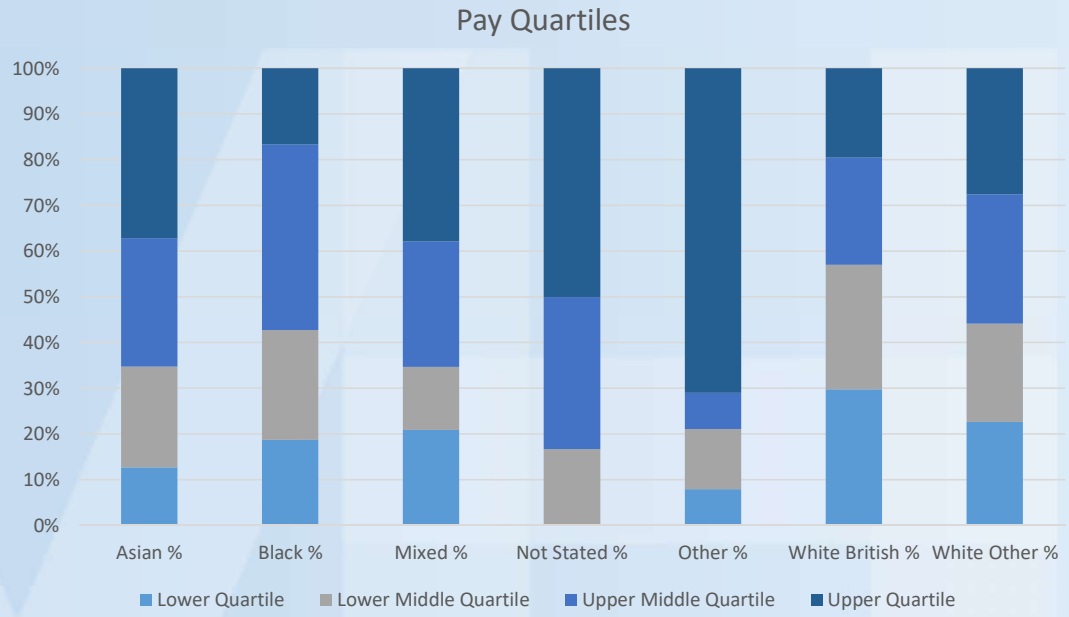


***NB 'Not Known' in terms of Mean and Median Hourly Rate consists of 6 individuals out of 1269 in scope of this report**

Queen Victoria Hospital
NHS Foundation Trust

Our Ethnicity Pay Gap Quartiles

	Asian %	Black %	Mixed %	Not Stated %	Other %	White British %	White Other %
Lower Quartile	7.96	3.18	1.91	0.00	0.96	77.71	8.28
Lower Middle Quartile	13.84	4.09	1.26	0.31	1.57	71.07	7.86
Upper Middle Quartile	17.55	6.90	2.51	0.63	0.94	61.13	10.34
Upper Quartile	23.27	2.83	3.46	0.94	8.49	50.94	10.06



Impacts upon our Ethnic Pay Gap

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

We have a total of 109 consultants in the workforce at QVH, of which 68 (62.39% of the consultant workforce) are white and 41 (37.61%) are BME. More white consultants compared to BME consultants received bonus payments in the form of Clinical Excellence Awards (CEA's) which were historically awarded prior to 2018

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

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

BME staff represent 24.44% of the Trust's voluntary resignations in 2025-26. Analysis of retention data shows BME staff cite work-life balance, relocation and undertaking further education and training as frequent reasons for their resignation.

This may also be linked to our 2025 Staff Survey results around career progression – while this year has seen a small increase (0.8%) in the number of BME colleagues reporting a belief that the Trust provides equal opportunities for career progression, the overall percentage remains low at approximately 55% of BME staff.

Our Commitment

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

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

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

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

Key Areas of Progress and Ongoing Actions for Next 12 Months

Culture Change	1. **Promotion of Vision and Values & Behavioural Framework -** These were launched in late 2024, with a behaviour framework to support an inclusive learning culture, increasing psychological safety of staff and supporting the embedding of an enhanced speak up process for staff. Workshops for managers, Session at Corporate of induction including cups/lanyard cards given out. 2. **Workforce Belonging & Value** – The Trust has in place a comprehensive action plan aligned with NHS England's EDI Improvement Plan to to create an environment that eliminates the conditions in which bullying, discrimination, harassment and physical violence at work occur. 3. **Inclusive Behaviours** – A module on EDI and inclusive management (including reasonable adjustments) has been added to the mandatory line manager's training offer in 2025-26. 4. **Freedom to Speak Up** – The Freedom to Speak Up Guardian for QVH meets with the Chief Executive and Chief Nurse on a regular basis. 5. **Cultural Listening Exercises** – The Wellbeing & Inclusion team have supported cultural listening exercises across several teams to understand and tackle behaviours than contribute to a more inclusive environment for our staff. 6. **Wellbeing Culture –** the Wellbeing & Inclusion team published the Trust's first staff wellbeing policy to document responsibilities and actions to be taken to support and enhance wellbeing at work.
Staff Engagement	1. **Experience –** the Wellbeing & Inclusion Manager conducted a deep dive into the experience of women at QVH across the employee lifecycle in line with our 2024-2025 Gender Pay Gap action plan, with the aim to identify potential contributors to pay disparities. 2. **Recognition –** a QVH EDI Champion sat on the judging panel of our annual Star Awards to encourage a balanced and inclusive approach to recognition. 3. **Wellbeing & Inclusion Resources** – The Wellbeing & Inclusion team have introduced a monthly bulletin and all-staff email to promote inclusive activities and initiatives.
Bullying & Harassment	1. **Violence, Aggression & Abuse -** The Trust's Violence Prevention and Reduction group has increased compliance against the national standards to 98% in 25/26. The Trust has implemented a Formal VPR group that meets monthly, along with collaborating with other Sussex Trusts on national VPR initiatives. 2. **Sexual Safety –** the Trust reached 87% compliance with the principles of NHS England's Sexual Safety Charter, with key achievements including the publication of our first Sexual Safety Policy, the addition of sexual safety to both AfC and Medical & Dental Induction programmes and to the line manager's training offer. 3. **NHS England High Impact Actions -** The Trust has in place a comprehensive action plan aligned with NHS England's EDI Improvement Plan, to address High Impact Action 6, which is to 'Create an environment that eliminates the conditions in which bullying, discrimination, harassment and physical violence at work occur. 4. **Restorative Just Culture** – The Employee Relations team have incorporated a Restorative Just and Learning Culture approach into their key policies and processes and Managing Essentials Programme.

Our Actions

Action	By When	Lead
Collaborate and engage on a flexible working toolkit for staff and managers	Q4 2026-27	Employee Relations team
Collaborate and engage on a Restorative Just and Learning Culture framework to further embed the approach into policy, process and culture of people management.	Q4 2026-27	Employee Relations team
Triangulate Employee Relations case work, Freedom to Speak Up reports, Occupational Health data, Staff Survey and Pulse Survey results and Wellbeing & Inclusion insights to capture and act on themes highlighted on a quarterly basis.	Q4 2026-27	Wellbeing & Inclusion Manager
Apply an EDI lens through lived experience to an end-to-end review of our current internal and external recruitment processes, with an EDI representative available for interview panels to support the de-biasing of the recruitment process.	Q3 2026-27	Resourcing Business Partner
Ongoing review of the structures and roles across departments specifically looking at succession planning and talent management from Band 8a to VSM.	Ongoing through 2026/27	CPO, supported by Head of OD&L
Implementation of a reciprocal mentoring programme, focussing on areas of inclusion support career progression.	Ongoing through 2026/27	CPO, supported by Head of OD&L
Development and implementation of a shadow board programme to develop future leaders, build board level experience and confidence to support succession planning and talent management.	Q4 2026/27	CPO

Report cover-page					
References					
Meeting title:	Board of Directors				
Meeting date:	16/09/2026		**Agenda reference:**	**72-26**	
Report title:	Culture Diagnostic Review – 2025/26				
Sponsor:	Helen Edmunds, Chief People Officer				
Author:	Annette Byers, Head of Organisational Development & Learning				
Appendices:	Appendix 1: Culture mapping tools and strategies used Appendix 2: Qualitative and Quantitative data used Appendix 3: Organisational Culture Assessment Instrument information Appendix 4: Wellbeing and Inclusion & Employee Relations data				
Executive summary					
Purpose of report:	Provide the Board with an updated analysis of QVH organisational culture mapped against our values and behaviour framework to inform understanding of our existing culture and sub-cultures and detail the gaps to support a future culture that will help deliver the QVH Strategy and help to improve staff and patient experience.				
Summary of key issues	• QVH has a strong cultural foundation, with committed staff, strong team relationships, and a shared focus on delivering high-quality patient care. • A gap exists between staff capability and organisational enablement, with staff willing to contribute and improve services but not always able to influence decisions or act on ideas. • Leadership is experienced more positively at local than organisational level, with variability in visibility, responsiveness and follow-through affecting confidence in leadership. • Communication, decision-making, and involvement remain inconsistent, with limited visibility of how feedback influences organisational action. • Wellbeing pressures remain, with workload, stress and capacity constraints affecting staff experience despite strong team support. • Staff experience is not consistent across all groups, with evidence of variation in inclusion, fairness, access to opportunity and overall experience. • Development and progression opportunities remain constrained, limiting the organisation's ability to fully use staff skills, potential, and innovation.				
Recommendation:	The Board is asked to **note** the content of the report and areas included for consideration / action to inform ongoing programmes of work that empower our staff, continue to develop QVH as a learning organisation and improve experiences for staff and patients.				
Action required	Approval	**Information**	Discussion	Assurance	Review
Link to key strategic objectives (KSOs):	KSO1: *To deliver outstanding care*	KSO2: *To innovate and improve*	**KSO3:** ***To be an excellent employer***	KSO4: *To deliver sustainable services*	KSO5: *To collaborate with others*
Implications					
Board assurance framework:	BAF – People				
Corporate risk register:	None				
Regulation:	None				
Legal:	None				
Resources:	Facilitation, coaching skills for managers, team development, management, and leadership programmes				
Assurance route					
Previously considered by:	Strategy and Culture Committee				
	Date:	3/09/2026	Decision	Present to the Board of Directors	
Next steps:	Continue with programmes of work across the trust to support culture transformation.				

Report to:	Board of Directors
Agenda item:	72-26
Date of meeting:	16 September 2026
Report from:	Helen Edmunds, Chief People Officer
Report author:	Annette Byers, Head of OD & Learning
Date of report:	19 August 2026
Appendices:	Appendix 1: Culture mapping tools and strategies used Appendix 2: Qualitative and Quantitative data used Appendix 3: OCAI information Appendix 4: Wellbeing and Inclusion & Employee Relations data Appendix 5: Additional documents / reports reference

Cultural Diagnostic Review 2025/26

1. Executive summary

The original cultural diagnostic report for 2024 sought to answer three questions:

1. *What is the current culture at QVH, and how does this map to our Values and Behaviour Framework?*
2. *What is the culture we aspire to have at QVH (this is in the context of the NHS 10 Year Plan and QVH Strategy)?*
3. *What are the gaps we need to address to support the culture we aspire to have?*

This culture diagnostic provides an evidence-based updated assessment of organisational culture at QVH, drawing on staff survey, people pulse, wellbeing, freedom to speak up (FTSU) and equality data. The findings confirm that QVH has a strong cultural foundation, with high levels of staff commitment, teamwork and focus on patient care. Staff continue to demonstrate motivation, strong team relationships, and a willingness to contribute to improvement.

This culture is not always experienced evenly across the organisation. Across all datasets, staff report variability in communication, involvement, leadership responsiveness, and access to support. This leaves a gap between staff capability and the extent to which organisational systems allow them to influence, act, and deliver effectively. This includes:

- reduced staff involvement and confidence in follow-through
- uneven leadership visibility and responsiveness
- sustained wellbeing pressure and variable organisational support
- varying experience across staff groups
- constraints in development, progression, and the ability to apply skills.

The findings suggest that the priority is not to redefine culture, but to improve consistency, alignment, and empowerment across the organisation, ensuring that systems, leadership, and ways of working support the culture that already exists.

1. Introduction

QVH adopts the definition of organisational culture developed by Professor Michael West, The King's Fund:

"Culture is the way we do things around here. It is the norms, rituals, expected behaviours, and unwritten rules within a work organisation. Culture is vital because it shapes our behaviour and values at work."

This updated culture diagnostic draws on multiple data sources, including the NHS annual staff survey (NHSSS), the national quarterly pulse survey (NQPS), freedom to speak up (FTSU) data, health & wellbeing analysis and workforce race equality standard (WRES) and workforce disability equality standard (WDES) information, alongside qualitative insight, to understand how culture is experienced across the organisation, providing a comprehensive view across teams, services, and staff groups. The assessment combines:

- Organisational Culture Assessment Instrument (OCAI) - define the overall cultural profile
- McKinsey 7S - to understand how culture is experienced in practice

In 2024, QVH introduced a new vision, values, and behavioural framework. This updated diagnostic builds on that work by assessing how consistently these are reflected in staff experience, and where greater alignment between organisational intent and lived culture is required.

2. Purpose, scope, and Data Sources

2.1. Purpose of the Culture Diagnostic

This updated report provides an evidence-based assessment of organisational culture at QVH in 2025/26, highlighting areas of strength and opportunities to improve consistency, alignment, and enablement across the organisation. It builds on the 2024 culture diagnostic, using the same analytical framework to support comparison over time. The report supports Board and senior leaders in understanding cultural strengths, emerging risks and areas for growth.

2.2. Data sources and timing

This diagnostic draws on multiple staff datasets collected at different points during the year:

- NHS Staff Survey 2025 (NHSSS25)
- NHS Quarterly Pulse Survey (NQPS) – Q1, Q2 and Q4 (otherwise known as People Pulse)
- Staff survey free-text and qualitative insight
- Freedom to Speak Up (FTSU) 2025 annual report/s.
- Workforce Race Equality Standard (WRES) and Workforce Disability Equality Standard (WDES) 2025/26
- Wellbeing and Inclusion survey results
- Listening exercises and organisational development insight

NHSSS25 provides the primary evidence base, with NQPS offering insight into in-year variation and the impact of operational pressures on staff experience.

3. Culture Diagnostic Framework

3.1. Analytical Framework

The McKinsey 7-S model continues to be used as the organising framework for this diagnostic. This allows culture to be understood as a system of interdependent elements, rather than a set of isolated attitudes or behaviours, and ensures comparability with the 2024 report.

Alongside the mapping tool, the Organisational Culture Assessment Instrument (OCAI) was repeated to name QVHs current and desired cultures (**Appendix 3**) and then compared to the previous diagnostic findings. This includes triangulated data from the Board, staff survey, wellbeing and inclusion and OD perspectives. These assessments have been mapped and triangulated against the tools and show similarities in the findings across all data sets.

To show our values in action, this report has been assessed for accessibility by our Wellbeing & Inclusion Manager to ensure it is easy to read and understand.

3.2. How evidence is interpreted

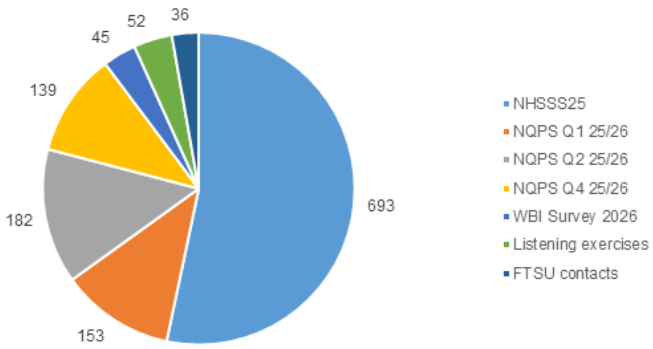
Findings are based on triangulation of:

- Quantitative survey indicators
- Qualitative staff voice
- Longitudinal patterns across the year

Judgement is applied to balance strengths and challenges and to avoid overreliance on any single dataset.

3.3. Responses and settings

The data set used in the exercise is shown within the chart below. This demonstrates the total inputs heard across all the qualitative data and quantitative data. In total, 1,300 (2024: 1,091) inputs were used from the data collated across 2024/2025 (see **Appendix 2**). NHSSS25 received 693 responses, consistent with previous year's data providing a robust evidence base.



The scope across which the culture has been considered is all QVH. It is also worthy of note that a decision was taken to apply an inclusion and wellbeing lens to the data to align with QVHs value of we are Caring and Inclusive over all else. These responses are all underpinned by QVHs values and behaviours framework, which are referenced throughout the qualitative findings. Due to the confidential nature and the limitations of the data sets available, we are unable to segment themes any lower than an overarching Trust level. Should strong themes emerge across groups (such as clinical and non-clinical), this will be highlighted.

3.4. Organisational Culture Assessment Inventory (OCAI)

The OCAI was completed using multiple organisational perspectives, including staff survey data (NHSSS25/NQPS), Health and Wellbeing analysis, Executive Leadership Team (ELT) input, and Organisational Development insight.

Across all perspectives, the organisational culture is consistently characterised by a balance between:

- **Clan culture**: strong teamwork, shared values, and commitment to patient care
- **Hierarchy culture**: structured processes, control, and organisational governance

This pattern is consistent across all datasets, indicating a shared experience of culture across the organisation. QVH demonstrates a strong team-based culture operating within established

organisational systems and structures that shape how work is experienced. This creates a clear, ongoing tension between collaborative, team-based working and organisational control and hierarchy. This position is consistent with the 2024 Culture Diagnostic, indicating that this dynamic remains embedded and continues to influence staff experience.

Staff express a preference for a more collaborative way of working, with greater emphasis on involvement, empowerment and inclusion over hierarchy and control. This aligns with FTSU findings, which suggest that staff may seek independent routes to raise concerns where organisational processes are experienced as less open or responsive.

The cultural profile (**Appendix 3**) provides context for the findings across the 7S themes that follow.

4. Quantitative and qualitative findings

Following the McKinsey 7-S framework, the findings in the data highlight aspects within the current culture below:

4.1. Change (Strategy)

Baseline position (2024 data)

The 2024 Culture Diagnostic identified frequent change at odds with frontline capacity, with limited staff involvement and inconsistent follow-through.

Current position (2025 data)

In general, staff remain motivated and continue to identify local opportunities for improvement but feel less able to influence decisions higher in the organisation, while others question the direction of travel. NQPS indicates improving communication of change over time, but continued constraints in staff ability to act. Change is experienced as demanding where priorities are unclear and staff involvement is minimal.

What has changed since 2024

Compared with 2024, the staff survey suggests a deterioration in how staff perceive engagement, influence, and organisational responsiveness. Fewer staff report being involved in decisions affecting their work, feeling that their voice counts, or believing that concerns will be addressed. Pulse survey data indicates some improvement in communication about organisational change in 2025, this has not translated into stronger feelings of involvement or influence.

What the data tells us

Evidence suggests that staff are invested in improving services and some areas continue to highlight opportunities for change locally, but staff experience change amid organisational pressure, competing priorities and limited capacity. Qualitative feedback highlights concerns about top-down change processes, limited frontline involvement, and a lack of clarity around organisational priorities. The evidence suggests staff are more likely to experience change as something communicated to them rather than something developed with them.

Risk / Opportunity

- *Risk*: staff become increasingly disengaged from organisational change if they do not feel involved in decisions or see evidence that feedback leads to action.
- *Opportunity*: strengthening co-production, prioritisation and visible follow-through could increase staff engagement, ownership of change and confidence in organisational decision-making.

4.2. Hierarchy (Structure)

Baseline position (2024 data)

Strong team identity and support, but inconsistent experience of wider organisational structures and early indications of disconnect between frontline teams and organisational decision-making.

Current position (2025 data)
Strong team cohesion continues, but there is limited improvement in staff experience of organisational alignment and involvement. Staff concerns arise around QVHs current structure and how we work within it. Staff report a growing gap between effective team working and wider organisational structure, particularly in communication, decision-making and service alignment.

What has changed since 2024

- Compared with 2024, strong team identity remains a clear strength, with staff continuing to report positive support within immediate teams. The staff survey suggests a widening gap between staff experience at team level and their experience of the wider organisation, with declines in involvement in decisions, voice, cross-team working and perceived freedom to work effectively. Staff concerns about hierarchy, organisational structure and decision-making are more prominent than in 2024.

  There are declines in:
  - cross-organisational working (q8a: 56.4% to 51.7%)
  - staff involvement in decisions (q3e: 54.7% to 49.3%)
  - team autonomy and freedom (q7f: 61.8% to 56.2%)

What the data tells us

- Team-level culture remains a clear strength, with strong and consistent collaboration within most teams. Organisational cohesion is less consistent, and staff experience a gap between how effectively teams operate locally and how the organisation functions more broadly. Reduced involvement, autonomy, and cross-team working suggest organisational structures and decision-making processes are not always supporting teams to operate effectively.

Risk / Opportunity

- *Risk*: A growing disconnect between frontline teams and organisational structures may reduce collaboration, autonomy, and confidence in organisational decision-making.
- *Opportunity*: Strengthening organisational alignment, cross-team working and staff involvement in decisions could improve cohesion, empowerment, and organisational effectiveness.

4.3. Communication (Systems)
Baseline position (2024 data)
Communication was identified as inconsistent, particularly in relation to organisational change, with gaps in how information was shared, understood, and translated into action. Feedback loops were not always visible, contributing to uncertainty among staff.

Current position (2025 data)
Communication remains more consistent at team level than across the organisation, with limited improvement in how information is shared, understood, and acted upon.

What has changed since 2024

- Compared with 2024, there is some evidence of improvement across 2025 in how staff experience organisational communication in the People Pulse survey. Some staff acknowledge greater visibility and transparency from senior leaders, the staff survey shows declines in Voice that Counts, involvement and feeling valued. Pulse survey results suggest staff feel increasingly informed about significant changes, but this has not been accompanied by a stronger sense of influence or confidence that communication leads to meaningful involvement.

  Decline in:
  - perception that the organisation values staff (q4b: 48.5% to 45.7%)

- cross-organisational working (q8a: 56.4% to 51.7%)

There has been some in-year improvements in staff:

- feeling informed about change (NQPS 47.7% to 61.2%)

What the data tells us

- Communication remains effective in local teams but is less consistent across the wider organisation. Some evidence suggests staff feel better informed about organisational changes, limited visibility of decision-making and inconsistent follow-through reduce confidence that staff feedback leads to action. FTSU and listening exercise findings reinforce that some staff do not feel heard or meaningfully involved in organisational processes.

Risk / Opportunity

- *Risk*: staff become increasingly disengaged if communication is seen as one-way, with limited evidence that feedback influences outcomes.
- *Opportunity*: strengthening feedback loops and demonstrating visible action in response to staff input may improve trust, involvement, and confidence in organisational decision-making.

4.4. Purpose and behaviours (Shared Values)

Baseline position (2024 data)

A strong sense of purpose was identified, with high commitment to patient care and organisational values. However, there were differences in how consistently values and behaviours were seen in practice, particularly at organisational level.

Current position (2025 data)

Staff continue to report a strong sense of purpose and commitment to patient care. There is limited improvement in how consistently organisational values and behaviours are experienced, particularly in how staff feel valued, treated, and supported.

- A strong sense of purpose remains evident, with staff continuing to demonstrate commitment to patient care and pride in the services they provide. Compared with 2024, the staff survey shows lower scores for motivation, engagement, morale, and recognition, alongside a reduction in the proportion of staff who believe the organisation is committed to patient care.

  There is decline in:

  - perception that patient care is prioritised (q25a: 88.6% to 82.2%)
  - perception that organisation respects individual differences (q21: 77.5% to 75%)

What the data tells us

- Purpose and commitment to patient care remain strong across the organisation. The experience of organisational values and behaviours is less consistent. While positive behaviours are sustained within most teams, there is a perceived gap between organisational intent and lived experience, particularly in how staff feel valued, respected, and supported in practice. Staff identify delivering excellent patient care as a primary motivator. Feedback from listening exercises and the 2026 Wellbeing & Inclusion Survey suggests some staff perceive a shift towards cost-saving and performance objectives over care for patients and staff, creating tension between organisational priorities and the values that motivate many employees.

Risk / Opportunity

- *Risk*: growing tension between staff commitment to care and perceived organisational priorities could erode trust, morale, and the sustainability of QVH's culture.
- *Opportunity*: demonstrating how organisational decisions balance quality, performance and staff wellbeing could strengthen alignment between organisational priorities and staff values.

4.5. Management and Leadership (Style)

Baseline position (2024 data)

The 2024 Culture Diagnostic identified strong support from immediate line managers, with variability in leadership experience beyond team level. Visibility, consistency, and follow-through at senior levels were less well established.

Current position (2025 data)

Staff continue to report positive relationships with immediate managers, but there is limited improvement in experience of leadership beyond the team. Leadership visibility, consistency, and the ability to respond to concerns remain variable.

What has changed since 2024

- Compared with 2024, supportive relationships with immediate managers remain a relative strength. The staff survey indicates lower levels of manager encouragement (76.6% to 73.3%), manager involvement in decisions (65.2% to 63.1%) and support for staff wellbeing (75.0% to 72.3%). Staff experience of leadership beyond the team shows limited improvement, with lower scores for engagement and morale and continued feedback highlighting variability in leadership visibility, consistency, and responsiveness.

What the data tells us

- Local leadership remains a relative strength, with some staff reporting supportive relationships with line managers. Leadership effectiveness is less consistent beyond the team, there appears to be a gap between senior leaders understanding issues and line managers being able to act on them. Variability in leadership experience, combined with organisational pressures and capacity constraints, appears to limit responsiveness, visibility, and follow-through. FTSU findings reinforce that some staff lack confidence that concerns raised internally will lead to action, while WRES/WDES data indicate experiences of leadership, fairness and opportunity vary across staff groups.

Risk / Opportunity

- *Risk*: variability in leadership visibility, responsiveness and follow-through may reduce trust and leave staff feeling that concerns are understood but not effectively addressed.
- *Opportunity*: Strengthening senior leadership visibility, empowering, and supporting managers to act, and demonstrating consistent follow-through on staff concerns could increase trust, engagement, and confidence.

4.6. Wellbeing and Inclusion (Staff)

Baseline position (2024 data)

The 2024 Culture Diagnostic identified increasing pressure on staff wellbeing, including workload, stress, and burnout. While team support acted as a protective factor, there was variability in how consistently staff felt supported by the organisation, particularly across different staff groups.

Current position (2025 data)

Wellbeing pressures remain, with limited improvement. Staff continue to report high workload and stress, alongside variable experience of organisational support. While team support remains a strength, organisational support is not consistently experienced.

What has changed since 2024

- Team support remains strong, but wellbeing pressures have intensified and are more visible in staff feedback, with reduced confidence in practical support for wellbeing:
    - increased work-related stress (32.4% to 39.3%)
    - reduced confidence that the organisation takes positive action on wellbeing (60.7% to 56.4%)
    - declining morale (6.2 to 5.9)

- There are also areas of improvement in inclusion experience for some staff groups, including:
    - reduced pressure on disabled staff to attend work when unwell (31.8% to 18.3%)
    - fewer BME staff reporting harassment, bullying or abuse from colleagues (25.2% to 17.6%)

What the data tells us

- Wellbeing pressure appears sustained rather than short-term, with staff continuing to experience high workload, stress, and fatigue. While strong team support remains a protective factor, organisational support (perceived as sufficient staffing and capacity to work sustainably) is experienced less consistently. FTSU findings suggest that psychological safety may vary, with some staff preferring independent routes to raise concerns.

Risk / Opportunity

- *Risk*: Sustained workload and staffing pressures, combined with uneven experiences of support and inclusion, could lead to increased burnout, reduced engagement, and retention challenges.
- *Opportunity*: Addressing the organisational drivers of stress and strengthening access to support could improve wellbeing, inclusion, retention, reduce sickness absence and the sustainability of high-quality patient care.

4.7. Ways of working (Skills)

Baseline position (2024 data)

Strong teamwork and capability across the organisation, with staff demonstrating commitment and adaptability. There were concerns regarding access to development, effectiveness of appraisal processes, and the ability to fully utilise skills in practice.

Current position (2025 data)

Staff continue to demonstrate strong teamwork and capability. There is limited improvement in access to development and progression, and increasing evidence that staff feel constrained in their ability to apply skills and contribute to improvements in practice.

What has changed since 2024

- Staff continue to demonstrate strong teamwork and commitment, but there is limited evidence of improvement in learning, development, and progression opportunities. The staff survey shows a decline in the Always Learning score (5.9 to 5.7), appraisal effectiveness (NHSSS25 5.0 to 4.8), alongside small reductions in access to relevant training and development (66.8% to 65.1%) and the ability to make improvements happen (56.7% to 54.6%).

What the data tells us

- Staff capability and commitment remain strong, with teams demonstrating effective collaboration and initiative. However, opportunities to grow and apply skills are increasingly constrained. There is a clear gap between staff potential and opportunity, with constraints on participating in development, progressing careers and making improvements. The evidence suggests this is driven less by willingness and capability than by staffing pressures and reduced capacity to engage with development opportunities or improvement activity.

Risk / Opportunity

- *Risk*: Staff may become disengaged if they are unable to access development opportunities, progress their careers or apply their skills to improve services
- *Opportunity*: Strengthening development pathways, supporting staff to attend training, and enabling them to apply their skills and improvement ideas would help unlock existing capability, improving both staff experience and organisational performance.

5. Summary conclusion

The combined findings from the OCAI and 7S analysis indicate that QVH has a strong cultural foundation, characterised by committed staff, effective teamwork, and a shared sense of purpose. This is consistently reflected across staff survey, pulse, wellbeing, inclusion, and leadership data.

This culture is not always consistently enabled at an organisational level. Across the data, staff describe differences in how systems, structures and processes support their ability to contribute, influence and act. A clear pattern emerges across all seven elements:

- Team-level culture is strong - collaborative, supportive and values-driven
- Staff are motivated, capable, and engaged
- Organisational systems and processes are not consistently enabling staff experience or effectiveness

This results in strong teams operating within a system that is not consistently enabling them. This is reflected in:

- sustained commitment alongside declining influence
- strong local leadership alongside variable organisational responsiveness
- staff generating ideas but experiencing constraints in acting on them

Cultural improvement at QVH is therefore less about defining new values, and more about:

- ensuring that organisational systems, structures, leadership practices, and ways of working consistently enable the behaviours and culture required for future success.

5.1. Key insights

1. Strong teamwork, commitment to patient care and local support remain defining strengths
2. Staff continue to identify opportunities for improvement and want to be actively involved
3. Leadership is experienced as supportive locally, but less consistent at organisational level
4. Communication, decision-making, and follow-through are not consistently visible or inclusive
5. Wellbeing pressures are sustained, with organisational support experienced as variable and not linked to the actual and perceived challenges staff face, such as reduced staffing
6. Staff capability and initiative are strong, but opportunities to develop skills are constrained
7. Experience is not consistent across all staff groups, with evidence of variation in equity and access

5.2. Cultural Alignment

There is evidence that organisational and system uncertainty may be affecting staff confidence in improvement activity. While staff identify and contribute opportunities for change, some feedback suggests uncertainty regarding partnership arrangements. Organisational developments may reduce confidence in investing time and effort in local change initiatives where future priorities, structures or service models are perceived as uncertain. These findings indicate that future cultural development should focus on creating the conditions that enable staff to collaborate, contribute, and innovate across organisational boundaries while supporting sustainable working and a positive staff experience.

Work will be developed with our partner organisations to share cultural assessments / mapping and a culture dashboard to enable us to prioritise priority areas to focus on collectively. These will include staff empowerment and engagement, being learning organisations and improved staff experience, leading to consistently excellent patient experience.

5.3. Areas for consideration / action:

Strengthen organisational alignment

- Improve clarity, consistency, and visibility of decision-making

- Ensure structures support, rather than constrain, team effectiveness
- Strengthen coordination across services and functions

Improve communication and involvement
- Increase visibility of decisions, actions, and follow-through
- Strengthen co-production and early staff involvement in change
- Ensure consistent messaging across the organisation

Enhance leadership capacity and consistency
- Increase leadership visibility beyond immediate teams
- Strengthen leaders' ability to respond to concerns and act
- Improve consistency of leadership experience across the organisation

Address wellbeing and sustainability
- Strengthen visibility and accessibility of wellbeing support
- Address workload and system pressures where possible
- Improve organisational responsiveness to staff wellbeing needs

Embed equity and inclusion
- Address variation in staff experience across diverse groups
- Improve access to development, opportunity, and progression
- Ensure inclusive practices are consistently applied across the organisation

Enable development and improvement
- Strengthen access to training and career pathways
- Enable staff to apply skills and contribute to improvement
- Reduce barriers to innovation and cross-team working

Through embedding these actions into ongoing programmes of work, including staff survey actions derived from priority areas of focus, QVH is striving to have:

1. **A Connected Organisation**
   - where teams, services and leaders work together around shared priorities
2. **An Empowered Workforce**
   - where staff feel heard, involved, and able to influence decisions and improvement
3. **A Sustainable and Inclusive Environment**
   - where wellbeing, equity and psychological safety are consistently experienced
4. **A Learning and Improving Organisation**
   - where staff can develop, innovate and apply their skills to improve care

Recommendation

The Board are asked to **note** the content of the report and areas included for consideration / action to inform ongoing programmes of work that empower our staff, continue to develop QVH as a learning organisation and improve experiences for staff and patients.

Appendix 1: Culture mapping tools and strategies used

McKinsey 7-S Model

The McKinsey 7-S Model is a framework used to analyse and improve organisational effectiveness. It looks at seven key elements that need to be aligned for an organisation to perform well. These elements are divided into "hard" and "soft" components:

Hard Elements (easier to define and manage)

1. Strategy – The plan to achieve competitive advantage and success.
2. Structure – How the organisation is arranged (e.g., hierarchy, departments).
3. Systems – The processes and procedures used in daily operations.

Soft Elements (more influenced by culture and people)

4. Shared Values – Core beliefs and culture that guide employee behaviour.
5. Skills – The capabilities and competencies of the staff.
6. Style – Leadership approach and management style.
7. Staff – The people in the organization and their general characteristics.

The idea is that all seven elements must be aligned and mutually supportive. If one changes (like strategy), others may need to change too (like structure or systems) to maintain effectiveness.

The Organisational Culture Assessment Instrument (OCAI)

The OCAI tool is a widely used framework developed by Kim Cameron and Robert Quinn to assess and understand organisational culture. It is based on the Competing Values Framework, which identifies four types of organisational culture:

- Clan Culture – Focuses on collaboration, teamwork, and a family-like environment.
- Adhocracy Culture – Emphasizes innovation, creativity, and risk-taking.
- Market Culture – Driven by competition, results, and achievement.
- Hierarchy Culture – Values structure, control, and efficiency.

Participants (employees or leaders) rate their organisation across six key areas:

1. Dominant characteristics
2. Organisational leadership
3. Management of employees
4. Organisational glue
5. Strategic emphases
6. Criteria of success

They assess both current and preferred culture, helping identify gaps and areas for development. Some of the benefits of using OCAI include:

- Clarity: Provides a clear snapshot of the current and desired culture
- Alignment: Helps align organisational culture with strategic goals
- Engagement: Encourages employee involvement in shaping the culture
- Change Management: Supports cultural change initiatives with data-driven insights
- Decision-Making: Informs leadership decisions about structure, strategy, and people management

QVH Strategy 2025/2030 (incl. QVH vision, values, and behaviour framework)

The strategy focuses on delivering excellence in specialist care while ensuring the hospital remains a trusted, sustainable, and innovative provider for both local and specialist services. These are underpinned by the core values and behaviour framework which focuses on being Caring and Inclusive, Supportive and Challenging, Listening to Improve, Succeeding Together. The Key Strategic Objectives (KSOs) are to:

1. **Deliver Excellent Care**
    - Maintain and improve ambitious standards in specialist services (e.g. burns, maxillofacial, reconstructive surgery)
    - Ensure patient safety, experience, and outcomes are central
2. **Be a Great Place to Work**
    - Support staff wellbeing and development
    - Foster a culture of inclusion, learning, and collaboration
3. **Sustain and Grow Services**
    - Strengthen partnerships across Kent, Surrey, and Sussex
    - Secure QVH's role in regional and national specialist networks
4. **Innovate and Improve**
    - Embrace digital transformation and research
    - Use data and feedback to drive continuous improvement
5. **Engage and Involve**
    - Work closely with patients, carers, and communities
    - Ensure transparency and co-production in service design

NHS 10-year long-term plan
There are three major shifts in NHS delivery listed highlighting the enablers of improvement:

1. **From hospital to community**
    - More care delivered closer to home
    - Strengthening primary and community care services
2. **From analogue to digital**
    - Embracing digital technology to reduce admin burden
    - Empowering patients to manage their care online
3. **From sickness to prevention**
    - Focus on early intervention and prevention
    - Making healthy choices easier and more accessible

Enablers of Improvement:

- Workforce: Recruitment, retention, and staff wellbeing
- Primary Care Networks: Integrated, multidisciplinary teams
- Digital Innovation: AI, apps, and electronic records
- Research & Innovation: Evidence-based improvements
- Engagement: Listening to patients and staff

Appendix 2: Quantitative and qualitative data used

Area	Narrative and data content	Comments
Culture Diagnostic Report 2024	Used to inform base position for new 2025 report – See Appendix 5	Board report
Staff Survey 2025	Staff Engagement Scores, all People Promise elements and themes (focusing on wellbeing and inclusion due to emergent themes) and thematic analysis	Anonymous and confidential
People Pulse (NQPS) q1, q2 and q4 2025/26	Staff Engagement Score, Sentiment/Mood, WI questions	Anonymous and confidential
WRES/WDES 2025/26	Findings from the WRES/WDES results	Anonymous
Wellbeing & Inclusion Survey 2026	Quantitative and qualitative data	Anonymous
Current ER casework	Number and types of cases (flexible working requests, investigations, disciplinary cases, performance management cases, etc.)	Confidential
Listening exercises 2025/26	Listening interviews, department listening, culture review, leavers interviews	Anonymous and confidential
FTSU 2025 annual report	Quantitative and qualitative data	Confidential
VPR and Sexual safety report	Quantitative and qualitative data	Anonymous

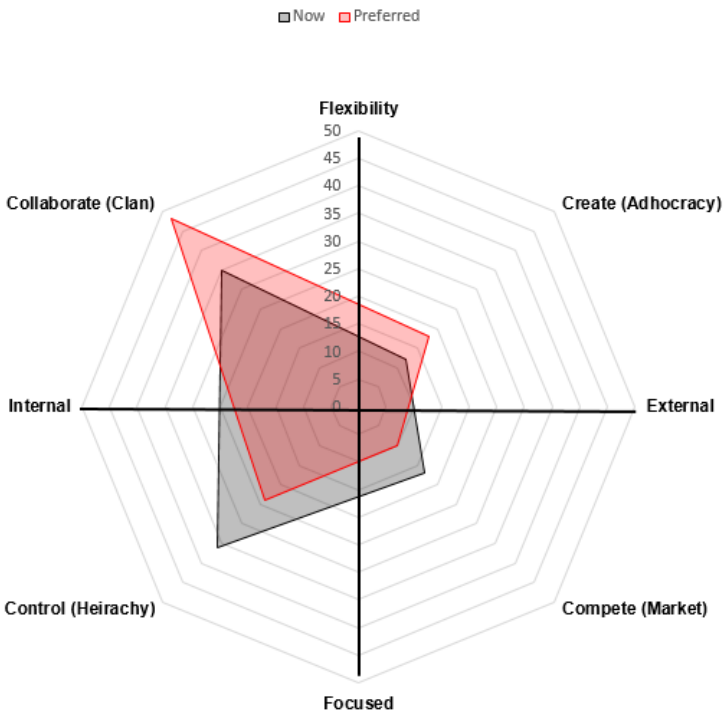
Please note: Due to staff numbers, confidentiality, anonymity and response rates, granular data is not available in all data sets. Therefore, overall report is based on an overall thematic analysis.

Appendix 3: Organisational Culture Assessment Instrument information

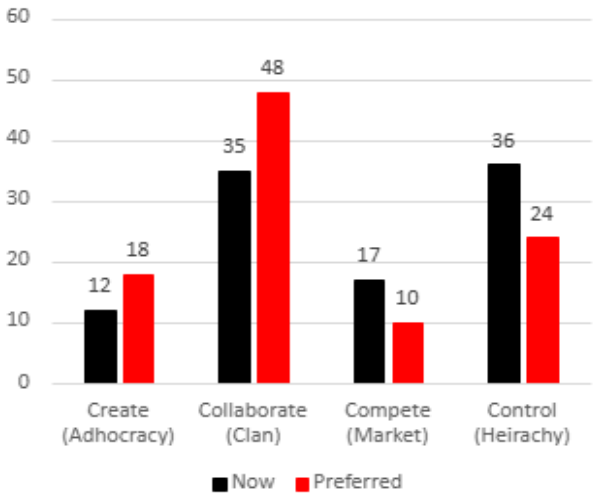
Mapping QVH current and desired culture to OCAI

The overall OCAI analysis incorporates four organisational perspectives to inform the current and desired culture at QVH. This provides a triangulated view of organisational culture across staff experience, leadership insight, and organisational systems. The OCAIs included:

- Staff Survey 2025 findings/NQPS 2025/26 (combined dataset)
- Wellbeing and inclusion analysis
- Executive perspective
- OD/Culture perspective (leadership datasets)



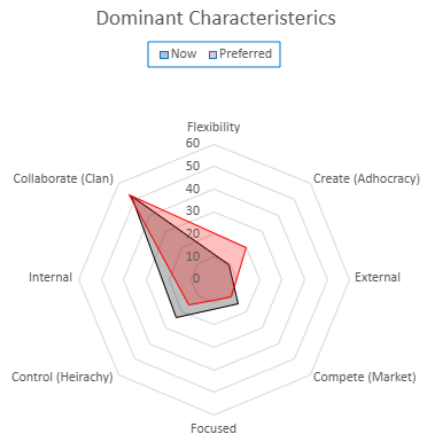
Av. QVH Scores based on Staff Survey/NQPS, H&W & Inclusion, Executive and OD&L Leadership findings

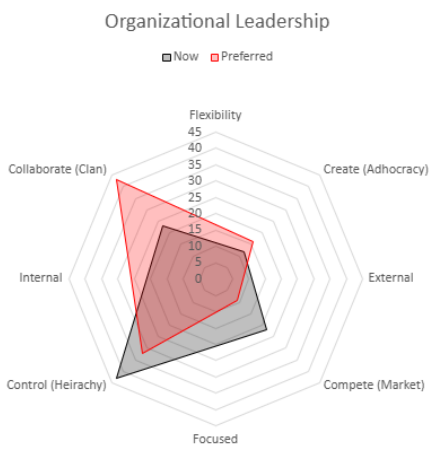


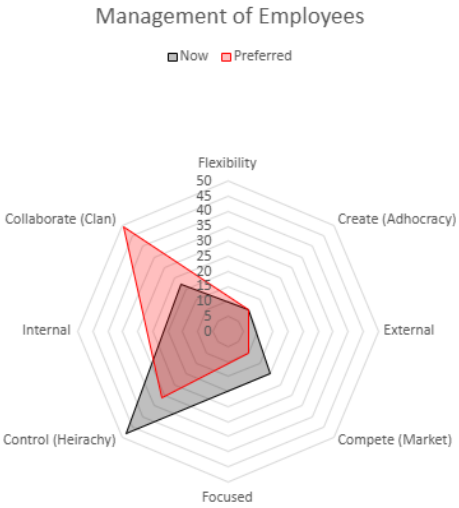
This combined profile indicates a balance between Clan and Hierarchy cultures, with a clear preference for a stronger emphasis on collaboration and reduced reliance on hierarchy.

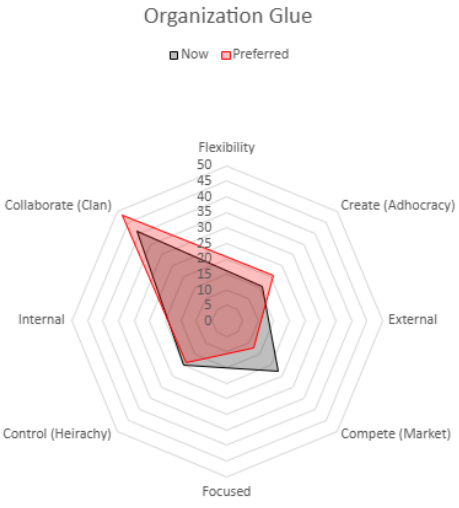
The OCAI assesses culture across six domains, including leadership, management style, organisational glue, and criteria of success. The visuals below show each of the six domains and highlights the current and desired culture differences.

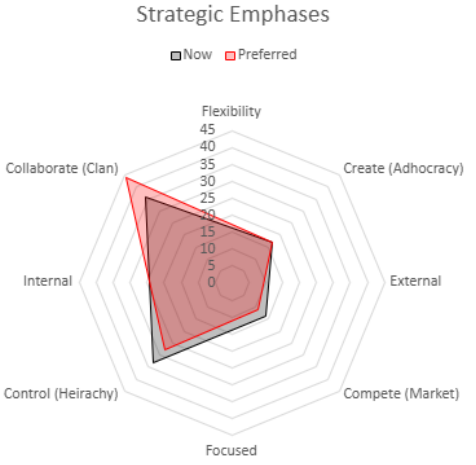
The six cultural domains alignment:

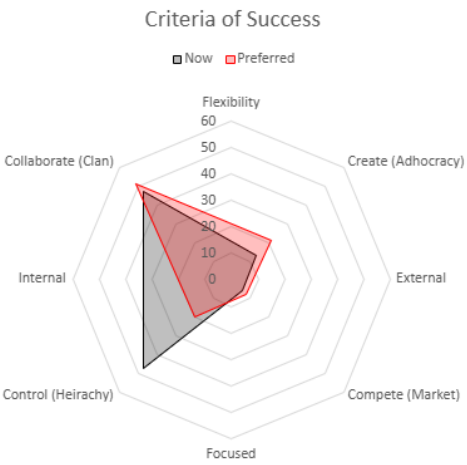












Key observations:

- Alignment to Dominant Characteristics, Organisational Glue and Strategic Emphases
- Differences in Organisational Leadership, Management of Employees and Criteria of Success are shown
- Clan and Hierarchy are consistently the dominant cultures across all perspectives
- Leadership perspectives show slightly higher emphasis on hierarchy
- Wellbeing & Inclusion data reflects comparatively lower Clan and higher pressure (Market)

The OCAI results indicate that:

- The organisation has a solid foundation of teamwork and shared values (Clan)
- This operates alongside established systems, structures, and governance (Hierarchy)
- This pattern is consistent across staff, leadership, and organisational perspectives

The preferred overarching profile demonstrates a clear and shared aspiration for:

- Greater participation and involvement
- Increased flexibility and empowerment
- Reduced emphasis on hierarchical control

Across all perspectives, there is a consistent shift toward:

- Increased Clan (collaboration, involvement, empowerment)
- Reduced Hierarchy (control, structure, formalisation)

The 2025/26 OCAI findings are consistent with the 2024 Culture Diagnostic, which also identified a balance between collaborative and hierarchical elements of culture.

Appendix 4: Wellbeing and Inclusion and Employee Relations data

To better understand the demography of our workforce and how this influences our culture, we have reviewed the characteristics that appear most frequently across protected characteristics where this data is held. This is shown in *Figure 1*.

This information helps us to establish the traits most represented in staff voice, and where further efforts are required to understand the experience of our diverse workforce.

It is important to note however that there are limitations in this data; for example, QVH's personnel system does not allow gender identities beyond the binary sexes to be recorded. This therefore limits our understanding of the experience of trans, non-binary, and intersex colleagues.

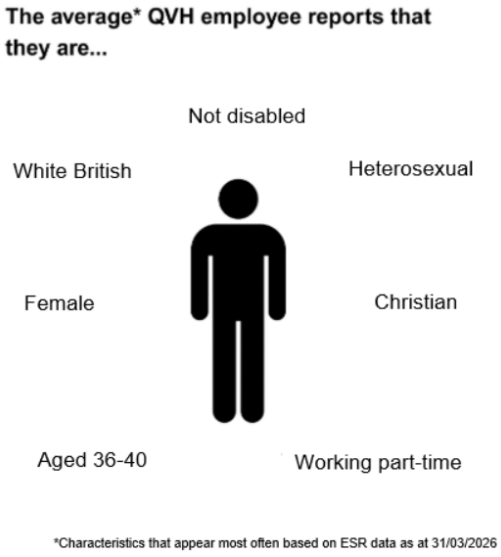


Figure 1

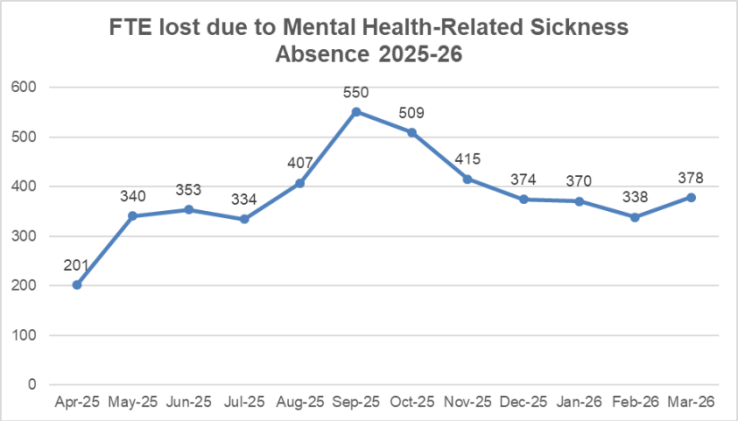


Figure 2

When reviewing wellbeing and inclusion data, we noted 22.2% of staff reported poor mental health and 11.1% reported very poor mental health, noting that this is sometimes exacerbated by management and work practices.

This is supported by the amount of FTE lost to mental health related absence over the reporting period (*Figure 2)*.

A review of ER casework reveals several processes at formal stages, which may contribute to the higher incidence of mental health related absence in previous months (*Figure 3*).

	Informal*	Formal
Appeal	0**	8
Bullying & harassment	0	12
Disciplinary	20	13
Grievance	0	4
Performance management	7	1

Figure 3

* This data does not include pre-policy case management, such as local 1:1 conversations, as these are not captured on the Trust's case management system.
** Appeals cannot be raised informally.

This is supported by our WRES data, which reveal that our ethnically diverse staff are more likely to enter formal processes compared to White colleagues (noting there are small numbers of cases). Our WDES data for 2025-26 reveals that disabled staff are more likely to experience bullying, harassment, and/or abuse from QVH colleagues or managers than non-disabled staff.

References:

- NHS Staff Survey 2025 -
- QVH Values and Behaviour Framework
- QVH 5 Year Strategy
- FTSU – Guardians Office – see Appendix 5
- OCAI
- McKinsey 7-S framework
- NHS Listening Well guidance
- NHS EDI Improvement Plan
- NHS 10 Year Plan
- Edgar Schein

Report cover-page					
References					
Meeting title:	Board of Directors				
Meeting date:	16/09/2026		**Agenda reference:**	**73-26**	
Report title:	National Cancer Patient Experience Survey (NCPES)				
Sponsor:	Liz Blackburn, Acting Chief Nursing Officer				
Author:	Clare Lancaster, Macmillan Lead Cancer Nurse				
Appendices:	Appendix 1 - NCPES Report				
Executive summary					
Purpose of report:	To update the Trust Board of the results from the National cancer Patient Experience Survey				
Summary of key issues	The National Cancer Patient Experience Survey (NCPES) 2025 provides valuable insight into the experiences of patients receiving cancer care at Queen Victoria Hospital NHS Foundation Trust (QVH). Of the 208 patients surveyed, 115 responded, giving a response rate of 54%, above the national average of 48%. Overall, QVH achieved an overall care rating of 9.0/10, with most results falling within or above the expected range. Key findings: • Six areas rated significantly above the expected range, including communication, involvement in care, emotional support, and dignity and respect. • 95% of patients found it easy to contact their main cancer contact person (national average 84%). • 98% of patients reported being treated with respect and dignity while in hospital (national average 88%). • Two questions relating to radiotherapy information and treatment outcomes were rated below the expected range and will be reviewed with partner organisations responsible for delivering radiotherapy services.				
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:	KSO1				
Organisational risk register:	None				
Regulation:	NHSE				
Legal:	None				
Resources:	None				
Assurance route					
Previously considered by:	Quality & safety committee				
	Date:	01/09/2296	Decision:	Submit to Board	
Next steps:					

Report to:	Board of Directors
Agenda item:	73-26
Date of meeting:	16 September 2026
Report from:	Liz Blackburn, Acting Chief Nursing Officer
Report author:	Clare Lancaster, Macmillan Cancer Lead Nurse
Date of report:	10 August 2026
Appendices:	Appendix 1 - NCPES Report

National Cancer Patient Experience Survey

Introduction

The National Cancer Patient Experience Survey (CPES) 2025 is the fifteenth iteration of the survey first undertaken in 2010. The survey was undertaken by Picker on behalf of NHS England and it was overseen by a National Cancer Patient Experience Advisory Group. This Advisory Group set the principles and objectives of the survey programme and guided questionnaire development. Trust results are based on the NHS trust where patients received cancer treatment and include all patients treated there, regardless of where they live in the UK.

Executive summary

The paper presents the key findings from the NCPES 2025 for Queen Victoria Hospital NHS Foundation Trust (QVH). The NCPES is designed to monitor progress in cancer care, identify opportunities for local service improvement, and provide valuable insights to commissioners, healthcare providers, charities, and other stakeholder groups involved in supporting people affected by cancer.

Situation

The 2025 survey included 130 NHS trusts and received 64,268 responses from 134,285 people invited to participate, representing an overall response rate of 48%. At QVH, 115 of the 208 patients surveyed responded, resulting in a higher response rate of 54%, with all responses being either by paper or online.

Background

The NCPES 2025 gathered feedback from adults aged 16 and over with a confirmed cancer diagnosis who received cancer-related inpatient or day-case treatment at NHS trusts between April and June 2025. Survey fieldwork was conducted between November 2025 and February 2026 using a mixed-method approach, enabling patients to respond either by post or online. Additional support, including a Freephone helpline, email assistance, telephone completion, and translation and interpreting services, was available to help maximise participation and accessibility.

Data is suppressed for two reasons: to ensure that unreliable results based on very small numbers of respondents are not released, and to prevent individuals from being identifiable in the data. Suppression data is noted in our Head and Neck tumour group. Of the 115 respondents, 105 (91.3%) reported their ethnicity as White
British.

Assessment

Overall, the survey demonstrates that QVH continues to deliver a high-quality cancer patient experience, with the majority of adjusted scores falling within or above the expected range, and an overall care rating of 9.0/10, in line with national performance.

Notably, QVH was identified as a positive outlier in six areas as outlined in table 1 below:

Table 1

Questions above expected range	2025 Trust score	2025 National score
Patient found it very or quite easy to contact their main contact person	95%	84%
Patient had confidence and trust in all of the team looking after them during their stay in hospital	91%	78%
Patient's family, or someone close, was definitely able to talk to a member of the team looking after the patient in hospital	90%	72%
Patient was always involved in decisions about their care and treatment whilst in hospital	84%	72%
Patient was always able to discuss worries and fears with hospital staff	85%	66%
Patient was always treated with respect and dignity while in hospital	98%	88%

However, two areas relating to radiotherapy information and treatment outcomes were rated significantly below the expected range. Although radiotherapy services are not provided directly by the QVH, these findings reflect the experiences of patients across their cancer pathway and should be considered in collaboration with partner organisations providing radiotherapy care. The Trust will work with these organisations to understand the factors contributing to these results, improve communication and information sharing across the cancer pathway, and use patient feedback to support service improvements.

Recommendation

The Board is asked to note the results from the NCPES 2025.

National Cancer Patient Experience Survey

2025 Results

Queen Victoria Hospital NHS Foundation Trust

Published July 2026

The National Cancer Patient Experience Survey is undertaken by Picker on behalf of NHS England

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Executive summary

Questions above expected range

	Case mix adjusted scores			National score
	2025 score	Lower expected range	Upper expected range	
Q18. Patient found it very or quite easy to contact their main contact person	**95%**	76%	93%	**84%**
Q31. Patient had confidence and trust in all of the team looking after them during their stay in hospital	**91%**	67%	89%	**78%**
Q32. Patient's family, or someone close, was definitely able to talk to a member of the team looking after the patient in hospital	**90%**	59%	85%	**72%**
Q33. Patient was always involved in decisions about their care and treatment whilst in hospital	**84%**	60%	84%	**72%**
Q35. Patient was always able to discuss worries and fears with hospital staff	**85%**	53%	79%	**66%**
Q37. Patient was always treated with respect and dignity while in hospital	**98%**	79%	96%	**88%**

Executive summary

Questions below expected range

	Case mix adjusted scores			National score
	2025 score	Lower expected range	Upper expected range	
Q41_3. Beforehand patient completely had enough understandable information about radiotherapy	**52%**	69%	100%	**89%**
Q42_3. Patient completely had enough understandable information about their response to radiotherapy	**59%**	62%	100%	**85%**

Introduction

The National Cancer Patient Experience Survey 2025 is the fifteenth iteration of the survey first undertaken in 2010. It has been designed to monitor progress on cancer care; to provide information to drive local quality improvements; to assist commissioners and providers of cancer care; and to inform the work of the various charities and stakeholder groups supporting cancer patients.

The survey was undertaken by Picker on behalf of NHS England and it was overseen by a National Cancer Patient Experience Advisory Group. This Advisory Group set the principles and objectives of the survey programme and guided questionnaire development. The survey was commissioned and managed by NHS England. The survey provider, Picker, is responsible for designing, running and analysing the survey.

The 2025 survey involved 130 NHS trusts. Out of 134,285 people, 64,268 people responded to the survey, yielding a response rate of 48%.

Methodology

Eligibility, fieldwork and survey methods

The sample for the survey included all adult (aged 16 and over) NHS patients, with a confirmed primary diagnosis of cancer, discharged from an NHS trust after an inpatient episode or day case attendance for cancer related treatment in the months of April, May and June 2025. The fieldwork for the survey was undertaken between November 2025 and February 2026.

As in the previous 10 years, the survey used a mixed mode methodology. Questionnaires were sent by post, with two reminders where necessary, but also included an option to complete the questionnaire online. A Freephone helpline and email was available for respondents to opt out, ask questions about the survey, enable them to complete their questionnaire over the phone and provide access to a translation and interpreting facility for those whose first language was not English.

Note on question comparability

The questionnaire was redeveloped for the 2021 National Cancer Patient Experience Survey. Year on year comparisons between 2021 and 2025 are included in this report for most questions. The below should be noted for comparability of results:

- Q23 and Q42: In 2023 the question text was amended. These questions are not comparable to 2021 or 2022, data is only comparable for 2023, 2024 and 2025.
- Q67: In 2023 the long-term condition question was amended to include “Autism or autism spectrum condition” as a response option, and update the answer option “Neurological condition” to “Neurological condition, such as epilepsy”. These answer options are not comparable to 2021 or 2022, data is only comparable for 2023, 2024 and 2025.
- Q71: In 2023 the ethnic group question was amended to include “Roma” as a response option. The ethnic group question is still deemed comparable to previous years, but data for the “Roma” response option is only available for 2023, 2024 and 2025.
- Q51 and Q52: In 2025 the question text was amended. These questions are not comparable to previous years, data is only available for 2025.

Case mix adjustment

Both unadjusted and adjusted scores are presented in this report. Case mix adjusted scores allow us to account for the impact that differing patient populations might have on results. By using the case mix adjusted estimates we can obtain a greater understanding of how a trust is performing given their patient population. The factors taken into account in this case mix adjustment are 'Which of the following best describes you?', age, ethnicity, deprivation, and cancer type.

Unadjusted data should be used to see the actual responses from patients relating to the trust. Case mix adjusted data, together with expected ranges, should be used to understand whether the results are significantly higher or lower than national results taking account of the patient mix.

How trust results are derived

Trust results are derived using the NHS trust where each patient received cancer related treatment. Trust results are presented at the 'National' level, meaning results include patients with addresses in England and elsewhere in the UK. Some patients may receive care at a trust which is not near to where they live.

Scoring methodology

Sixty-one questions from the questionnaire are scored as these questions relate directly to patient experience. For all but one question (Q59), the score shows the percentage of respondents who gave the most favourable response to a question. For Q59, respondents rate their overall care on a scale of 0 to 10, of which the average was calculated for this question's score. The percentages in this report have been rounded to the nearest percentage point. Therefore, in some cases the figures do not appear to add up to 100%.

In 2022, following a review of the scoring methodology, a change was made to the scoring of Q12 such that the response option "No, I was told by letter or email" is no longer considered neutral and is now scored as negative.

The full scoring for all questions at a trust level is available in the trust Excel tables available at www.ncpes.co.uk.

Statistical significance

In the reporting of 2025 results, appropriate statistical tests have been undertaken to identify unadjusted scores for which the change over time is 'statistically significant'. A statistically significant difference means that the change in the result is very unlikely to have occurred by chance.

Suppression

Data is suppressed for two reasons: to ensure unreliable results based on very small numbers of respondents are not released, and to prevent individuals being identifiable in the data.

In cases where a result is based on fewer than 10 responses, the result has been suppressed. For example, where fewer than 10 people answered a question from a particular trust, the results are not shown for that question for that trust.

For trusts with an eligible population of 1,000 or fewer, data relating to the respondent and their condition has been suppressed where 5 people or fewer were in a particular category. In instances where only one has been suppressed, the next lowest category has been suppressed to prevent back calculation from the total number of responses.

Additional suppression

Additional suppression happens if only one trust has a score suppressed. If this happens, we will suppress another trust's results (both the trust level and subgroup results for the question) based on the next lowest number of respondents for the score. We do this so that the national score cannot be used to work out the score for the individual trust.

The same rule applies to groups in each subgroup breakdown. For example, if only one trust has the 85+ age group suppressed for Q25 we will need to suppress another trust's results for the 85+ age group on Q25. This suppression is based on the 85+ age group with the next lowest number of respondents for Q25.

Understanding the results

This report shows how this trust scored for each question in the survey compared with national results. It is aimed at helping individual trusts to understand their performance and identify areas for local improvement. Below is a description of the type of results presented within this report and how to understand them.

Expected range charts

The expected range charts in this report show a bar with the lowest and highest score received for each question nationally. Within this bar, an expected range is given (within the grey bar) and a black diamond represents the actual score for this trust.

Trusts whose score is above the upper limit of the expected range (in the dark blue) are positive outliers, with a score statistically significantly higher than the national mean. This indicates that the trust performs better than how trusts of the same size and demographics are expected to perform. The opposite is true if the score is below the lower limit of the expected range (in the light blue); these are negative outliers. For scores within the expected range (in the grey), the score is what we would expect given the trust's size and demographics.

Comparability tables

The comparability tables show the 2024 and 2025 unadjusted scores for this trust for each scored question. The columns 'Change 2024-2025' and 'Change overall' include arrows to show if there is statistically significant variation between years. An upwards arrow indicates a statistically significant increase, a downwards arrow indicates a statistically significant decrease, and no arrow indicates no statistically significant change.

The adjusted 2025 score will also be presented for each scored question along with the lower and upper expected range and national score. Scores above the upper limit of the expected range will be highlighted dark blue, scores below the lower limit of the expected range will be highlighted light blue, and scores within the lower and upper limit of the expected ranges will be highlighted grey.

Subgroup breakdowns

Unadjusted scores are shown for tumour group, age, 'Which of the following best describes you?', ethnicity, IMD quintile, long-term condition status, and impact of long-term conditions(s) on day-to-day activities. Unadjusted scores for the same subgroup across different trusts may not be comparable, as they do not account for the impact that differing patient populations might have on results.

Tumour group tables

The tumour group tables show the unadjusted scores for each scored question for each of the 13 tumour groups. Central nervous system is abbreviated as 'CNS' and lower gastrointestinal tract is abbreviated as 'LGT' throughout this report.

Age group tables

The age group tables show the unadjusted scores for each scored question for each of the eight age groups.

‘Which of the following best describes you?’

These tables show the unadjusted scores for the following groups male; female; non-binary; prefer to self-describe; and prefer not to say.

Ethnicity tables

The ethnicity tables show the unadjusted scores for six ethnicity groups.

Long-term condition status tables

The long-term condition status tables show the unadjusted scores for two groups: those who indicate they have one or more long-term conditions and those who indicate that they have no long-term conditions.

Impact of long-term condition(s) (excluding cancer) on day-to-day activities tables

The impact of long-term condition(s) tables show unadjusted scores for respondents with an additional long-term condition(s) and whether these affect their day-to-day activities.

IMD quintile tables

The IMD quintile tables show the unadjusted scores for five quintiles based on relative disadvantage, with quintile 1 being the most deprived and quintile 5 being the least deprived.

Year on year charts

The year on year charts show five columns representing the unadjusted scores of the last five years (2021, 2022, 2023, 2024 and 2025) for each scored question. Arrows are included to show if there is statistically significant variation between 2024 and 2025 or overall between 2021 and 2025. An upwards arrow indicates a statistically significant increase, a downwards arrow indicates a statistically significant decrease, and no arrow indicates no statistically significant change.

National level and England level data

In some cases (333 respondents in 2025), patients from outside England (from Wales, Scotland, Northern Ireland, the Channel Islands or the Isle of Man) are referred to English NHS trusts for treatment. These patients are described as ‘Non-England’ in the data.

National level data (England and Non-England) is used for:

- Response rate section
- National column in comparability tables section
- Subgroup tables section (Tumour group tables, Age group tables, ‘Which of the following best describes you?’, Ethnicity tables, IMD quintile tables, Long-term condition status tables and Impact of long-term condition(s) (excluding cancer) on day-to-day activities tables).

England only level data is used for:

- Expected range charts section (as case mix adjustment includes IMD data specific to England)
- Comparability tables section
- Year on year charts section.

Further information

This research was carried out in accordance with the international standard for organisations conducting market and social research (accreditation to ISO20252:2019; certificate number GB08/74322). Our statistical practice is regulated by the Office for Statistics Regulation (OSR). OSR sets the standards of trustworthiness, quality, and value in the Code of Practice for Statistics that all producers of official statistics should adhere to. You are welcome to contact us directly with any comments about how we meet these standards. Alternatively, you can contact OSR by emailing regulation@statistics.gov.uk or via the OSR website.

To view all outputs and supporting materials for 2025 and previous years, please visit the website www.ncpes.co.uk. This includes:

- All Excel data tables, PDF reports and the interactive dashboard available at national, Integrated Care Board, Cancer Alliance and NHS trust level.
- Analysis of free text data available in the national qualitative thematic report. Free text workbooks are also shared directly with the NHS trust and Cancer Alliance leads.
- The Technical Document, providing more information about the methodology including significance testing, suppression and question comparability.
- Additional resources, including reports which explore key driver analysis for a high rating of care, and a video demonstration on using the outputs.
- The questionnaire, survey guidance and survey materials.

These resources will help users to explore trends over time, analyse results by demographic and clinical subgroups, and benchmark organisations against national scores and other providers.

Response rate

Overall response rate

115 patients responded out of a total of 208 patients, resulting in a response rate of 55%.

	Sample size	Adjusted sample	Completed	Response rate
Overall response rate	213	208	115	55%
National	143,951	134,285	64,268	48%

Respondents by survey mode

	Number of respondents
Paper	92
Online	23
Phone	0
Translation service	0
Total	**115**

Respondents by tumour group

	Number of respondents
Brain / CNS	0
Breast	20
Colorectal / LGT	0
Gynaecological	0
Haematological	0
Head and neck	*
Lung	0
Prostate	0
Sarcoma	0
Skin	76
Upper gastro	0
Urological	0
Other	*
Total	**115**

* indicates the count is not shown due to suppression

Respondents by ethnicity

	Number of respondents
White	
English / Welsh / Scottish / Northern Irish / British	105
Irish	*
Gypsy or Irish Traveller	*
Roma	*
Any other White background	*
Mixed / Multiple Ethnic Groups	
White and Black Caribbean	*
White and Black African	*
White and Asian	*
Any other Mixed / multiple ethnic background	*
Asian or Asian British	
Indian	*
Pakistani	*
Bangladeshi	*
Chinese	*
Any other Asian background	*
Black / African / Caribbean / Black British	
African	*
Caribbean	*
Any other Black / African / Caribbean background	*
Other Ethnic Group	
Arab	*
Any other ethnic group	*
Not given	
Not given	*
Total	**115**

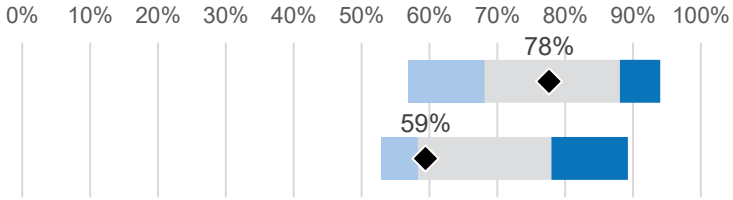
* indicates the count is not shown due to suppression

Expected range charts

Lower expected range | Within expected range | Upper expected range | Case mix adjusted score

The left outer edge of the bars is the lowest score achieved of all trusts. The right outer edge of the bars is the highest score achieved of all trusts.

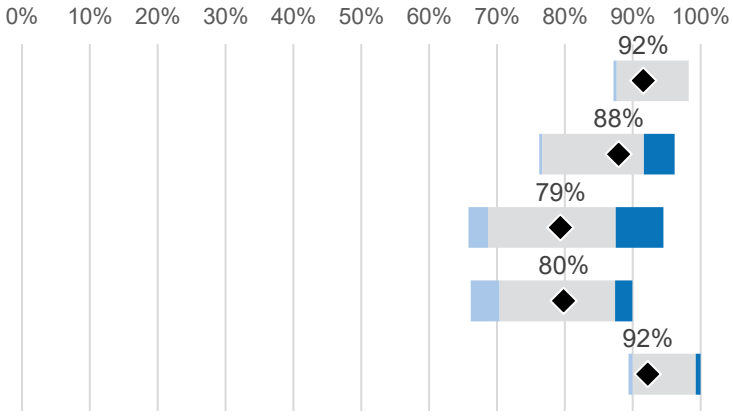
SUPPORT FROM YOUR GP PRACTICE



Q2. Patient only spoke to primary care professional once or twice before cancer diagnosis

Q3. Referral for diagnosis was explained in a way the patient could completely understand

DIAGNOSTIC TESTS



Q5. Patient received all the information needed about the diagnostic test in advance

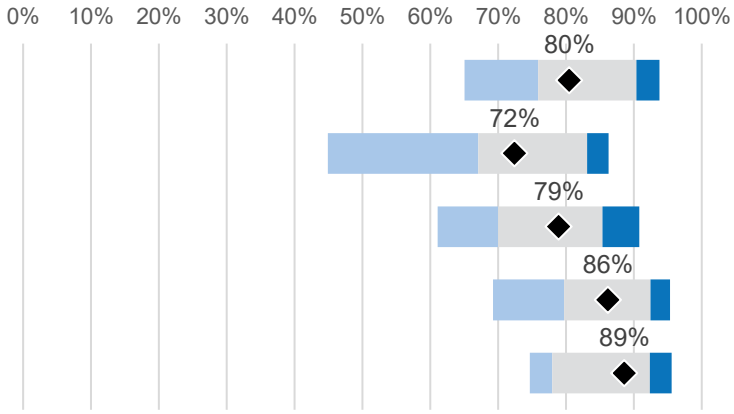
Q6. Diagnostic test staff appeared to completely have all the information they needed about the patient

Q7. Patient felt the length of time waiting for diagnostic test results was about right

Q8. Diagnostic test results were explained in a way the patient could completely understand

Q9. Enough privacy was always given to the patient when receiving diagnostic test results

FINDING OUT THAT YOU HAD CANCER



Q12. Patient was told they could have a family member, carer or friend with them when told diagnosis

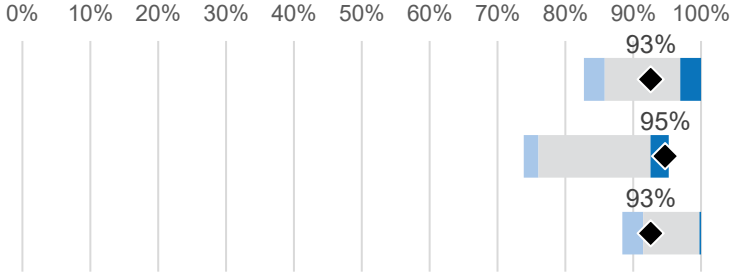
Q13. Patient was definitely told sensitively that they had cancer

Q14. Cancer diagnosis explained in a way the patient could completely understand

Q15. Patient was definitely told about their diagnosis in an appropriate place

Q16. Patient was told they could go back later for more information about their diagnosis

SUPPORT FROM A MAIN CONTACT PERSON



Q17. Patient had a main point of contact within the care team

Q18. Patient found it very or quite easy to contact their main contact person

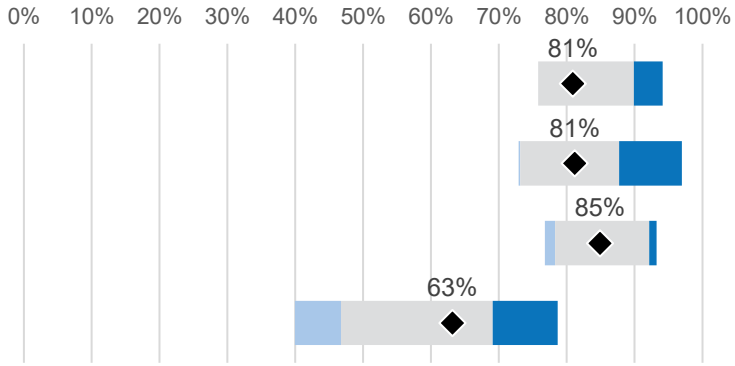
Q19. Patient found advice from main contact person was very or quite helpful

Expected range charts

Lower expected range | Within expected range | Upper expected range | Case mix adjusted score

The left outer edge of the bars is the lowest score achieved of all trusts. The right outer edge of the bars is the highest score achieved of all trusts.

DECIDING ON THE BEST TREATMENT



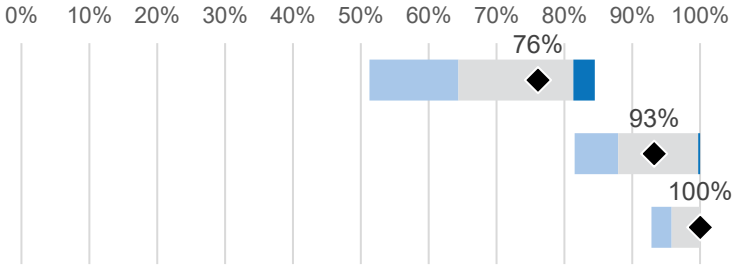
Q20. Treatment options were explained in a way the patient could completely understand

Q21. Patient was definitely involved as much as they wanted to be in decisions about their treatment

Q22. Family and / or carers were definitely involved as much as the patient wanted them to be in decisions about treatment options

Q23. Patient could get further advice from a different healthcare professional before making decisions about their treatment options

CARE PLANNING

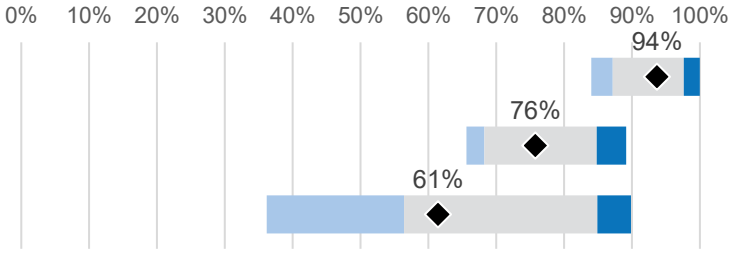


Q24. Patient was definitely able to have a discussion about their needs or concerns prior to treatment

Q25. A member of their care team helped the patient create a care plan to address any needs or concerns

Q26. Care team reviewed the patient's care plan with them to ensure it was up to date

SUPPORT FROM HOSPITAL STAFF

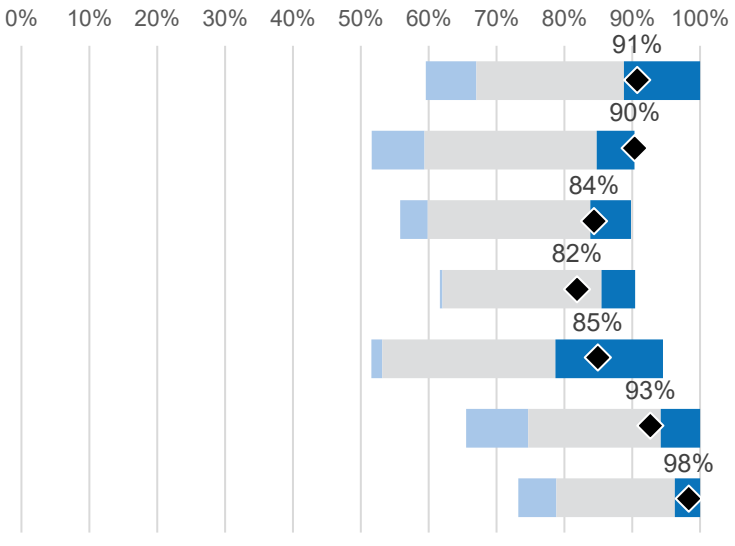


Q27. Staff provided the patient with relevant information on available support

Q28. Patient definitely got the right level of support for their overall health and well being from hospital staff

Q29. Patient was offered information about how to get financial help or benefits

HOSPITAL CARE



Q31. Patient had confidence and trust in all of the team looking after them during their stay in hospital

Q32. Patient's family, or someone close, was definitely able to talk to a member of the team looking after the patient in hospital

Q33. Patient was always involved in decisions about their care and treatment whilst in hospital

Q34. Patient was always able to get help from ward staff when needed

Q35. Patient was always able to discuss worries and fears with hospital staff

Q36. Hospital staff always did everything they could to help the patient control pain

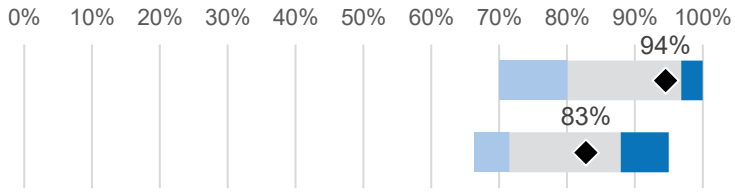
Q37. Patient was always treated with respect and dignity while in hospital

Expected range charts

Lower expected range | Within expected range | Upper expected range | Case mix adjusted score

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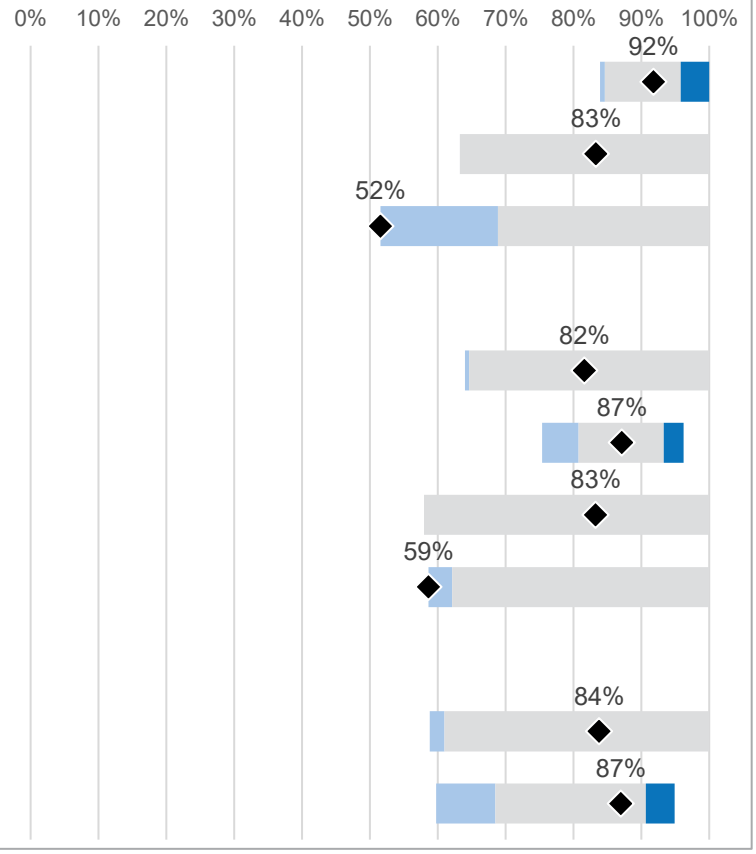
HOSPITAL CARE CONTINUED



Q38. Patient received easily understandable information about what they should or should not do after leaving hospital

Q39. Patient was always able to discuss worries and fears with hospital staff while being treated as an outpatient or day case

YOUR TREATMENT



Q41_1. Beforehand patient completely had enough understandable information about surgery

Q41_2. Beforehand patient completely had enough understandable information about chemotherapy

Q41_3. Beforehand patient completely had enough understandable information about radiotherapy

Q41_4. Beforehand patient completely had enough understandable information about hormone therapy

Q41_5. Beforehand patient completely had enough understandable information about immunotherapy

Q42_1. Patient completely had enough understandable information about their response to surgery

Q42_2. Patient completely had enough understandable information about their response to chemotherapy

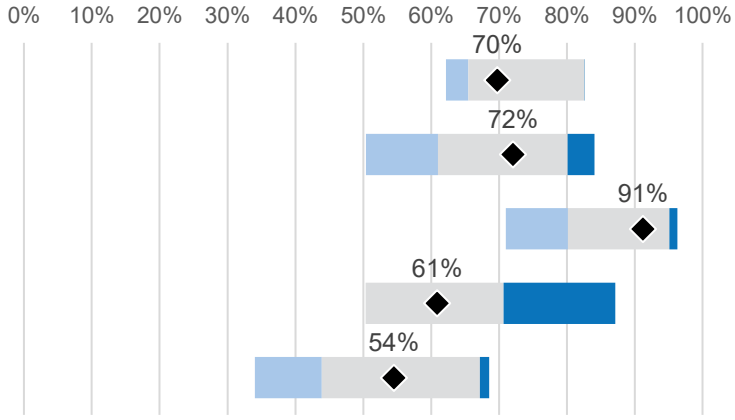
Q42_3. Patient completely had enough understandable information about their response to radiotherapy

Q42_4. Patient completely had enough understandable information about their response to hormone therapy

Q42_5. Patient completely had enough understandable information about their response to immunotherapy

Q43. Patient felt the length of waiting time at clinic and day unit for cancer treatment was about right

IMMEDIATE AND LONG-TERM SIDE EFFECTS



Q44. Possible side effects from treatment were definitely explained in a way the patient could understand

Q45. Patient was always offered practical advice on dealing with any immediate side effects from treatment

Q46. Patient was given information that they could access about support in dealing with immediate side effects from treatment

Q47. Patient felt possible long-term side effects were definitely explained in a way they could understand in advance of their treatment

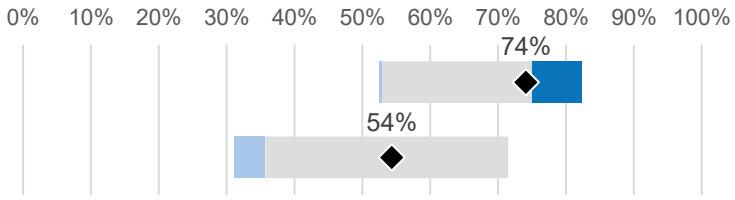
Q48. Patient was definitely able to discuss options for managing the impact of any long-term side effects

Expected range charts

Lower expected range | Within expected range | Upper expected range | Case mix adjusted score

The left outer edge of the bars is the lowest score achieved of all trusts. The right outer edge of the bars is the highest score achieved of all trusts.

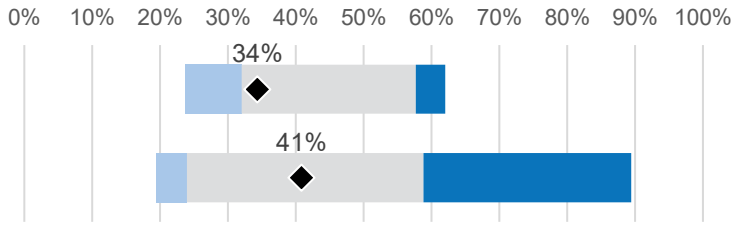
SUPPORT WHILE AT HOME



Q49. Care team gave family, or someone close, all the information needed to help care for the patient at home

Q50. During treatment, the patient definitely got enough care and support at home from community or voluntary services

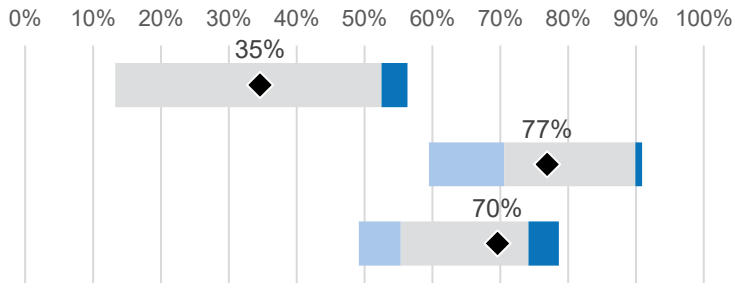
CARE FROM YOUR GP PRACTICE



Q51. Patient definitely received the help or support needed from their GP practice since their cancer diagnosis

Q52. Patient has had a cancer care review with someone from their GP practice (excluding patients who have not had a review but were diagnosed less than or around 12 months ago)

LIVING WITH AND BEYOND CANCER

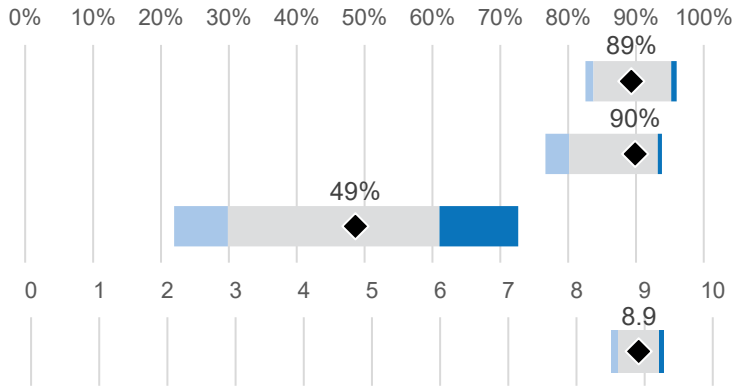


Q53. After treatment, the patient definitely could get enough emotional support at home from community or voluntary services

Q54. The right amount of information and support was offered to the patient between final treatment and the follow up appointment

Q55. Patient was given enough information about the possibility and signs of cancer coming back or spreading

YOUR OVERALL NHS CARE



Q56. The whole care team worked well together

Q57. Administration of care was very good or good

Q58. Cancer research opportunities were discussed with patient

Q59. Patient's average rating of care scored from very poor to very good

Comparability tables

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\- No score available.

▲ or ▼ Change 2024-2025: Statistically significant increase or decrease between 2024 and 2025.

△ or ▽ Change overall: Statistically significant increase or decrease from 2021 to 2025.

Adjusted score below lower expected range

Adjusted score between upper and lower expected ranges

Adjusted score above upper expected range

SUPPORT FROM YOUR GP PRACTICE	Unadjusted scores						Case mix adjusted scores			National score
	2024 n	2024 score	2025 n	2025 score	Change 2024-2025	Change overall	2025 score	Lower expected range	Upper expected range	
Q2. Patient only spoke to primary care professional once or twice before cancer diagnosis	43	**86%**	66	**86%**			**78%**	68%	88%	**78%**
Q3. Referral for diagnosis was explained in a way the patient could completely understand	58	**84%**	86	**64%**			**59%**	58%	78%	**68%**

DIAGNOSTIC TESTS	Unadjusted scores						Case mix adjusted scores			National score
	2024 n	2024 score	2025 n	2025 score	Change 2024-2025	Change overall	2025 score	Lower expected range	Upper expected range	
Q5. Patient received all the information needed about the diagnostic test in advance	52	**85%**	89	**92%**			**92%**	88%	98%	**93%**
Q6. Diagnostic test staff appeared to completely have all the information they needed about the patient	55	**84%**	91	**89%**			**88%**	77%	92%	**84%**
Q7. Patient felt the length of time waiting for diagnostic test results was about right	56	**70%**	90	**76%**			**79%**	69%	87%	**78%**
Q8. Diagnostic test results were explained in a way the patient could completely understand	56	**86%**	90	**84%**			**80%**	70%	87%	**79%**
Q9. Enough privacy was always given to the patient when receiving diagnostic test results	56	**96%**	91	**95%**			**92%**	90%	99%	**95%**

FINDING OUT THAT YOU HAD CANCER	Unadjusted scores						Case mix adjusted scores			National score
	2024 n	2024 score	2025 n	2025 score	Change 2024-2025	Change overall	2025 score	Lower expected range	Upper expected range	
Q12. Patient was told they could have a family member, carer or friend with them when told diagnosis	76	**79%**	109	**76%**		△	**80%**	76%	90%	**83%**
Q13. Patient was definitely told sensitively that they had cancer	82	**78%**	114	**75%**			**72%**	67%	83%	**75%**
Q14. Cancer diagnosis explained in a way the patient could completely understand	84	**83%**	113	**83%**			**79%**	70%	85%	**78%**
Q15. Patient was definitely told about their diagnosis in an appropriate place	83	**89%**	114	**89%**			**86%**	80%	92%	**86%**
Q16. Patient was told they could go back later for more information about their diagnosis	75	**81%**	102	**90%**			**89%**	78%	92%	**85%**

SUPPORT FROM A MAIN CONTACT PERSON	Unadjusted scores						Case mix adjusted scores			National score
	2024 n	2024 score	2025 n	2025 score	Change 2024-2025	Change overall	2025 score	Lower expected range	Upper expected range	
Q17. Patient had a main point of contact within the care team	79	**85%**	110	**92%**			**93%**	86%	97%	**91%**
Q18. Patient found it very or quite easy to contact their main contact person	58	**93%**	85	**95%**			**95%**	76%	93%	**84%**
Q19. Patient found advice from main contact person was very or quite helpful	64	**97%**	93	**94%**	▼		**93%**	91%	100%	**96%**

Comparability tables

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\- No score available.

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△ or ▽ Change overall: Statistically significant increase or decrease from 2021 to 2025.

Adjusted score below lower expected range

Adjusted score between upper and lower expected ranges

Adjusted score above upper expected range

DECIDING ON THE BEST TREATMENT	Unadjusted scores						Case mix adjusted scores			National score
	2024 n	2024 score	2025 n	2025 score	Change 2024-2025	Change overall	2025 score	Lower expected range	Upper expected range	
Q20. Treatment options were explained in a way the patient could completely understand	75	**88%**	110	**84%**			**81%**	76%	90%	**83%**
Q21. Patient was definitely involved as much as they wanted to be in decisions about their treatment	83	**83%**	114	**83%**			**81%**	73%	88%	**80%**
Q22. Family and / or carers were definitely involved as much as the patient wanted them to be in decisions about treatment options	70	**91%**	103	**85%**			**85%**	78%	92%	**85%**
Q23. Patient could get further advice from a different healthcare professional before making decisions about their treatment options	37	**68%**	75	**63%**			**63%**	47%	69%	**58%**

CARE PLANNING	Unadjusted scores						Case mix adjusted scores			National score
	2024 n	2024 score	2025 n	2025 score	Change 2024-2025	Change overall	2025 score	Lower expected range	Upper expected range	
Q24. Patient was definitely able to have a discussion about their needs or concerns prior to treatment	69	**78%**	107	**77%**			**76%**	64%	81%	**73%**
Q25. A member of their care team helped the patient create a care plan to address any needs or concerns	41	**95%**	64	**95%**			**93%**	88%	100%	**94%**
Q26. Care team reviewed the patient's care plan with them to ensure it was up to date	32	**97%**	48	**100%**			**100%**	96%	100%	**99%**

SUPPORT FROM HOSPITAL STAFF	Unadjusted scores						Case mix adjusted scores			National score
	2024 n	2024 score	2025 n	2025 score	Change 2024-2025	Change overall	2025 score	Lower expected range	Upper expected range	
Q27. Staff provided the patient with relevant information on available support	65	**95%**	98	**95%**			**94%**	87%	98%	**92%**
Q28. Patient definitely got the right level of support for their overall health and well being from hospital staff	79	**84%**	113	**79%**			**76%**	68%	85%	**77%**
Q29. Patient was offered information about how to get financial help or benefits	28	**75%**	45	**62%**			**61%**	56%	85%	**71%**

Comparability tables

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Adjusted score below lower expected range

Adjusted score between upper and lower expected ranges

Adjusted score above upper expected range

HOSPITAL CARE	Unadjusted scores						Case mix adjusted scores			National score
	2024 n	2024 score	2025 n	2025 score	Change 2024-2025	Change overall	2025 score	Lower expected range	Upper expected range	
Q31. Patient had confidence and trust in all of the team looking after them during their stay in hospital	30	**87%**	56	**89%**			**91%**	67%	89%	**78%**
Q32. Patient's family, or someone close, was definitely able to talk to a member of the team looking after the patient in hospital	28	**89%**	48	**90%**			**90%**	59%	85%	**72%**
Q33. Patient was always involved in decisions about their care and treatment whilst in hospital	30	**97%**	54	**83%**			**84%**	60%	84%	**72%**
Q34. Patient was always able to get help from ward staff when needed	30	**97%**	55	**80%**			**82%**	62%	85%	**74%**
Q35. Patient was always able to discuss worries and fears with hospital staff	30	**87%**	53	**83%**			**85%**	53%	79%	**66%**
Q36. Hospital staff always did everything they could to help the patient control pain	27	**85%**	53	**92%**			**93%**	75%	94%	**84%**
Q37. Patient was always treated with respect and dignity while in hospital	30	**97%**	55	**98%**			**98%**	79%	96%	**88%**
Q38. Patient received easily understandable information about what they should or should not do after leaving hospital	27	**96%**	56	**95%**			**94%**	80%	97%	**88%**
Q39. Patient was always able to discuss worries and fears with hospital staff while being treated as an outpatient or day case	71	**87%**	99	**84%**			**83%**	71%	88%	**80%**

YOUR TREATMENT	Unadjusted scores						Case mix adjusted scores			National score
	2024 n	2024 score	2025 n	2025 score	Change 2024-2025	Change overall	2025 score	Lower expected range	Upper expected range	
Q41_1. Beforehand patient completely had enough understandable information about surgery	78	**90%**	109	**92%**			**92%**	85%	96%	**90%**
Q41_2. Beforehand patient completely had enough understandable information about chemotherapy	*	*	10	**80%**			**83%**	63%	100%	**85%**
Q41_3. Beforehand patient completely had enough understandable information about radiotherapy	*	*	10	**50%**			**52%**	69%	100%	**89%**
Q41_4. Beforehand patient completely had enough understandable information about hormone therapy	*	*	*	*			*	*	*	**78%**
Q41_5. Beforehand patient completely had enough understandable information about immunotherapy	10	**90%**	15	**87%**			**82%**	65%	100%	**83%**
Q42_1. Patient completely had enough understandable information about their response to surgery	79	**90%**	110	**87%**			**87%**	81%	93%	**87%**
Q42_2. Patient completely had enough understandable information about their response to chemotherapy	*	*	10	**80%**			**83%**	58%	100%	**82%**
Q42_3. Patient completely had enough understandable information about their response to radiotherapy	*	*	10	**60%**			**59%**	62%	100%	**85%**
Q42_4. Patient completely had enough understandable information about their response to hormone therapy	*	*	*	*			*	*	*	**75%**
Q42_5. Patient completely had enough understandable information about their response to immunotherapy	10	**80%**	15	**87%**	▲		**84%**	61%	100%	**81%**
Q43. Patient felt the length of waiting time at clinic and day unit for cancer treatment was about right	81	**74%**	114	**88%**			**87%**	68%	91%	**80%**

Comparability tables

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Adjusted score below lower expected range

Adjusted score between upper and lower expected ranges

Adjusted score above upper expected range

IMMEDIATE AND LONG-TERM SIDE EFFECTS	Unadjusted scores						Case mix adjusted scores			National score
	2024 n	2024 score	2025 n	2025 score	Change 2024-2025	Change overall	2025 score	Lower expected range	Upper expected range	
Q44. Possible side effects from treatment were definitely explained in a way the patient could understand	67	**88%**	101	**72%**			**70%**	66%	83%	**74%**
Q45. Patient was always offered practical advice on dealing with any immediate side effects from treatment	64	**75%**	98	**74%**			**72%**	61%	80%	**71%**
Q46. Patient was given information that they could access about support in dealing with immediate side effects from treatment	56	**89%**	77	**92%**			**91%**	80%	95%	**88%**
Q47. Patient felt possible long-term side effects were definitely explained in a way they could understand in advance of their treatment	62	**81%**	90	**64%**			**61%**	50%	71%	**61%**
Q48. Patient was definitely able to discuss options for managing the impact of any long-term side effects	48	**69%**	72	**58%**			**54%**	44%	67%	**56%**

SUPPORT WHILE AT HOME	Unadjusted scores						Case mix adjusted scores			National score
	2024 n	2024 score	2025 n	2025 score	Change 2024-2025	Change overall	2025 score	Lower expected range	Upper expected range	
Q49. Care team gave family, or someone close, all the information needed to help care for the patient at home	61	**75%**	78	**77%**			**74%**	53%	75%	**64%**
Q50. During treatment, the patient definitely got enough care and support at home from community or voluntary services	28	**61%**	30	**57%**			**54%**	36%	71%	**54%**

CARE FROM YOUR GP PRACTICE	Unadjusted scores						Case mix adjusted scores			National score
	2024 n	2024 score	2025 n	2025 score	Change 2024-2025	Change overall	2025 score	Lower expected range	Upper expected range	
Q51. Patient definitely received the help or support needed from their GP practice since their cancer diagnosis	-	-	59	**37%**			**34%**	32%	58%	**45%**
Q52. Patient has had a cancer care review with someone from their GP practice (excluding patients who have not had a review but were diagnosed less than or around 12 months ago)	-	-	46	**46%**			**41%**	24%	59%	**41%**

LIVING WITH AND BEYOND CANCER	Unadjusted scores						Case mix adjusted scores			National score
	2024 N	2024 score	2025 n	2025 score	Change 2024-2025	Change overall	2025 score	Lower expected range	Upper expected range	
Q53. After treatment, the patient definitely could get enough emotional support at home from community or voluntary services	21	**29%**	22	**36%**			**35%**	13%	53%	**33%**
Q54. The right amount of information and support was offered to the patient between final treatment and the follow up appointment	57	**89%**	65	**83%**			**77%**	71%	90%	**80%**
Q55. Patient was given enough information about the possibility and signs of cancer coming back or spreading	78	**79%**	101	**78%**			**70%**	55%	74%	**65%**

Comparability tables

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▲ or ▼ Change 2024-2025: Statistically significant increase or decrease between 2024 and 2025.

△ or ▽ Change overall: Statistically significant increase or decrease from 2021 to 2025.

Adjusted score below lower expected range

Adjusted score between upper and lower expected ranges

Adjusted score above upper expected range

YOUR OVERALL NHS CARE	Unadjusted scores						Case mix adjusted scores			National score
	2024 n	2024 score	2025 n	2025 score	Change 2024-2025	Change overall	2025 score	Lower expected range	Upper expected range	
Q56. The whole care team worked well together	82	**87%**	110	**91%**			**89%**	84%	95%	**89%**
Q57. Administration of care was very good or good	84	**87%**	112	**90%**			**90%**	80%	93%	**87%**
Q58. Cancer research opportunities were discussed with patient	40	**35%**	55	**53%**			**49%**	30%	61%	**45%**
Q59. Patient's average rating of care scored from very poor to very good	81	**9.1**	111	**9**			**8.9**	8.6	9.2	**8.9**

Tumour group tables

* Indicates where a score is not available due to suppression or a low base size.

SUPPORT FROM YOUR GP PRACTICE	Tumour group													
	Brain / CNS	Breast	Colorectal / LGT	Gynaecological	Haematological	Head and neck	Lung	Prostate	Sarcoma	Skin	Upper gastro	Urological	Other	**All**
Q2. Patient only spoke to primary care professional once or twice before cancer diagnosis	*	*	*	*	*	*	*	*	*	90%	*	*	*	86%
Q3. Referral for diagnosis was explained in a way the patient could completely understand	*	*	*	*	*	*	*	*	*	67%	*	*	*	64%

DIAGNOSTIC TESTS	Tumour group													
	Brain / CNS	Breast	Colorectal / LGT	Gynaecological	Haematological	Head and neck	Lung	Prostate	Sarcoma	Skin	Upper gastro	Urological	Other	**All**
Q5. Patient received all the information needed about the diagnostic test in advance	*	*	*	*	*	*	*	*	*	91%	*	*	*	92%
Q6. Diagnostic test staff appeared to completely have all the information they needed about the patient	*	90%	*	*	*	*	*	*	*	89%	*	*	*	89%
Q7. Patient felt the length of time waiting for diagnostic test results was about right	*	70%	*	*	*	*	*	*	*	78%	*	*	*	76%
Q8. Diagnostic test results were explained in a way the patient could completely understand	*	100%	*	*	*	*	*	*	*	84%	*	*	*	84%
Q9. Enough privacy was always given to the patient when receiving diagnostic test results	*	100%	*	*	*	*	*	*	*	94%	*	*	*	95%

FINDING OUT THAT YOU HAD CANCER	Tumour group													
	Brain / CNS	Breast	Colorectal / LGT	Gynaecological	Haematological	Head and neck	Lung	Prostate	Sarcoma	Skin	Upper gastro	Urological	Other	**All**
Q12. Patient was told they could have a family member, carer or friend with them when told diagnosis	*	95%	*	*	*	*	*	*	*	70%	*	*	*	76%
Q13. Patient was definitely told sensitively that they had cancer	*	90%	*	*	*	*	*	*	*	73%	*	*	*	75%
Q14. Cancer diagnosis explained in a way the patient could completely understand	*	90%	*	*	*	*	*	*	*	84%	*	*	*	83%
Q15. Patient was definitely told about their diagnosis in an appropriate place	*	100%	*	*	*	*	*	*	*	87%	*	*	*	89%
Q16. Patient was told they could go back later for more information about their diagnosis	*	100%	*	*	*	*	*	*	*	85%	*	*	*	90%

Tumour group tables

* Indicates where a score is not available due to suppression or a low base size.

SUPPORT FROM A MAIN CONTACT PERSON	Tumour group													
	Brain / CNS	Breast	Colorectal / LGT	Gynaecological	Haematological	Head and neck	Lung	Prostate	Sarcoma	Skin	Upper gastro	Urological	Other	**All**
Q17. Patient had a main point of contact within the care team	*	85%	*	*	*	*	*	*	*	92%	*	*	*	92%
Q18. Patient found it very or quite easy to contact their main contact person	*	100%	*	*	*	*	*	*	*	98%	*	*	*	95%
Q19. Patient found advice from main contact person was very or quite helpful	*	93%	*	*	*	*	*	*	*	95%	*	*	*	94%

DECIDING ON THE BEST TREATMENT	Tumour group													
	Brain / CNS	Breast	Colorectal / LGT	Gynaecological	Haematological	Head and neck	Lung	Prostate	Sarcoma	Skin	Upper gastro	Urological	Other	**All**
Q20. Treatment options were explained in a way the patient could completely understand	*	90%	*	*	*	*	*	*	*	84%	*	*	*	84%
Q21. Patient was definitely involved as much as they wanted to be in decisions about their treatment	*	85%	*	*	*	*	*	*	*	85%	*	*	*	83%
Q22. Family and / or carers were definitely involved as much as the patient wanted them to be in decisions about treatment options	*	84%	*	*	*	*	*	*	*	85%	*	*	*	85%
Q23. Patient could get further advice from a different healthcare professional before making decisions about their treatment options	*	71%	*	*	*	*	*	*	*	65%	*	*	*	63%

CARE PLANNING	Tumour group													
	Brain / CNS	Breast	Colorectal / LGT	Gynaecological	Haematological	Head and neck	Lung	Prostate	Sarcoma	Skin	Upper gastro	Urological	Other	**All**
Q24. Patient was definitely able to have a discussion about their needs or concerns prior to treatment	*	85%	*	*	*	*	*	*	*	73%	*	*	*	77%
Q25. A member of their care team helped the patient create a care plan to address any needs or concerns	*	91%	*	*	*	*	*	*	*	98%	*	*	*	95%
Q26. Care team reviewed the patient's care plan with them to ensure it was up to date	*	*	*	*	*	*	*	*	*	100%	*	*	*	100%

SUPPORT FROM HOSPITAL STAFF	Tumour group													
	Brain / CNS	Breast	Colorectal / LGT	Gynaecological	Haematological	Head and neck	Lung	Prostate	Sarcoma	Skin	Upper gastro	Urological	Other	**All**
Q27. Staff provided the patient with relevant information on available support	*	100%	*	*	*	*	*	*	*	93%	*	*	*	95%
Q28. Patient definitely got the right level of support for their overall health and well being from hospital staff	*	79%	*	*	*	*	*	*	*	81%	*	*	*	79%
Q29. Patient was offered information about how to get financial help or benefits	*	60%	*	*	*	*	*	*	*	65%	*	*	*	62%

Tumour group tables

* Indicates where a score is not available due to suppression or a low base size.

HOSPITAL CARE	Tumour group													
	Brain / CNS	Breast	Colorectal / LGT	Gynaecological	Haematological	Head and neck	Lung	Prostate	Sarcoma	Skin	Upper gastro	Urological	Other	**All**
Q31. Patient had confidence and trust in all of the team looking after them during their stay in hospital	*	95%	*	*	*	*	*	*	*	78%	*	*	*	89%
Q32. Patient's family, or someone close, was definitely able to talk to a member of the team looking after the patient in hospital	*	88%	*	*	*	*	*	*	*	80%	*	*	*	90%
Q33. Patient was always involved in decisions about their care and treatment whilst in hospital	*	89%	*	*	*	*	*	*	*	78%	*	*	*	83%
Q34. Patient was always able to get help from ward staff when needed	*	85%	*	*	*	*	*	*	*	76%	*	*	*	80%
Q35. Patient was always able to discuss worries and fears with hospital staff	*	95%	*	*	*	*	*	*	*	73%	*	*	*	83%
Q36. Hospital staff always did everything they could to help the patient control pain	*	95%	*	*	*	*	*	*	*	81%	*	*	*	92%
Q37. Patient was always treated with respect and dignity while in hospital	*	100%	*	*	*	*	*	*	*	94%	*	*	*	98%
Q38. Patient received easily understandable information about what they should or should not do after leaving hospital	*	100%	*	*	*	*	*	*	*	83%	*	*	*	95%
Q39. Patient was always able to discuss worries and fears with hospital staff while being treated as an outpatient or day case	*	88%	*	*	*	*	*	*	*	83%	*	*	*	84%

YOUR TREATMENT	Tumour group													
	Brain / CNS	Breast	Colorectal / LGT	Gynaecological	Haematological	Head and neck	Lung	Prostate	Sarcoma	Skin	Upper gastro	Urological	Other	**All**
Q41_1. Beforehand patient completely had enough understandable information about surgery	*	100%	*	*	*	*	*	*	*	91%	*	*	*	92%
Q41_2. Beforehand patient completely had enough understandable information about chemotherapy	*	*	*	*	*	*	*	*	*	*	*	*	*	80%
Q41_3. Beforehand patient completely had enough understandable information about radiotherapy	*	*	*	*	*	*	*	*	*	*	*	*	*	50%
Q41_4. Beforehand patient completely had enough understandable information about hormone therapy	*	*	*	*	*	*	*	*	*	*	*	*	*	*
Q41_5. Beforehand patient completely had enough understandable information about immunotherapy	*	*	*	*	*	*	*	*	*	87%	*	*	*	87%
Q42_1. Patient completely had enough understandable information about their response to surgery	*	90%	*	*	*	*	*	*	*	89%	*	*	*	87%
Q42_2. Patient completely had enough understandable information about their response to chemotherapy	*	*	*	*	*	*	*	*	*	*	*	*	*	80%
Q42_3. Patient completely had enough understandable information about their response to radiotherapy	*	*	*	*	*	*	*	*	*	*	*	*	*	60%
Q42_4. Patient completely had enough understandable information about their response to hormone therapy	*	*	*	*	*	*	*	*	*	*	*	*	*	*
Q42_5. Patient completely had enough understandable information about their response to immunotherapy	*	*	*	*	*	*	*	*	*	87%	*	*	*	87%
Q43. Patient felt the length of waiting time at clinic and day unit for cancer treatment was about right	*	95%	*	*	*	*	*	*	*	84%	*	*	*	88%

Tumour group tables

* Indicates where a score is not available due to suppression or a low base size.

IMMEDIATE AND LONG-TERM SIDE EFFECTS	Tumour group													
	Brain / CNS	Breast	Colorectal / LGT	Gynaecological	Haematological	Head and neck	Lung	Prostate	Sarcoma	Skin	Upper gastro	Urological	Other	**All**
Q44. Possible side effects from treatment were definitely explained in a way the patient could understand	*	79%	*	*	*	*	*	*	*	75%	*	*	*	72%
Q45. Patient was always offered practical advice on dealing with any immediate side effects from treatment	*	72%	*	*	*	*	*	*	*	79%	*	*	*	74%
Q46. Patient was given information that they could access about support in dealing with immediate side effects from treatment	*	100%	*	*	*	*	*	*	*	91%	*	*	*	92%
Q47. Patient felt possible long-term side effects were definitely explained in a way they could understand in advance of their treatment	*	61%	*	*	*	*	*	*	*	72%	*	*	*	64%
Q48. Patient was definitely able to discuss options for managing the impact of any long-term side effects	*	69%	*	*	*	*	*	*	*	56%	*	*	*	58%

SUPPORT WHILE AT HOME	Tumour group													
	Brain / CNS	Breast	Colorectal / LGT	Gynaecological	Haematological	Head and neck	Lung	Prostate	Sarcoma	Skin	Upper gastro	Urological	Other	**All**
Q49. Care team gave family, or someone close, all the information needed to help care for the patient at home	*	78%	*	*	*	*	*	*	*	80%	*	*	*	77%
Q50. During treatment, the patient definitely got enough care and support at home from community or voluntary services	*	*	*	*	*	*	*	*	*	47%	*	*	*	57%

CARE FROM YOUR GP PRACTICE	Tumour group													
	Brain / CNS	Breast	Colorectal / LGT	Gynaecological	Haematological	Head and neck	Lung	Prostate	Sarcoma	Skin	Upper gastro	Urological	Other	**All**
Q51. Patient definitely received the help or support needed from their GP practice since their cancer diagnosis	*	*	*	*	*	*	*	*	*	38%	*	*	*	37%
Q52. Patient has had a cancer care review with someone from their GP practice (excluding patients who have not had a review but were diagnosed less than or around 12 months ago)	*	*	*	*	*	*	*	*	*	40%	*	*	*	46%

Tumour group tables

* Indicates where a score is not available due to suppression or a low base size.

LIVING WITH AND BEYOND CANCER	Tumour group													
	Brain / CNS	Breast	Colorectal / LGT	Gynaecological	Haematological	Head and neck	Lung	Prostate	Sarcoma	Skin	Upper gastro	Urological	Other	**All**
Q53. After treatment, the patient definitely could get enough emotional support at home from community or voluntary services	*	*	*	*	*	*	*	*	*	17%	*	*	*	36%
Q54. The right amount of information and support was offered to the patient between final treatment and the follow up appointment	*	*	*	*	*	*	*	*	*	84%	*	*	*	83%
Q55. Patient was given enough information about the possibility and signs of cancer coming back or spreading	*	56%	*	*	*	*	*	*	*	84%	*	*	*	78%

YOUR OVERALL NHS CARE	Tumour group													
	Brain / CNS	Breast	Colorectal / LGT	Gynaecological	Haematological	Head and neck	Lung	Prostate	Sarcoma	Skin	Upper gastro	Urological	Other	**All**
Q56. The whole care team worked well together	*	95%	*	*	*	*	*	*	*	89%	*	*	*	91%
Q57. Administration of care was very good or good	*	95%	*	*	*	*	*	*	*	88%	*	*	*	90%
Q58. Cancer research opportunities were discussed with patient	*	75%	*	*	*	*	*	*	*	51%	*	*	*	53%
Q59. Patient's average rating of care scored from very poor to very good	*	9.1	*	*	*	*	*	*	*	9	*	*	*	9

Age group tables

* Indicates where a score is not available due to suppression or a low base size.

SUPPORT FROM YOUR GP PRACTICE	Age								
	16 - 24	25 - 34	35 - 44	45 - 54	55 - 64	65 - 74	75 - 84	85+	**All**
Q2. Patient only spoke to primary care professional once or twice before cancer diagnosis	*	*	*	*	93%	88%	82%	*	86%
Q3. Referral for diagnosis was explained in a way the patient could completely understand	*	*	*	*	56%	57%	68%	54%	64%

DIAGNOSTIC TESTS	Age								
	16 - 24	25 - 34	35 - 44	45 - 54	55 - 64	65 - 74	75 - 84	85+	**All**
Q5. Patient received all the information needed about the diagnostic test in advance	*	*	*	*	100%	93%	95%	73%	92%
Q6. Diagnostic test staff appeared to completely have all the information they needed about the patient	*	*	*	*	94%	83%	90%	87%	89%
Q7. Patient felt the length of time waiting for diagnostic test results was about right	*	*	*	*	63%	80%	80%	80%	76%
Q8. Diagnostic test results were explained in a way the patient could completely understand	*	*	*	*	93%	87%	90%	73%	84%
Q9. Enough privacy was always given to the patient when receiving diagnostic test results	*	*	*	*	100%	93%	95%	87%	95%

FINDING OUT THAT YOU HAD CANCER	Age								
	16 - 24	25 - 34	35 - 44	45 - 54	55 - 64	65 - 74	75 - 84	85+	**All**
Q12. Patient was told they could have a family member, carer or friend with them when told diagnosis	*	*	*	70%	62%	88%	83%	71%	76%
Q13. Patient was definitely told sensitively that they had cancer	*	*	*	90%	73%	72%	75%	80%	75%
Q14. Cancer diagnosis explained in a way the patient could completely understand	*	*	*	90%	91%	77%	92%	67%	83%
Q15. Patient was definitely told about their diagnosis in an appropriate place	*	*	*	100%	77%	97%	88%	87%	89%
Q16. Patient was told they could go back later for more information about their diagnosis	*	*	*	100%	100%	94%	86%	71%	90%

SUPPORT FROM A MAIN CONTACT PERSON	Age								
	16 - 24	25 - 34	35 - 44	45 - 54	55 - 64	65 - 74	75 - 84	85+	**All**
Q17. Patient had a main point of contact within the care team	*	*	*	80%	95%	94%	100%	77%	92%
Q18. Patient found it very or quite easy to contact their main contact person	*	*	*	*	94%	96%	95%	*	95%
Q19. Patient found advice from main contact person was very or quite helpful	*	*	*	*	95%	93%	91%	*	94%

DECIDING ON THE BEST TREATMENT	Age								
	16 - 24	25 - 34	35 - 44	45 - 54	55 - 64	65 - 74	75 - 84	85+	**All**
Q20. Treatment options were explained in a way the patient could completely understand	*	*	*	90%	86%	82%	83%	79%	84%
Q21. Patient was definitely involved as much as they wanted to be in decisions about their treatment	*	*	*	90%	86%	92%	87%	63%	83%
Q22. Family and / or carers were definitely involved as much as the patient wanted them to be in decisions about treatment options	*	*	*	90%	80%	91%	78%	92%	85%
Q23. Patient could get further advice from a different healthcare professional before making decisions about their treatment options	*	*	*	*	71%	58%	73%	36%	63%

Age group tables

* Indicates where a score is not available due to suppression or a low base size.

CARE PLANNING	Age								
	16 - 24	25 - 34	35 - 44	45 - 54	55 - 64	65 - 74	75 - 84	85+	**All**
Q24. Patient was definitely able to have a discussion about their needs or concerns prior to treatment	*	*	*	90%	80%	76%	70%	69%	77%
Q25. A member of their care team helped the patient create a care plan to address any needs or concerns	*	*	*	*	91%	100%	94%	*	95%
Q26. Care team reviewed the patient's care plan with them to ensure it was up to date	*	*	*	*	*	100%	100%	*	100%

SUPPORT FROM HOSPITAL STAFF	Age								
	16 - 24	25 - 34	35 - 44	45 - 54	55 - 64	65 - 74	75 - 84	85+	**All**
Q27. Staff provided the patient with relevant information on available support	*	*	*	100%	100%	91%	94%	*	95%
Q28. Patient definitely got the right level of support for their overall health and well being from hospital staff	*	*	*	*	86%	83%	83%	56%	79%
Q29. Patient was offered information about how to get financial help or benefits	*	*	*	*	80%	60%	*	*	62%

HOSPITAL CARE	Age								
	16 - 24	25 - 34	35 - 44	45 - 54	55 - 64	65 - 74	75 - 84	85+	**All**
Q31. Patient had confidence and trust in all of the team looking after them during their stay in hospital	*	*	*	*	92%	95%	*	*	89%
Q32. Patient's family, or someone close, was definitely able to talk to a member of the team looking after the patient in hospital	*	*	*	*	91%	100%	*	*	90%
Q33. Patient was always involved in decisions about their care and treatment whilst in hospital	*	*	*	*	92%	86%	*	*	83%
Q34. Patient was always able to get help from ward staff when needed	*	*	*	*	83%	95%	*	*	80%
Q35. Patient was always able to discuss worries and fears with hospital staff	*	*	*	*	92%	90%	*	*	83%
Q36. Hospital staff always did everything they could to help the patient control pain	*	*	*	*	100%	100%	*	*	92%
Q37. Patient was always treated with respect and dignity while in hospital	*	*	*	*	100%	100%	*	*	98%
Q38. Patient received easily understandable information about what they should or should not do after leaving hospital	*	*	*	*	100%	100%	*	*	95%
Q39. Patient was always able to discuss worries and fears with hospital staff while being treated as an outpatient or day case	*	*	*	*	85%	93%	87%	77%	84%

Age group tables

* Indicates where a score is not available due to suppression or a low base size.

YOUR TREATMENT	Age								
	16 - 24	25 - 34	35 - 44	45 - 54	55 - 64	65 - 74	75 - 84	85+	**All**
Q41_1. Beforehand patient completely had enough understandable information about surgery	*	*	*	100%	91%	97%	91%	79%	92%
Q41_2. Beforehand patient completely had enough understandable information about chemotherapy	*	*	*	*	*	*	*	*	80%
Q41_3. Beforehand patient completely had enough understandable information about radiotherapy	*	*	*	*	*	*	*	*	50%
Q41_4. Beforehand patient completely had enough understandable information about hormone therapy	*	*	*	*	*	*	*	*	*
Q41_5. Beforehand patient completely had enough understandable information about immunotherapy	*	*	*	*	*	*	*	*	87%
Q42_1. Patient completely had enough understandable information about their response to surgery	*	*	*	90%	86%	97%	88%	64%	87%
Q42_2. Patient completely had enough understandable information about their response to chemotherapy	*	*	*	*	*	*	*	*	80%
Q42_3. Patient completely had enough understandable information about their response to radiotherapy	*	*	*	*	*	*	*	*	60%
Q42_4. Patient completely had enough understandable information about their response to hormone therapy	*	*	*	*	*	*	*	*	*
Q42_5. Patient completely had enough understandable information about their response to immunotherapy	*	*	*	*	*	*	*	*	87%
Q43. Patient felt the length of waiting time at clinic and day unit for cancer treatment was about right	*	*	*	100%	86%	92%	83%	81%	88%

IMMEDIATE AND LONG-TERM SIDE EFFECTS	Age								
	16 - 24	25 - 34	35 - 44	45 - 54	55 - 64	65 - 74	75 - 84	85+	**All**
Q44. Possible side effects from treatment were definitely explained in a way the patient could understand	*	*	*	*	76%	79%	61%	57%	72%
Q45. Patient was always offered practical advice on dealing with any immediate side effects from treatment	*	*	*	*	67%	81%	88%	62%	74%
Q46. Patient was given information that they could access about support in dealing with immediate side effects from treatment	*	*	*	*	94%	92%	88%	*	92%
Q47. Patient felt possible long-term side effects were definitely explained in a way they could understand in advance of their treatment	*	*	*	*	72%	65%	69%	42%	64%
Q48. Patient was definitely able to discuss options for managing the impact of any long-term side effects	*	*	*	*	77%	59%	60%	*	58%

SUPPORT WHILE AT HOME	Age								
	16 - 24	25 - 34	35 - 44	45 - 54	55 - 64	65 - 74	75 - 84	85+	**All**
Q49. Care team gave family, or someone close, all the information needed to help care for the patient at home	*	*	*	*	73%	71%	93%	80%	77%
Q50. During treatment, the patient definitely got enough care and support at home from community or voluntary services	*	*	*	*	*	73%	*	*	57%

CARE FROM YOUR GP PRACTICE	Age								
	16 - 24	25 - 34	35 - 44	45 - 54	55 - 64	65 - 74	75 - 84	85+	**All**
Q51. Patient definitely received the help or support needed from their GP practice since their cancer diagnosis	*	*	*	*	46%	40%	36%	*	37%
Q52. Patient has had a cancer care review with someone from their GP practice (excluding patients who have not had a review but were diagnosed less than or around 12 months ago)	*	*	*	*	10%	47%	*	*	46%

Age group tables

* Indicates where a score is not available due to suppression or a low base size.

LIVING WITH AND BEYOND CANCER	Age								
	16 - 24	25 - 34	35 - 44	45 - 54	55 - 64	65 - 74	75 - 84	85+	**All**
Q53. After treatment, the patient definitely could get enough emotional support at home from community or voluntary services	*	*	*	*	*	*	*	*	36%
Q54. The right amount of information and support was offered to the patient between final treatment and the follow up appointment	*	*	*	*	90%	78%	92%	75%	83%
Q55. Patient was given enough information about the possibility and signs of cancer coming back or spreading	*	*	*	*	85%	75%	90%	73%	78%

YOUR OVERALL NHS CARE	Age								
	16 - 24	25 - 34	35 - 44	45 - 54	55 - 64	65 - 74	75 - 84	85+	**All**
Q56. The whole care team worked well together	*	*	*	100%	95%	97%	78%	87%	91%
Q57. Administration of care was very good or good	*	*	*	100%	76%	94%	91%	94%	90%
Q58. Cancer research opportunities were discussed with patient	*	*	*	*	57%	63%	*	*	53%
Q59. Patient's average rating of care scored from very poor to very good	*	*	*	8.8	9.2	9.3	8.9	8.6	9

‘Which of the following best describes you?’ tables

* Indicates where a score is not available due to suppression or a low base size.

SUPPORT FROM YOUR GP PRACTICE	Which of the following best describes you?						
	Female	Male	Non-binary	Prefer to self-describe	Prefer not to say	Not given	**All**
Q2. Patient only spoke to primary care professional once or twice before cancer diagnosis	82%	*	*	*	*	*	86%
Q3. Referral for diagnosis was explained in a way the patient could completely understand	67%	*	*	*	*	*	64%

DIAGNOSTIC TESTS	Which of the following best describes you?						
	Female	Male	Non-binary	Prefer to self-describe	Prefer not to say	Not given	**All**
Q5. Patient received all the information needed about the diagnostic test in advance	88%	*	*	*	*	*	92%
Q6. Diagnostic test staff appeared to completely have all the information they needed about the patient	90%	*	*	*	*	*	89%
Q7. Patient felt the length of time waiting for diagnostic test results was about right	69%	*	*	*	*	*	76%
Q8. Diagnostic test results were explained in a way the patient could completely understand	79%	*	*	*	*	*	84%
Q9. Enough privacy was always given to the patient when receiving diagnostic test results	92%	*	*	*	*	*	95%

FINDING OUT THAT YOU HAD CANCER	Which of the following best describes you?						
	Female	Male	Non-binary	Prefer to self-describe	Prefer not to say	Not given	**All**
Q12. Patient was told they could have a family member, carer or friend with them when told diagnosis	69%	*	*	*	*	*	76%
Q13. Patient was definitely told sensitively that they had cancer	70%	*	*	*	*	*	75%
Q14. Cancer diagnosis explained in a way the patient could completely understand	81%	*	*	*	*	*	83%
Q15. Patient was definitely told about their diagnosis in an appropriate place	89%	*	*	*	*	*	89%
Q16. Patient was told they could go back later for more information about their diagnosis	89%	*	*	*	*	*	90%

SUPPORT FROM A MAIN CONTACT PERSON	Which of the following best describes you?						
	Female	Male	Non-binary	Prefer to self-describe	Prefer not to say	Not given	**All**
Q17. Patient had a main point of contact within the care team	92%	*	*	*	*	*	92%
Q18. Patient found it very or quite easy to contact their main contact person	96%	*	*	*	*	*	95%
Q19. Patient found advice from main contact person was very or quite helpful	96%	*	*	*	*	*	94%

‘Which of the following best describes you?’ tables

* Indicates where a score is not available due to suppression or a low base size.

DECIDING ON THE BEST TREATMENT	Which of the following best describes you?						
	Female	Male	Non-binary	Prefer to self-describe	Prefer not to say	Not given	**All**
Q20. Treatment options were explained in a way the patient could completely understand	80%	*	*	*	*	*	84%
Q21. Patient was definitely involved as much as they wanted to be in decisions about their treatment	81%	*	*	*	*	*	83%
Q22. Family and / or carers were definitely involved as much as the patient wanted them to be in decisions about treatment options	84%	*	*	*	*	*	85%
Q23. Patient could get further advice from a different healthcare professional before making decisions about their treatment options	59%	*	*	*	*	*	63%

CARE PLANNING	Which of the following best describes you?						
	Female	Male	Non-binary	Prefer to self-describe	Prefer not to say	Not given	**All**
Q24. Patient was definitely able to have a discussion about their needs or concerns prior to treatment	78%	*	*	*	*	*	77%
Q25. A member of their care team helped the patient create a care plan to address any needs or concerns	94%	*	*	*	*	*	95%
Q26. Care team reviewed the patient's care plan with them to ensure it was up to date	100%	*	*	*	*	*	100%

SUPPORT FROM HOSPITAL STAFF	Which of the following best describes you?						
	Female	Male	Non-binary	Prefer to self-describe	Prefer not to say	Not given	**All**
Q27. Staff provided the patient with relevant information on available support	90%	*	*	*	*	*	95%
Q28. Patient definitely got the right level of support for their overall health and well being from hospital staff	74%	*	*	*	*	*	79%
Q29. Patient was offered information about how to get financial help or benefits	58%	*	*	*	*	*	62%

‘Which of the following best describes you?’ tables

* Indicates where a score is not available due to suppression or a low base size.

HOSPITAL CARE	Which of the following best describes you?						
	Female	Male	Non-binary	Prefer to self-describe	Prefer not to say	Not given	**All**
Q31. Patient had confidence and trust in all of the team looking after them during their stay in hospital	91%	*	*	*	*	*	89%
Q32. Patient's family, or someone close, was definitely able to talk to a member of the team looking after the patient in hospital	90%	*	*	*	*	*	90%
Q33. Patient was always involved in decisions about their care and treatment whilst in hospital	88%	*	*	*	*	*	83%
Q34. Patient was always able to get help from ward staff when needed	77%	*	*	*	*	*	80%
Q35. Patient was always able to discuss worries and fears with hospital staff	85%	*	*	*	*	*	83%
Q36. Hospital staff always did everything they could to help the patient control pain	88%	*	*	*	*	*	92%
Q37. Patient was always treated with respect and dignity while in hospital	97%	*	*	*	*	*	98%
Q38. Patient received easily understandable information about what they should or should not do after leaving hospital	97%	*	*	*	*	*	95%
Q39. Patient was always able to discuss worries and fears with hospital staff while being treated as an outpatient or day case	80%	*	*	*	*	*	84%

YOUR TREATMENT	Which of the following best describes you?						
	Female	Male	Non-binary	Prefer to self-describe	Prefer not to say	Not given	**All**
Q41_1. Beforehand patient completely had enough understandable information about surgery	88%	*	*	*	*	*	92%
Q41_2. Beforehand patient completely had enough understandable information about chemotherapy	*	*	*	*	*	*	80%
Q41_3. Beforehand patient completely had enough understandable information about radiotherapy	*	*	*	*	*	*	50%
Q41_4. Beforehand patient completely had enough understandable information about hormone therapy	*	*	*	*	*	*	*
Q41_5. Beforehand patient completely had enough understandable information about immunotherapy	*	*	*	*	*	*	87%
Q42_1. Patient completely had enough understandable information about their response to surgery	82%	*	*	*	*	*	87%
Q42_2. Patient completely had enough understandable information about their response to chemotherapy	*	*	*	*	*	*	80%
Q42_3. Patient completely had enough understandable information about their response to radiotherapy	*	*	*	*	*	*	60%
Q42_4. Patient completely had enough understandable information about their response to hormone therapy	*	*	*	*	*	*	*
Q42_5. Patient completely had enough understandable information about their response to immunotherapy	*	*	*	*	*	*	87%
Q43. Patient felt the length of waiting time at clinic and day unit for cancer treatment was about right	86%	*	*	*	*	*	88%

‘Which of the following best describes you?’ tables

* Indicates where a score is not available due to suppression or a low base size.

IMMEDIATE AND LONG-TERM SIDE EFFECTS	Which of the following best describes you?						
	Female	Male	Non-binary	Prefer to self-describe	Prefer not to say	Not given	**All**
Q44. Possible side effects from treatment were definitely explained in a way the patient could understand	71%	*	*	*	*	*	72%
Q45. Patient was always offered practical advice on dealing with any immediate side effects from treatment	78%	*	*	*	*	*	74%
Q46. Patient was given information that they could access about support in dealing with immediate side effects from treatment	93%	*	*	*	*	*	92%
Q47. Patient felt possible long-term side effects were definitely explained in a way they could understand in advance of their treatment	64%	*	*	*	*	*	64%
Q48. Patient was definitely able to discuss options for managing the impact of any long-term side effects	59%	*	*	*	*	*	58%

SUPPORT WHILE AT HOME	Which of the following best describes you?						
	Female	Male	Non-binary	Prefer to self-describe	Prefer not to say	Not given	**All**
Q49. Care team gave family, or someone close, all the information needed to help care for the patient at home	70%	*	*	*	*	*	77%
Q50. During treatment, the patient definitely got enough care and support at home from community or voluntary services	47%	*	*	*	*	*	57%

CARE FROM YOUR GP PRACTICE	Which of the following best describes you?						
	Female	Male	Non-binary	Prefer to self-describe	Prefer not to say	Not given	**All**
Q51. Patient definitely received the help or support needed from their GP practice since their cancer diagnosis	33%	*	*	*	*	*	37%
Q52. Patient has had a cancer care review with someone from their GP practice (excluding patients who have not had a review but were diagnosed less than or around 12 months ago)	48%	*	*	*	*	*	46%

LIVING WITH AND BEYOND CANCER	Which of the following best describes you?						
	Female	Male	Non-binary	Prefer to self-describe	Prefer not to say	Not given	**All**
Q53. After treatment, the patient definitely could get enough emotional support at home from community or voluntary services	46%	*	*	*	*	*	36%
Q54. The right amount of information and support was offered to the patient between final treatment and the follow up appointment	81%	*	*	*	*	*	83%
Q55. Patient was given enough information about the possibility and signs of cancer coming back or spreading	69%	*	*	*	*	*	78%

‘Which of the following best describes you?’ tables

* Indicates where a score is not available due to suppression or a low base size.

YOUR OVERALL NHS CARE	Which of the following best describes you?						
	Female	Male	Non-binary	Prefer to self-describe	Prefer not to say	Not given	**All**
Q56. The whole care team worked well together	89%	*	*	*	*	*	91%
Q57. Administration of care was very good or good	90%	*	*	*	*	*	90%
Q58. Cancer research opportunities were discussed with patient	53%	*	*	*	*	*	53%
Q59. Patient's average rating of care scored from very poor to very good	8.8	*	*	*	*	*	9

Ethnicity tables

* Indicates where a score is not available due to suppression or a low base size.

SUPPORT FROM YOUR GP PRACTICE	Ethnicity						
	White	Mixed	Asian	Black	Other	Not given	**All**
Q2. Patient only spoke to primary care professional once or twice before cancer diagnosis	86%	*	*	*	*	*	86%
Q3. Referral for diagnosis was explained in a way the patient could completely understand	63%	*	*	*	*	*	64%

DIAGNOSTIC TESTS	Ethnicity						
	White	Mixed	Asian	Black	Other	Not given	**All**
Q5. Patient received all the information needed about the diagnostic test in advance	92%	*	*	*	*	*	92%
Q6. Diagnostic test staff appeared to completely have all the information they needed about the patient	90%	*	*	*	*	*	89%
Q7. Patient felt the length of time waiting for diagnostic test results was about right	76%	*	*	*	*	*	76%
Q8. Diagnostic test results were explained in a way the patient could completely understand	84%	*	*	*	*	*	84%
Q9. Enough privacy was always given to the patient when receiving diagnostic test results	94%	*	*	*	*	*	95%

FINDING OUT THAT YOU HAD CANCER	Ethnicity						
	White	Mixed	Asian	Black	Other	Not given	**All**
Q12. Patient was told they could have a family member, carer or friend with them when told diagnosis	76%	*	*	*	*	*	76%
Q13. Patient was definitely told sensitively that they had cancer	75%	*	*	*	*	*	75%
Q14. Cancer diagnosis explained in a way the patient could completely understand	82%	*	*	*	*	*	83%
Q15. Patient was definitely told about their diagnosis in an appropriate place	89%	*	*	*	*	*	89%
Q16. Patient was told they could go back later for more information about their diagnosis	89%	*	*	*	*	*	90%

SUPPORT FROM A MAIN CONTACT PERSON	Ethnicity						
	White	Mixed	Asian	Black	Other	Not given	**All**
Q17. Patient had a main point of contact within the care team	92%	*	*	*	*	*	92%
Q18. Patient found it very or quite easy to contact their main contact person	95%	*	*	*	*	*	95%
Q19. Patient found advice from main contact person was very or quite helpful	93%	*	*	*	*	*	94%

DECIDING ON THE BEST TREATMENT	Ethnicity						
	White	Mixed	Asian	Black	Other	Not given	**All**
Q20. Treatment options were explained in a way the patient could completely understand	83%	*	*	*	*	*	84%
Q21. Patient was definitely involved as much as they wanted to be in decisions about their treatment	83%	*	*	*	*	*	83%
Q22. Family and / or carers were definitely involved as much as the patient wanted them to be in decisions about treatment options	85%	*	*	*	*	*	85%
Q23. Patient could get further advice from a different healthcare professional before making decisions about their treatment options	62%	*	*	*	*	*	63%

Ethnicity tables

* Indicates where a score is not available due to suppression or a low base size.

CARE PLANNING	Ethnicity						
	White	Mixed	Asian	Black	Other	Not given	**All**
Q24. Patient was definitely able to have a discussion about their needs or concerns prior to treatment	76%	*	*	*	*	*	77%
Q25. A member of their care team helped the patient create a care plan to address any needs or concerns	95%	*	*	*	*	*	95%
Q26. Care team reviewed the patient's care plan with them to ensure it was up to date	100%	*	*	*	*	*	100%

SUPPORT FROM HOSPITAL STAFF	Ethnicity						
	White	Mixed	Asian	Black	Other	Not given	**All**
Q27. Staff provided the patient with relevant information on available support	95%	*	*	*	*	*	95%
Q28. Patient definitely got the right level of support for their overall health and well being from hospital staff	78%	*	*	*	*	*	79%
Q29. Patient was offered information about how to get financial help or benefits	63%	*	*	*	*	*	62%

HOSPITAL CARE	Ethnicity						
	White	Mixed	Asian	Black	Other	Not given	**All**
Q31. Patient had confidence and trust in all of the team looking after them during their stay in hospital	88%	*	*	*	*	*	89%
Q32. Patient's family, or someone close, was definitely able to talk to a member of the team looking after the patient in hospital	89%	*	*	*	*	*	90%
Q33. Patient was always involved in decisions about their care and treatment whilst in hospital	82%	*	*	*	*	*	83%
Q34. Patient was always able to get help from ward staff when needed	80%	*	*	*	*	*	80%
Q35. Patient was always able to discuss worries and fears with hospital staff	82%	*	*	*	*	*	83%
Q36. Hospital staff always did everything they could to help the patient control pain	92%	*	*	*	*	*	92%
Q37. Patient was always treated with respect and dignity while in hospital	98%	*	*	*	*	*	98%
Q38. Patient received easily understandable information about what they should or should not do after leaving hospital	94%	*	*	*	*	*	95%
Q39. Patient was always able to discuss worries and fears with hospital staff while being treated as an outpatient or day case	83%	*	*	*	*	*	84%

Ethnicity tables

* Indicates where a score is not available due to suppression or a low base size.

YOUR TREATMENT	Ethnicity						
	White	Mixed	Asian	Black	Other	Not given	**All**
Q41_1. Beforehand patient completely had enough understandable information about surgery	91%	*	*	*	*	*	92%
Q41_2. Beforehand patient completely had enough understandable information about chemotherapy	*	*	*	*	*	*	80%
Q41_3. Beforehand patient completely had enough understandable information about radiotherapy	50%	*	*	*	*	*	50%
Q41_4. Beforehand patient completely had enough understandable information about hormone therapy	*	*	*	*	*	*	*
Q41_5. Beforehand patient completely had enough understandable information about immunotherapy	86%	*	*	*	*	*	87%
Q42_1. Patient completely had enough understandable information about their response to surgery	86%	*	*	*	*	*	87%
Q42_2. Patient completely had enough understandable information about their response to chemotherapy	*	*	*	*	*	*	80%
Q42_3. Patient completely had enough understandable information about their response to radiotherapy	60%	*	*	*	*	*	60%
Q42_4. Patient completely had enough understandable information about their response to hormone therapy	*	*	*	*	*	*	*
Q42_5. Patient completely had enough understandable information about their response to immunotherapy	86%	*	*	*	*	*	87%
Q43. Patient felt the length of waiting time at clinic and day unit for cancer treatment was about right	88%	*	*	*	*	*	88%

IMMEDIATE AND LONG-TERM SIDE EFFECTS	Ethnicity						
	White	Mixed	Asian	Black	Other	Not given	**All**
Q44. Possible side effects from treatment were definitely explained in a way the patient could understand	72%	*	*	*	*	*	72%
Q45. Patient was always offered practical advice on dealing with any immediate side effects from treatment	75%	*	*	*	*	*	74%
Q46. Patient was given information that they could access about support in dealing with immediate side effects from treatment	92%	*	*	*	*	*	92%
Q47. Patient felt possible long-term side effects were definitely explained in a way they could understand in advance of their treatment	65%	*	*	*	*	*	64%
Q48. Patient was definitely able to discuss options for managing the impact of any long-term side effects	59%	*	*	*	*	*	58%

SUPPORT WHILE AT HOME	Ethnicity						
	White	Mixed	Asian	Black	Other	Not given	**All**
Q49. Care team gave family, or someone close, all the information needed to help care for the patient at home	76%	*	*	*	*	*	77%
Q50. During treatment, the patient definitely got enough care and support at home from community or voluntary services	57%	*	*	*	*	*	57%

CARE FROM YOUR GP PRACTICE	Ethnicity						
	White	Mixed	Asian	Black	Other	Not given	**All**
Q51. Patient definitely received the help or support needed from their GP practice since their cancer diagnosis	38%	*	*	*	*	*	37%
Q52. Patient has had a cancer care review with someone from their GP practice (excluding patients who have not had a review but were diagnosed less than or around 12 months ago)	45%	*	*	*	*	*	46%

Ethnicity tables

* Indicates where a score is not available due to suppression or a low base size.

LIVING WITH AND BEYOND CANCER	Ethnicity						
	White	Mixed	Asian	Black	Other	Not given	**All**
Q53. After treatment, the patient definitely could get enough emotional support at home from community or voluntary services	40%	*	*	*	*	*	36%
Q54. The right amount of information and support was offered to the patient between final treatment and the follow up appointment	82%	*	*	*	*	*	83%
Q55. Patient was given enough information about the possibility and signs of cancer coming back or spreading	77%	*	*	*	*	*	78%

YOUR OVERALL NHS CARE	Ethnicity						
	White	Mixed	Asian	Black	Other	Not given	**All**
Q56. The whole care team worked well together	90%	*	*	*	*	*	91%
Q57. Administration of care was very good or good	90%	*	*	*	*	*	90%
Q58. Cancer research opportunities were discussed with patient	51%	*	*	*	*	*	53%
Q59. Patient's average rating of care scored from very poor to very good	9	*	*	*	*	*	9

IMD quintile tables

* Indicates where a score is not available due to suppression or a low base size.

SUPPORT FROM YOUR GP PRACTICE	IMD quintile						
	1 (most deprived)	2	3	4	5 (least deprived)	Non-England	**All**
Q2. Patient only spoke to primary care professional once or twice before cancer diagnosis	*	*	93%	86%	81%	*	86%
Q3. Referral for diagnosis was explained in a way the patient could completely understand	*	*	53%	79%	58%	*	64%

DIAGNOSTIC TESTS	IMD quintile						
	1 (most deprived)	2	3	4	5 (least deprived)	Non-England	**All**
Q5. Patient received all the information needed about the diagnostic test in advance	*	*	88%	97%	89%	*	92%
Q6. Diagnostic test staff appeared to completely have all the information they needed about the patient	*	*	94%	97%	83%	*	89%
Q7. Patient felt the length of time waiting for diagnostic test results was about right	*	*	82%	73%	76%	*	76%
Q8. Diagnostic test results were explained in a way the patient could completely understand	*	*	71%	94%	86%	*	84%
Q9. Enough privacy was always given to the patient when receiving diagnostic test results	*	*	100%	97%	90%	*	95%

FINDING OUT THAT YOU HAD CANCER	IMD quintile						
	1 (most deprived)	2	3	4	5 (least deprived)	Non-England	**All**
Q12. Patient was told they could have a family member, carer or friend with them when told diagnosis	*	*	75%	83%	73%	*	76%
Q13. Patient was definitely told sensitively that they had cancer	*	*	57%	89%	74%	*	75%
Q14. Cancer diagnosis explained in a way the patient could completely understand	*	*	86%	86%	82%	*	83%
Q15. Patient was definitely told about their diagnosis in an appropriate place	*	*	95%	89%	89%	*	89%
Q16. Patient was told they could go back later for more information about their diagnosis	*	*	89%	91%	90%	*	90%

SUPPORT FROM A MAIN CONTACT PERSON	IMD quintile						
	1 (most deprived)	2	3	4	5 (least deprived)	Non-England	**All**
Q17. Patient had a main point of contact within the care team	*	*	95%	89%	88%	*	92%
Q18. Patient found it very or quite easy to contact their main contact person	*	*	88%	100%	92%	*	95%
Q19. Patient found advice from main contact person was very or quite helpful	*	*	94%	97%	89%	*	94%

IMD quintile tables

* Indicates where a score is not available due to suppression or a low base size.

DECIDING ON THE BEST TREATMENT	IMD quintile						
	1 (most deprived)	2	3	4	5 (least deprived)	Non-England	**All**
Q20. Treatment options were explained in a way the patient could completely understand	*	*	83%	92%	77%	*	84%
Q21. Patient was definitely involved as much as they wanted to be in decisions about their treatment	*	*	85%	95%	75%	*	83%
Q22. Family and / or carers were definitely involved as much as the patient wanted them to be in decisions about treatment options	*	*	100%	89%	80%	*	85%
Q23. Patient could get further advice from a different healthcare professional before making decisions about their treatment options	*	*	67%	63%	61%	*	63%

CARE PLANNING	IMD quintile						
	1 (most deprived)	2	3	4	5 (least deprived)	Non-England	**All**
Q24. Patient was definitely able to have a discussion about their needs or concerns prior to treatment	*	*	89%	78%	71%	*	77%
Q25. A member of their care team helped the patient create a care plan to address any needs or concerns	*	*	100%	100%	85%	*	95%
Q26. Care team reviewed the patient's care plan with them to ensure it was up to date	*	*	100%	100%	100%	*	100%

SUPPORT FROM HOSPITAL STAFF	IMD quintile						
	1 (most deprived)	2	3	4	5 (least deprived)	Non-England	**All**
Q27. Staff provided the patient with relevant information on available support	*	*	94%	94%	97%	*	95%
Q28. Patient definitely got the right level of support for their overall health and well being from hospital staff	*	*	76%	89%	71%	*	79%
Q29. Patient was offered information about how to get financial help or benefits	*	*	*	69%	59%	*	62%

HOSPITAL CARE	IMD quintile						
	1 (most deprived)	2	3	4	5 (least deprived)	Non-England	**All**
Q31. Patient had confidence and trust in all of the team looking after them during their stay in hospital	*	*	*	89%	82%	*	89%
Q32. Patient's family, or someone close, was definitely able to talk to a member of the team looking after the patient in hospital	*	*	*	100%	75%	*	90%
Q33. Patient was always involved in decisions about their care and treatment whilst in hospital	*	*	*	89%	76%	*	83%
Q34. Patient was always able to get help from ward staff when needed	*	*	*	89%	71%	*	80%
Q35. Patient was always able to discuss worries and fears with hospital staff	*	*	*	84%	84%	*	83%
Q36. Hospital staff always did everything they could to help the patient control pain	*	*	*	100%	85%	*	92%
Q37. Patient was always treated with respect and dignity while in hospital	*	*	*	100%	95%	*	98%
Q38. Patient received easily understandable information about what they should or should not do after leaving hospital	*	*	*	95%	91%	*	95%
Q39. Patient was always able to discuss worries and fears with hospital staff while being treated as an outpatient or day case	*	*	88%	91%	77%	*	84%

IMD quintile tables

* Indicates where a score is not available due to suppression or a low base size.

YOUR TREATMENT	IMD quintile						
	1 (most deprived)	2	3	4	5 (least deprived)	Non-England	**All**
Q41_1. Beforehand patient completely had enough understandable information about surgery	*	*	90%	94%	89%	*	92%
Q41_2. Beforehand patient completely had enough understandable information about chemotherapy	*	*	*	*	*	*	80%
Q41_3. Beforehand patient completely had enough understandable information about radiotherapy	*	*	*	*	*	*	50%
Q41_4. Beforehand patient completely had enough understandable information about hormone therapy	*	*	*	*	*	*	*
Q41_5. Beforehand patient completely had enough understandable information about immunotherapy	*	*	*	*	*	*	87%
Q42_1. Patient completely had enough understandable information about their response to surgery	*	*	85%	89%	83%	*	87%
Q42_2. Patient completely had enough understandable information about their response to chemotherapy	*	*	*	*	*	*	80%
Q42_3. Patient completely had enough understandable information about their response to radiotherapy	*	*	*	*	*	*	60%
Q42_4. Patient completely had enough understandable information about their response to hormone therapy	*	*	*	*	*	*	*
Q42_5. Patient completely had enough understandable information about their response to immunotherapy	*	*	*	*	*	*	87%
Q43. Patient felt the length of waiting time at clinic and day unit for cancer treatment was about right	*	*	90%	81%	86%	*	88%

IMMEDIATE AND LONG-TERM SIDE EFFECTS	IMD quintile						
	1 (most deprived)	2	3	4	5 (least deprived)	Non-England	**All**
Q44. Possible side effects from treatment were definitely explained in a way the patient could understand	*	*	65%	78%	68%	*	72%
Q45. Patient was always offered practical advice on dealing with any immediate side effects from treatment	*	*	78%	78%	68%	*	74%
Q46. Patient was given information that they could access about support in dealing with immediate side effects from treatment	*	*	93%	96%	92%	*	92%
Q47. Patient felt possible long-term side effects were definitely explained in a way they could understand in advance of their treatment	*	*	59%	68%	62%	*	64%
Q48. Patient was definitely able to discuss options for managing the impact of any long-term side effects	*	*	60%	65%	48%	*	58%

SUPPORT WHILE AT HOME	IMD quintile						
	1 (most deprived)	2	3	4	5 (least deprived)	Non-England	**All**
Q49. Care team gave family, or someone close, all the information needed to help care for the patient at home	*	*	77%	87%	57%	*	77%
Q50. During treatment, the patient definitely got enough care and support at home from community or voluntary services	*	*	*	*	*	*	57%

CARE FROM YOUR GP PRACTICE	IMD quintile						
	1 (most deprived)	2	3	4	5 (least deprived)	Non-England	**All**
Q51. Patient definitely received the help or support needed from their GP practice since their cancer diagnosis	*	*	50%	53%	25%	*	37%
Q52. Patient has had a cancer care review with someone from their GP practice (excluding patients who have not had a review but were diagnosed less than or around 12 months ago)	*	*	50%	36%	47%	*	46%

IMD quintile tables

* Indicates where a score is not available due to suppression or a low base size.

LIVING WITH AND BEYOND CANCER	IMD quintile						
	1 (most deprived)	2	3	4	5 (least deprived)	Non-England	**All**
Q53. After treatment, the patient definitely could get enough emotional support at home from community or voluntary services	*	*	*	*	*	*	36%
Q54. The right amount of information and support was offered to the patient between final treatment and the follow up appointment	*	*	100%	79%	70%	*	83%
Q55. Patient was given enough information about the possibility and signs of cancer coming back or spreading	*	*	68%	71%	83%	*	78%

YOUR OVERALL NHS CARE	IMD quintile						
	1 (most deprived)	2	3	4	5 (least deprived)	Non-England	**All**
Q56. The whole care team worked well together	*	*	90%	95%	88%	*	91%
Q57. Administration of care was very good or good	*	*	100%	92%	88%	*	90%
Q58. Cancer research opportunities were discussed with patient	*	*	73%	38%	46%	*	53%
Q59. Patient's average rating of care scored from very poor to very good	*	*	9.4	9.1	8.5	*	9

Long-term condition status tables

* Indicates where a score is not available due to suppression or a low base size.

SUPPORT FROM YOUR GP PRACTICE	Long-term condition status			
	Yes	No	Not given	**All**
Q2. Patient only spoke to primary care professional once or twice before cancer diagnosis	89%	81%	*	86%
Q3. Referral for diagnosis was explained in a way the patient could completely understand	57%	70%	*	64%

DIAGNOSTIC TESTS	Long-term condition status			
	Yes	No	Not given	**All**
Q5. Patient received all the information needed about the diagnostic test in advance	90%	94%	*	92%
Q6. Diagnostic test staff appeared to completely have all the information they needed about the patient	89%	91%	*	89%
Q7. Patient felt the length of time waiting for diagnostic test results was about right	81%	69%	*	76%
Q8. Diagnostic test results were explained in a way the patient could completely understand	79%	90%	*	84%
Q9. Enough privacy was always given to the patient when receiving diagnostic test results	94%	94%	*	95%

FINDING OUT THAT YOU HAD CANCER	Long-term condition status			
	Yes	No	Not given	**All**
Q12. Patient was told they could have a family member, carer or friend with them when told diagnosis	85%	64%	*	76%
Q13. Patient was definitely told sensitively that they had cancer	72%	80%	*	75%
Q14. Cancer diagnosis explained in a way the patient could completely understand	77%	91%	*	83%
Q15. Patient was definitely told about their diagnosis in an appropriate place	89%	91%	*	89%
Q16. Patient was told they could go back later for more information about their diagnosis	87%	95%	*	90%

SUPPORT FROM A MAIN CONTACT PERSON	Long-term condition status			
	Yes	No	Not given	**All**
Q17. Patient had a main point of contact within the care team	92%	91%	*	92%
Q18. Patient found it very or quite easy to contact their main contact person	93%	97%	*	95%
Q19. Patient found advice from main contact person was very or quite helpful	92%	95%	*	94%

DECIDING ON THE BEST TREATMENT	Long-term condition status			
	Yes	No	Not given	**All**
Q20. Treatment options were explained in a way the patient could completely understand	79%	91%	*	84%
Q21. Patient was definitely involved as much as they wanted to be in decisions about their treatment	77%	91%	*	83%
Q22. Family and / or carers were definitely involved as much as the patient wanted them to be in decisions about treatment options	84%	88%	*	85%
Q23. Patient could get further advice from a different healthcare professional before making decisions about their treatment options	57%	68%	*	63%

Long-term condition status tables

* Indicates where a score is not available due to suppression or a low base size.

CARE PLANNING	Long-term condition status			
	Yes	No	Not given	**All**
Q24. Patient was definitely able to have a discussion about their needs or concerns prior to treatment	73%	81%	*	77%
Q25. A member of their care team helped the patient create a care plan to address any needs or concerns	97%	92%	*	95%
Q26. Care team reviewed the patient's care plan with them to ensure it was up to date	100%	100%	*	100%

SUPPORT FROM HOSPITAL STAFF	Long-term condition status			
	Yes	No	Not given	**All**
Q27. Staff provided the patient with relevant information on available support	94%	95%	*	95%
Q28. Patient definitely got the right level of support for their overall health and well being from hospital staff	75%	81%	*	79%
Q29. Patient was offered information about how to get financial help or benefits	65%	57%	*	62%

HOSPITAL CARE	Long-term condition status			
	Yes	No	Not given	**All**
Q31. Patient had confidence and trust in all of the team looking after them during their stay in hospital	91%	86%	*	89%
Q32. Patient's family, or someone close, was definitely able to talk to a member of the team looking after the patient in hospital	89%	89%	*	90%
Q33. Patient was always involved in decisions about their care and treatment whilst in hospital	81%	85%	*	83%
Q34. Patient was always able to get help from ward staff when needed	84%	73%	*	80%
Q35. Patient was always able to discuss worries and fears with hospital staff	79%	86%	*	83%
Q36. Hospital staff always did everything they could to help the patient control pain	93%	91%	*	92%
Q37. Patient was always treated with respect and dignity while in hospital	100%	95%	*	98%
Q38. Patient received easily understandable information about what they should or should not do after leaving hospital	94%	95%	*	95%
Q39. Patient was always able to discuss worries and fears with hospital staff while being treated as an outpatient or day case	80%	87%	*	84%

Long-term condition status tables

* Indicates where a score is not available due to suppression or a low base size.

YOUR TREATMENT	Long-term condition status			
	Yes	No	Not given	**All**
Q41_1. Beforehand patient completely had enough understandable information about surgery	89%	95%	*	92%
Q41_2. Beforehand patient completely had enough understandable information about chemotherapy	*	*	*	80%
Q41_3. Beforehand patient completely had enough understandable information about radiotherapy	*	*	*	50%
Q41_4. Beforehand patient completely had enough understandable information about hormone therapy	*	*	*	*
Q41_5. Beforehand patient completely had enough understandable information about immunotherapy	*	80%	*	87%
Q42_1. Patient completely had enough understandable information about their response to surgery	84%	90%	*	87%
Q42_2. Patient completely had enough understandable information about their response to chemotherapy	*	*	*	80%
Q42_3. Patient completely had enough understandable information about their response to radiotherapy	*	*	*	60%
Q42_4. Patient completely had enough understandable information about their response to hormone therapy	*	*	*	*
Q42_5. Patient completely had enough understandable information about their response to immunotherapy	*	80%	*	87%
Q43. Patient felt the length of waiting time at clinic and day unit for cancer treatment was about right	86%	91%	*	88%

IMMEDIATE AND LONG-TERM SIDE EFFECTS	Long-term condition status			
	Yes	No	Not given	**All**
Q44. Possible side effects from treatment were definitely explained in a way the patient could understand	70%	76%	*	72%
Q45. Patient was always offered practical advice on dealing with any immediate side effects from treatment	71%	81%	*	74%
Q46. Patient was given information that they could access about support in dealing with immediate side effects from treatment	90%	94%	*	92%
Q47. Patient felt possible long-term side effects were definitely explained in a way they could understand in advance of their treatment	58%	76%	*	64%
Q48. Patient was definitely able to discuss options for managing the impact of any long-term side effects	53%	65%	*	58%

SUPPORT WHILE AT HOME	Long-term condition status			
	Yes	No	Not given	**All**
Q49. Care team gave family, or someone close, all the information needed to help care for the patient at home	75%	76%	*	77%
Q50. During treatment, the patient definitely got enough care and support at home from community or voluntary services	53%	*	*	57%

CARE FROM YOUR GP PRACTICE	Long-term condition status			
	Yes	No	Not given	**All**
Q51. Patient definitely received the help or support needed from their GP practice since their cancer diagnosis	33%	43%	*	37%
Q52. Patient has had a cancer care review with someone from their GP practice (excluding patients who have not had a review but were diagnosed less than or around 12 months ago)	48%	44%	*	46%

Long-term condition status tables

* Indicates where a score is not available due to suppression or a low base size.

LIVING WITH AND BEYOND CANCER	Long-term condition status			
	Yes	No	Not given	**All**
Q53. After treatment, the patient definitely could get enough emotional support at home from community or voluntary services	38%	*	*	36%
Q54. The right amount of information and support was offered to the patient between final treatment and the follow up appointment	76%	92%	*	83%
Q55. Patient was given enough information about the possibility and signs of cancer coming back or spreading	76%	79%	*	78%

YOUR OVERALL NHS CARE	Long-term condition status			
	Yes	No	Not given	**All**
Q56. The whole care team worked well together	89%	93%	*	91%
Q57. Administration of care was very good or good	89%	91%	*	90%
Q58. Cancer research opportunities were discussed with patient	48%	57%	*	53%
Q59. Patient's average rating of care scored from very poor to very good	9	8.9	*	9

Impact of long-term condition(s) (excluding cancer) on day-to-day activities tables

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† Please note: the 'All' column shows the overall score including all cases within the organisation. The impact of long-term condition(s) (excluding cancer) on day-to-day activities breakdown is based on a routed question, so figures may not align.

SUPPORT FROM YOUR GP PRACTICE	Impact of long-term condition(s) (excluding cancer) on day-to-day activities				
	A lot	A little	Not at all	Not given	**All** †
Q2. Patient only spoke to primary care professional once or twice before cancer diagnosis	*	91%	92%	*	86%
Q3. Referral for diagnosis was explained in a way the patient could completely understand	42%	50%	71%	*	64%

DIAGNOSTIC TESTS	Impact of long-term condition(s) (excluding cancer) on day-to-day activities				
	A lot	A little	Not at all	Not given	**All**
Q5. Patient received all the information needed about the diagnostic test in advance	82%	89%	100%	*	92%
Q6. Diagnostic test staff appeared to completely have all the information they needed about the patient	82%	80%	100%	*	89%
Q7. Patient felt the length of time waiting for diagnostic test results was about right	82%	80%	86%	*	76%
Q8. Diagnostic test results were explained in a way the patient could completely understand	73%	75%	87%	*	84%
Q9. Enough privacy was always given to the patient when receiving diagnostic test results	82%	95%	100%	*	95%

FINDING OUT THAT YOU HAD CANCER	Impact of long-term condition(s) (excluding cancer) on day-to-day activities				
	A lot	A little	Not at all	Not given	**All**
Q12. Patient was told they could have a family member, carer or friend with them when told diagnosis	79%	88%	87%	*	76%
Q13. Patient was definitely told sensitively that they had cancer	64%	74%	69%	*	75%
Q14. Cancer diagnosis explained in a way the patient could completely understand	64%	78%	81%	*	83%
Q15. Patient was definitely told about their diagnosis in an appropriate place	86%	96%	75%	*	89%
Q16. Patient was told they could go back later for more information about their diagnosis	85%	88%	93%	*	90%

SUPPORT FROM A MAIN CONTACT PERSON	Impact of long-term condition(s) (excluding cancer) on day-to-day activities				
	A lot	A little	Not at all	Not given	**All**
Q17. Patient had a main point of contact within the care team	92%	89%	93%	*	92%
Q18. Patient found it very or quite easy to contact their main contact person	*	94%	91%	*	95%
Q19. Patient found advice from main contact person was very or quite helpful	*	95%	86%	*	94%

DECIDING ON THE BEST TREATMENT	Impact of long-term condition(s) (excluding cancer) on day-to-day activities				
	A lot	A little	Not at all	Not given	**All**
Q20. Treatment options were explained in a way the patient could completely understand	62%	85%	81%	*	84%
Q21. Patient was definitely involved as much as they wanted to be in decisions about their treatment	53%	81%	88%	*	83%
Q22. Family and / or carers were definitely involved as much as the patient wanted them to be in decisions about treatment options	67%	91%	80%	*	85%
Q23. Patient could get further advice from a different healthcare professional before making decisions about their treatment options	50%	50%	60%	*	63%

Impact of long-term condition(s) (excluding cancer) on day-to-day activities tables

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† Please note: the 'All' column shows the overall score including all cases within the organisation. The impact of long-term condition(s) (excluding cancer) on day-to-day activities breakdown is based on a routed question, so figures may not align.

CARE PLANNING	Impact of long-term condition(s) (excluding cancer) on day-to-day activities				
	A lot	A little	Not at all	Not given	**All †**
Q24. Patient was definitely able to have a discussion about their needs or concerns prior to treatment	58%	81%	63%	*	77%
Q25. A member of their care team helped the patient create a care plan to address any needs or concerns	*	100%	*	*	95%
Q26. Care team reviewed the patient's care plan with them to ensure it was up to date	*	100%	*	*	100%

SUPPORT FROM HOSPITAL STAFF	Impact of long-term condition(s) (excluding cancer) on day-to-day activities				
	A lot	A little	Not at all	Not given	**All**
Q27. Staff provided the patient with relevant information on available support	92%	100%	100%	*	95%
Q28. Patient definitely got the right level of support for their overall health and well being from hospital staff	47%	85%	81%	*	79%
Q29. Patient was offered information about how to get financial help or benefits	*	*	*	*	62%

HOSPITAL CARE	Impact of long-term condition(s) (excluding cancer) on day-to-day activities				
	A lot	A little	Not at all	Not given	**All**
Q31. Patient had confidence and trust in all of the team looking after them during their stay in hospital	*	100%	*	*	89%
Q32. Patient's family, or someone close, was definitely able to talk to a member of the team looking after the patient in hospital	*	86%	*	*	90%
Q33. Patient was always involved in decisions about their care and treatment whilst in hospital	*	88%	*	*	83%
Q34. Patient was always able to get help from ward staff when needed	*	100%	*	*	80%
Q35. Patient was always able to discuss worries and fears with hospital staff	*	94%	*	*	83%
Q36. Hospital staff always did everything they could to help the patient control pain	*	94%	*	*	92%
Q37. Patient was always treated with respect and dignity while in hospital	*	100%	*	*	98%
Q38. Patient received easily understandable information about what they should or should not do after leaving hospital	*	100%	*	*	95%
Q39. Patient was always able to discuss worries and fears with hospital staff while being treated as an outpatient or day case	67%	87%	79%	*	84%

Impact of long-term condition(s) (excluding cancer) on day-to-day activities tables

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YOUR TREATMENT	Impact of long-term condition(s) (excluding cancer) on day-to-day activities				
	A lot	A little	Not at all	Not given	**All †**
Q41_1. Beforehand patient completely had enough understandable information about surgery	79%	100%	88%	*	92%
Q41_2. Beforehand patient completely had enough understandable information about chemotherapy	*	*	*	*	80%
Q41_3. Beforehand patient completely had enough understandable information about radiotherapy	*	*	*	*	50%
Q41_4. Beforehand patient completely had enough understandable information about hormone therapy	*	*	*	*	*
Q41_5. Beforehand patient completely had enough understandable information about immunotherapy	*	*	*	*	87%
Q42_1. Patient completely had enough understandable information about their response to surgery	71%	92%	88%	*	87%
Q42_2. Patient completely had enough understandable information about their response to chemotherapy	*	*	*	*	80%
Q42_3. Patient completely had enough understandable information about their response to radiotherapy	*	*	*	*	60%
Q42_4. Patient completely had enough understandable information about their response to hormone therapy	*	*	*	*	*
Q42_5. Patient completely had enough understandable information about their response to immunotherapy	*	*	*	*	87%
Q43. Patient felt the length of waiting time at clinic and day unit for cancer treatment was about right	87%	88%	81%	*	88%

IMMEDIATE AND LONG-TERM SIDE EFFECTS	Impact of long-term condition(s) (excluding cancer) on day-to-day activities				
	A lot	A little	Not at all	Not given	**All**
Q44. Possible side effects from treatment were definitely explained in a way the patient could understand	64%	78%	63%	*	72%
Q45. Patient was always offered practical advice on dealing with any immediate side effects from treatment	67%	69%	77%	*	74%
Q46. Patient was given information that they could access about support in dealing with immediate side effects from treatment	*	87%	100%	*	92%
Q47. Patient felt possible long-term side effects were definitely explained in a way they could understand in advance of their treatment	55%	64%	46%	*	64%
Q48. Patient was definitely able to discuss options for managing the impact of any long-term side effects	*	67%	*	*	58%

SUPPORT WHILE AT HOME	Impact of long-term condition(s) (excluding cancer) on day-to-day activities				
	A lot	A little	Not at all	Not given	**All**
Q49. Care team gave family, or someone close, all the information needed to help care for the patient at home	58%	76%	90%	*	77%
Q50. During treatment, the patient definitely got enough care and support at home from community or voluntary services	*	70%	*	*	57%

Impact of long-term condition(s) (excluding cancer) on day-to-day activities tables

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CARE FROM YOUR GP PRACTICE	Impact of long-term condition(s) (excluding cancer) on day-to-day activities				
	A lot	A little	Not at all	Not given	**All †**
Q51. Patient definitely received the help or support needed from their GP practice since their cancer diagnosis	*	25%	*	*	37%
Q52. Patient has had a cancer care review with someone from their GP practice (excluding patients who have not had a review but were diagnosed less than or around 12 months ago)	*	*	*	*	46%

LIVING WITH AND BEYOND CANCER	Impact of long-term condition(s) (excluding cancer) on day-to-day activities				
	A lot	A little	Not at all	Not given	**All**
Q53. After treatment, the patient definitely could get enough emotional support at home from community or voluntary services	*	*	*	*	36%
Q54. The right amount of information and support was offered to the patient between final treatment and the follow up appointment	50%	87%	*	*	83%
Q55. Patient was given enough information about the possibility and signs of cancer coming back or spreading	86%	78%	80%	*	78%

YOUR OVERALL NHS CARE	Impact of long-term condition(s) (excluding cancer) on day-to-day activities				
	A lot	A little	Not at all	Not given	**All**
Q56. The whole care team worked well together	86%	93%	87%	*	91%
Q57. Administration of care was very good or good	80%	96%	87%	*	90%
Q58. Cancer research opportunities were discussed with patient	*	*	*	*	53%
Q59. Patient's average rating of care scored from very poor to very good	8.6	9.2	8.9	*	9

Year on year charts

* Indicates where a score is not available due to suppression or a low base size.

\- No score available.

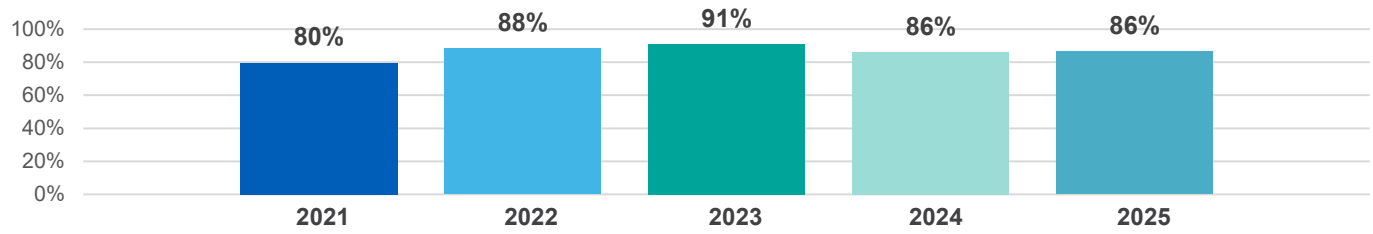
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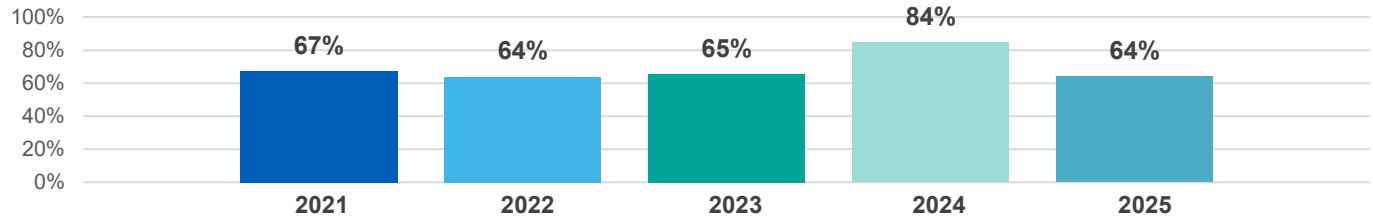
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SUPPORT FROM YOUR GP PRACTICE

Q2. Patient only spoke to primary care professional once or twice before cancer diagnosis

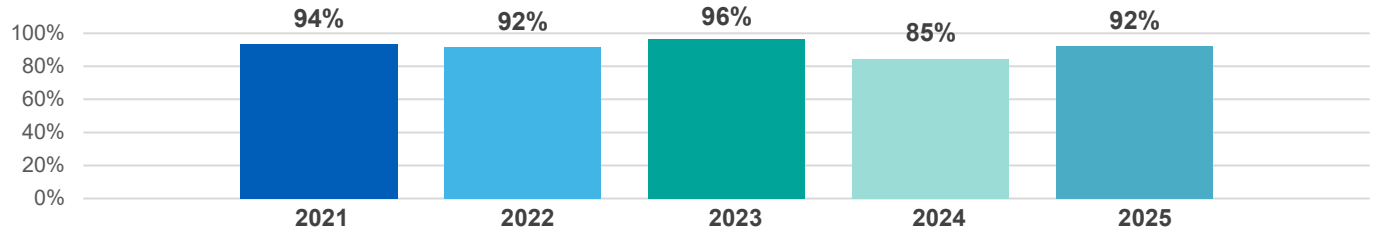


Q3. Referral for diagnosis was explained in a way the patient could completely understand

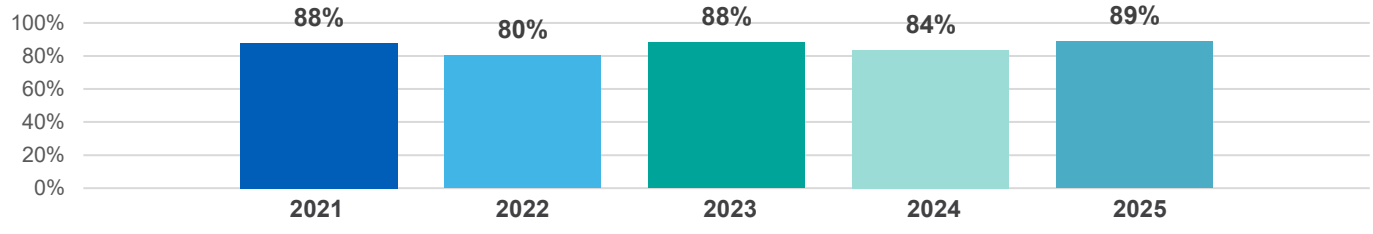


DIAGNOSTIC TESTS

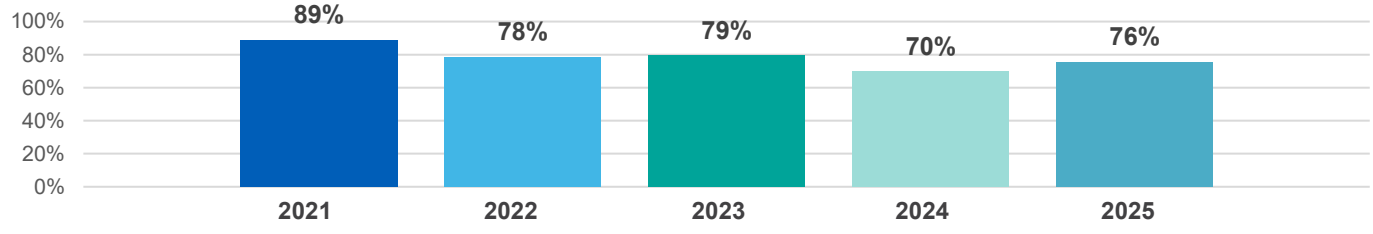
Q5. Patient received all the information needed about the diagnostic test in advance



Q6. Diagnostic test staff appeared to completely have all the information they needed about the patient



Q7. Patient felt the length of time waiting for diagnostic test results was about right



Year on year charts

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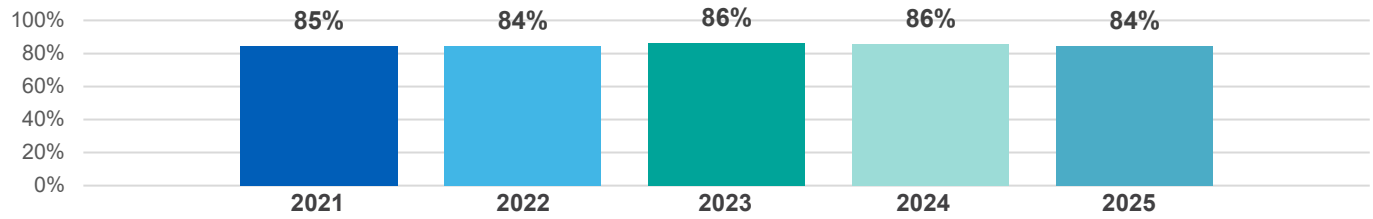
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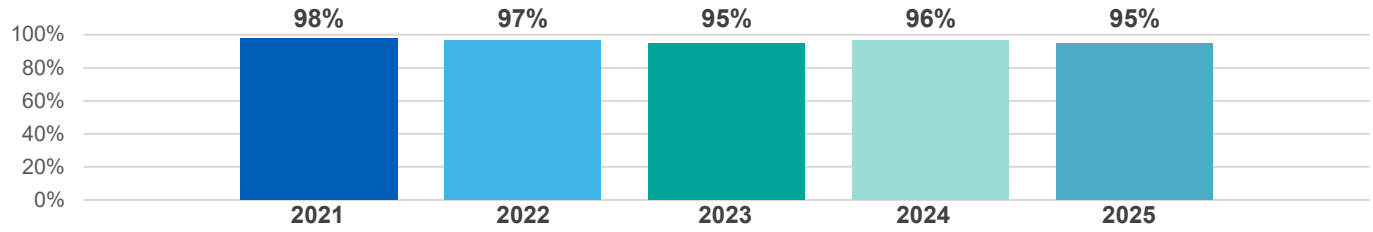
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Q8. Diagnostic test results were explained in a way the patient could completely understand

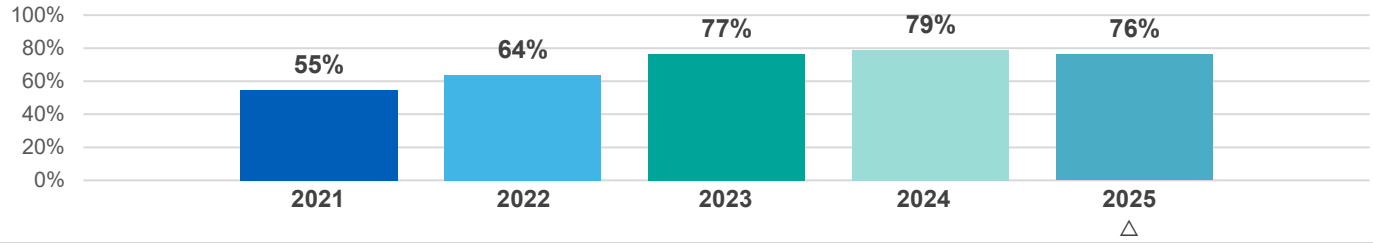


Q9. Enough privacy was always given to the patient when receiving diagnostic test results

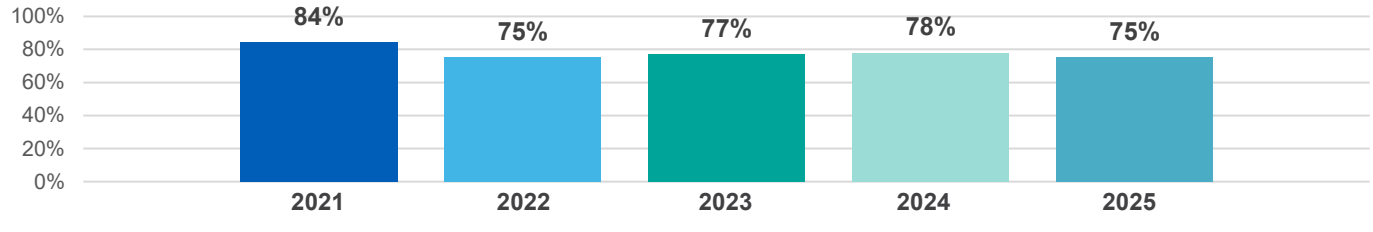


FINDING OUT THAT YOU HAD CANCER

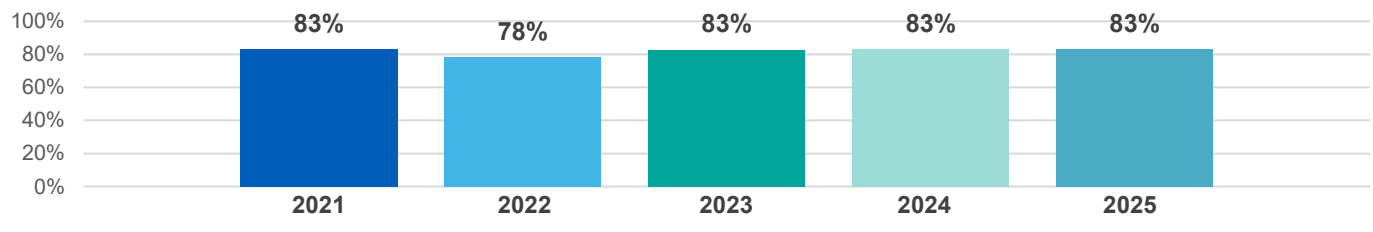
Q12. Patient was told they could have a family member, carer or friend with them when told diagnosis



Q13. Patient was definitely told sensitively that they had cancer



Q14. Cancer diagnosis explained in a way the patient could completely understand



Year on year charts

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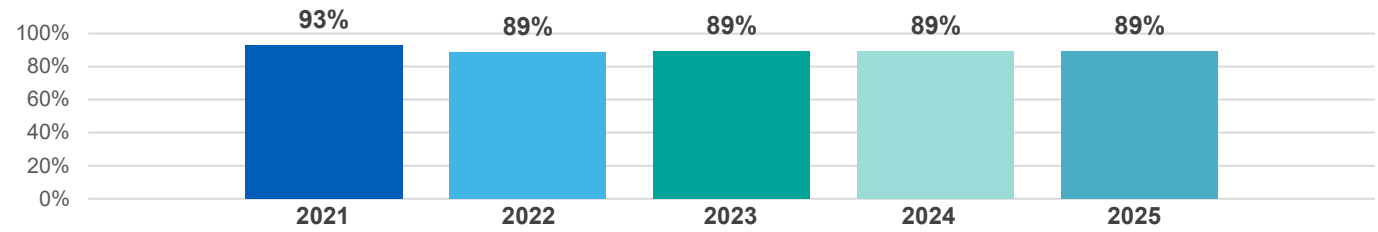
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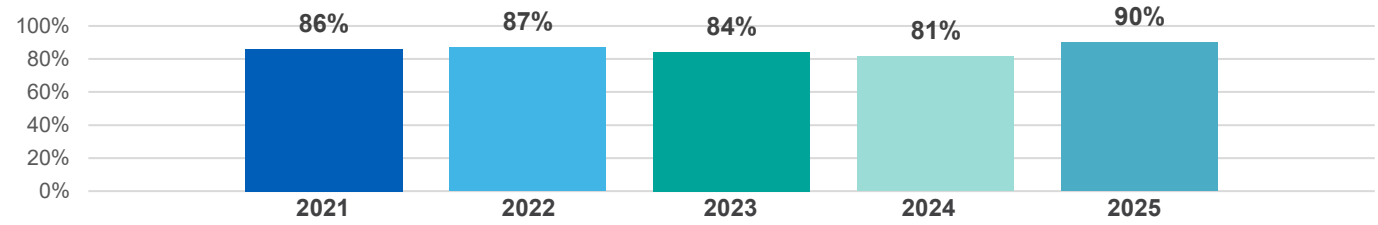
▲ or ▼ Statistically significant increase or decrease between 2024 and 2025

△ or ▽ Statistically significant increase or decrease from 2021 to 2025

Q15. Patient was definitely told about their diagnosis in an appropriate place

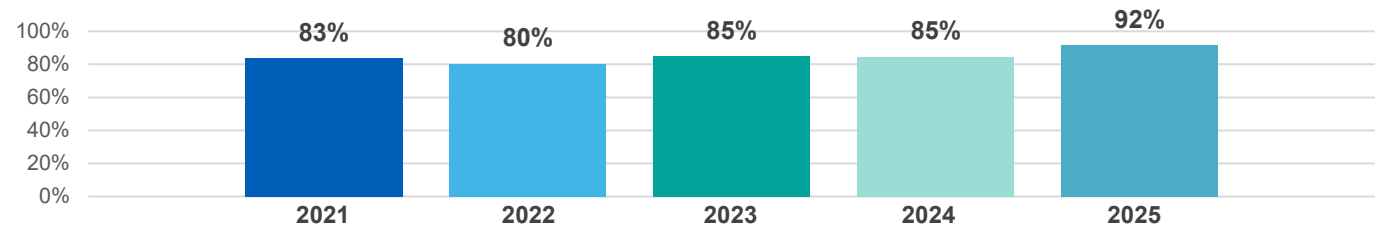


Q16. Patient was told they could go back later for more information about their diagnosis

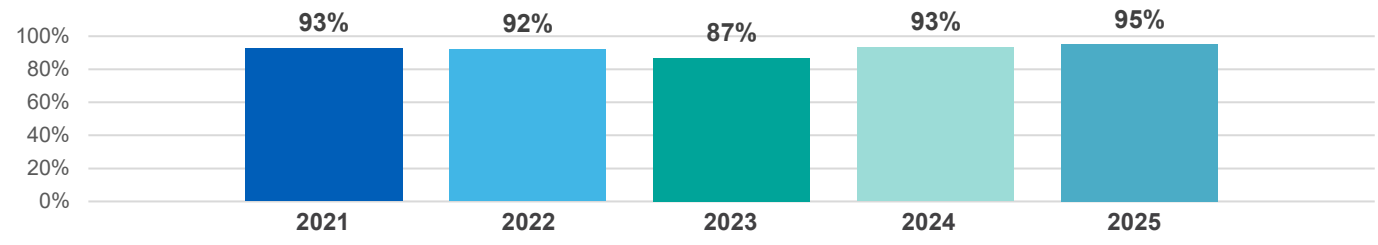


SUPPORT FROM A MAIN CONTACT PERSON

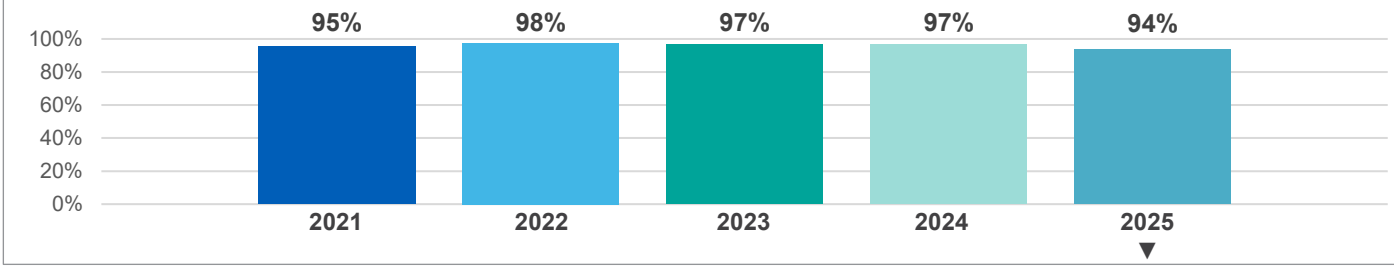
Q17. Patient had a main point of contact within the care team



Q18. Patient found it very or quite easy to contact their main contact person



Q19. Patient found advice from main contact person was very or quite helpful



Year on year charts

* Indicates where a score is not available due to suppression or a low base size.

\- No score available.

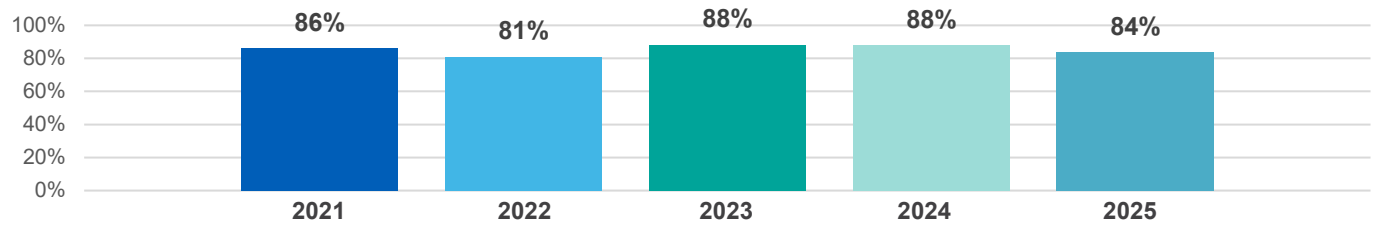
The scores are unadjusted and based on England scores only.

▲ or ▼ Statistically significant increase or decrease between 2024 and 2025

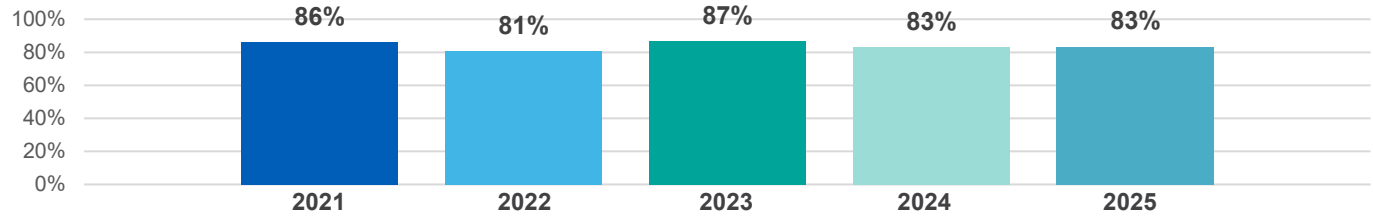
△ or ▽ Statistically significant increase or decrease from 2021 to 2025

DECIDING ON THE BEST TREATMENT

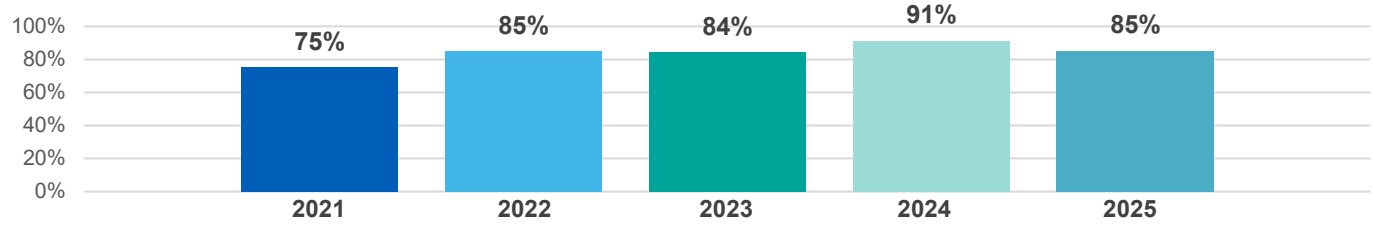
Q20. Treatment options were explained in a way the patient could completely understand



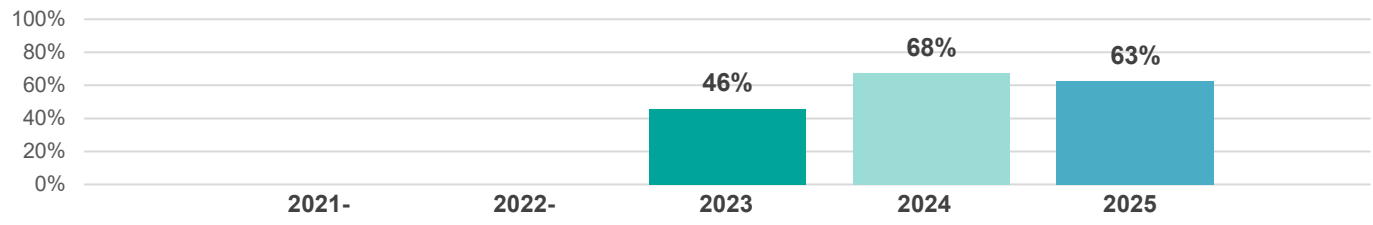
Q21. Patient was definitely involved as much as they wanted to be in decisions about their treatment



Q22. Family and / or carers were definitely involved as much as the patient wanted them to be in decisions about treatment options

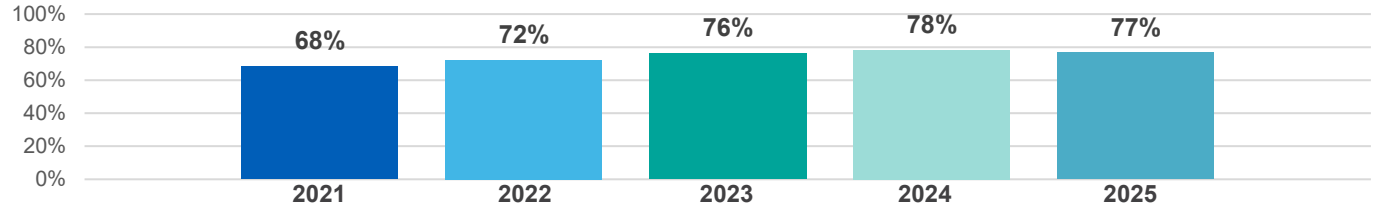


Q23. Patient could get further advice from a different healthcare professional before making decisions about their treatment options



CARE PLANNING

Q24. Patient was definitely able to have a discussion about their needs or concerns prior to treatment



Back to start

Year on year charts

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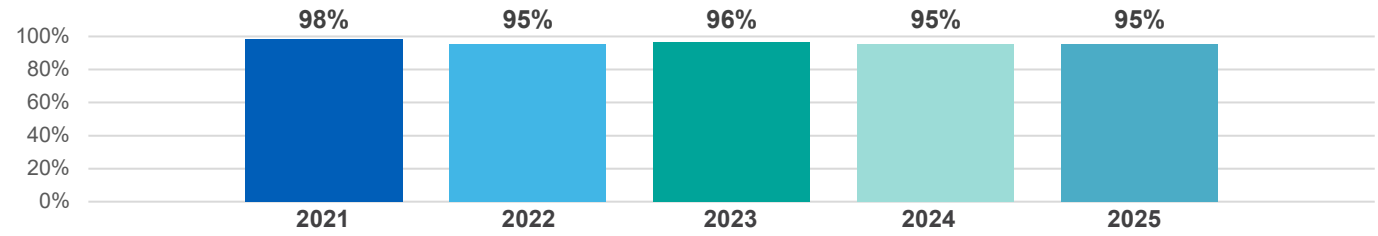
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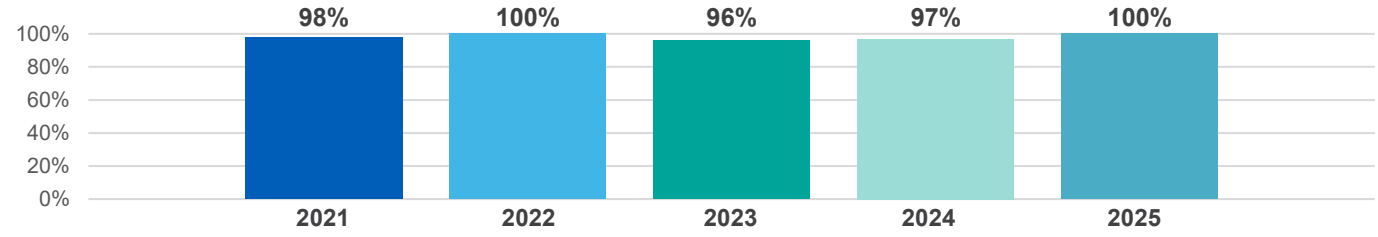
▲ or ▼ Statistically significant increase or decrease between 2024 and 2025

△ or ▽ Statistically significant increase or decrease from 2021 to 2025

Q25. A member of their care team helped the patient create a care plan to address any needs or concerns

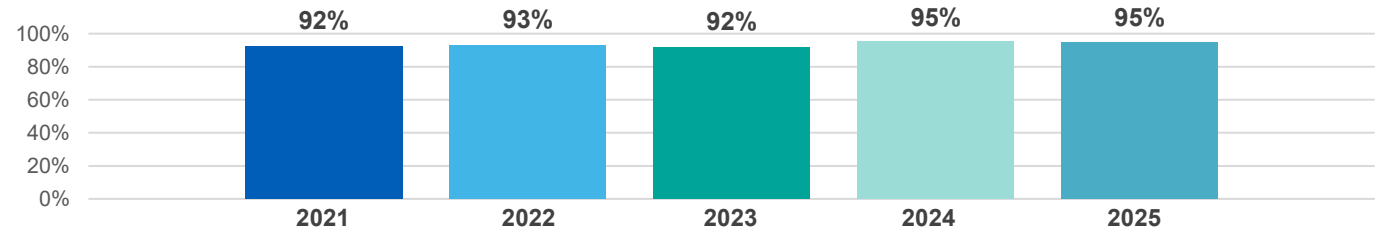


Q26. Care team reviewed the patient's care plan with them to ensure it was up to date

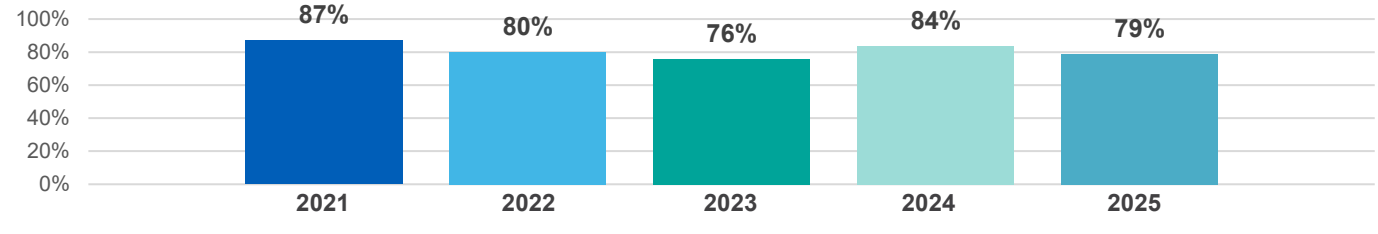


SUPPORT FROM HOSPITAL STAFF

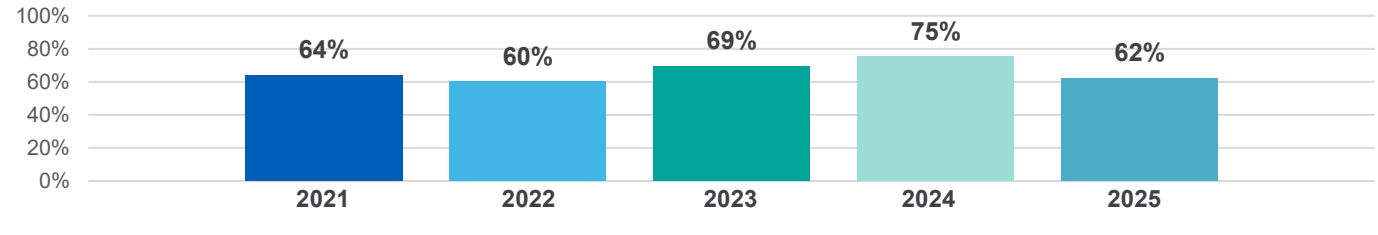
Q27. Staff provided the patient with relevant information on available support



Q28. Patient definitely got the right level of support for their overall health and well being from hospital staff



Q29. Patient was offered information about how to get financial help or benefits

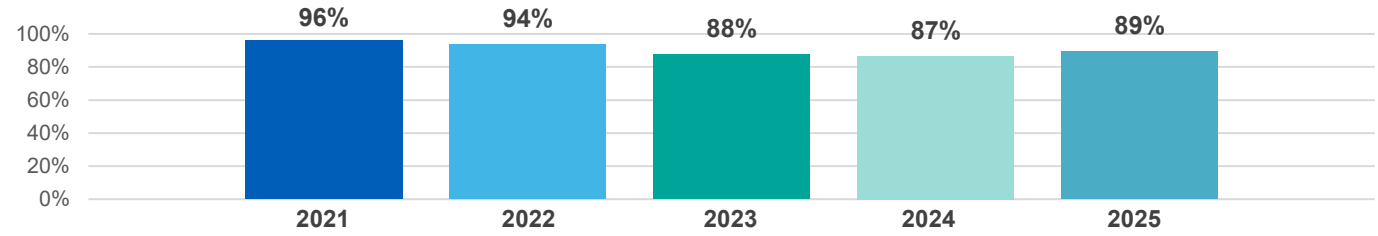


Year on year charts

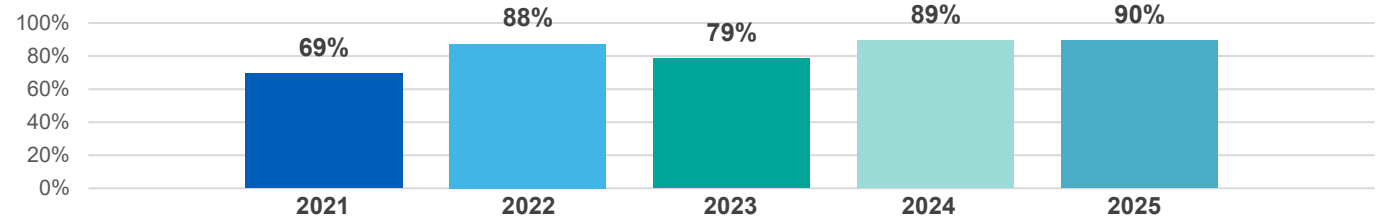
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HOSPITAL CARE

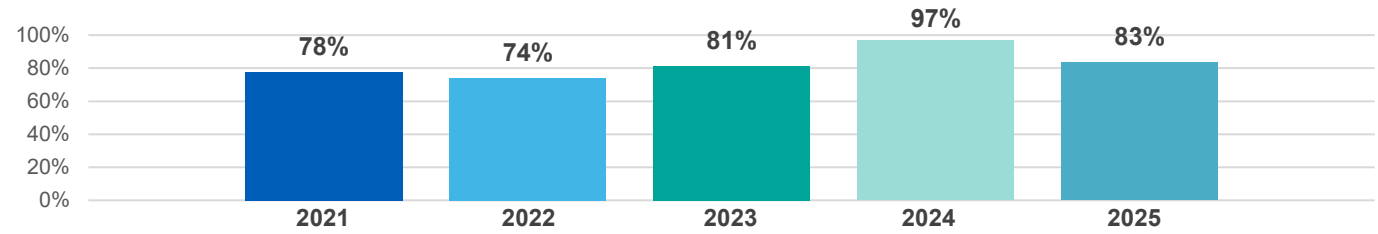
Q31. Patient had confidence and trust in all of the team looking after them during their stay in hospital



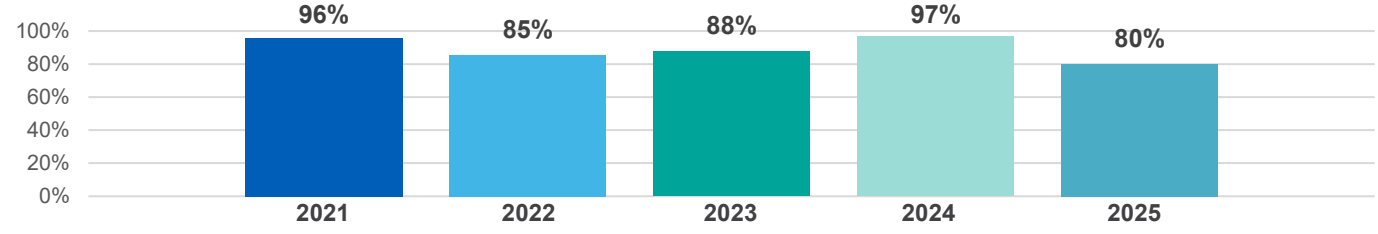
Q32. Patient's family, or someone close, was definitely able to talk to a member of the team looking after the patient in hospital



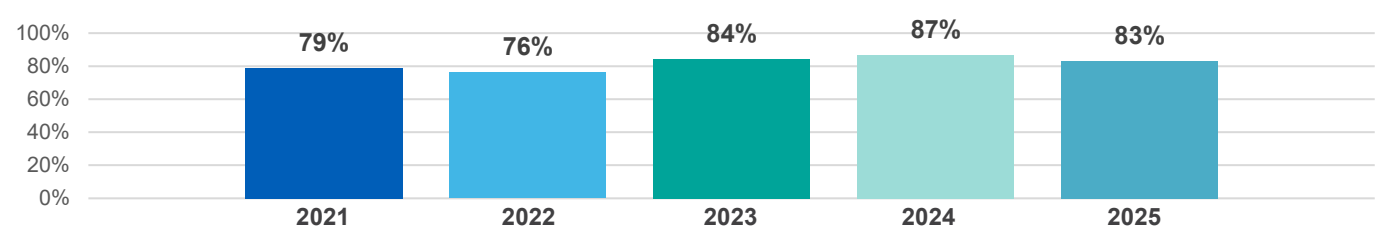
Q33. Patient was always involved in decisions about their care and treatment whilst in hospital



Q34. Patient was always able to get help from ward staff when needed



Q35. Patient was always able to discuss worries and fears with hospital staff



Year on year charts

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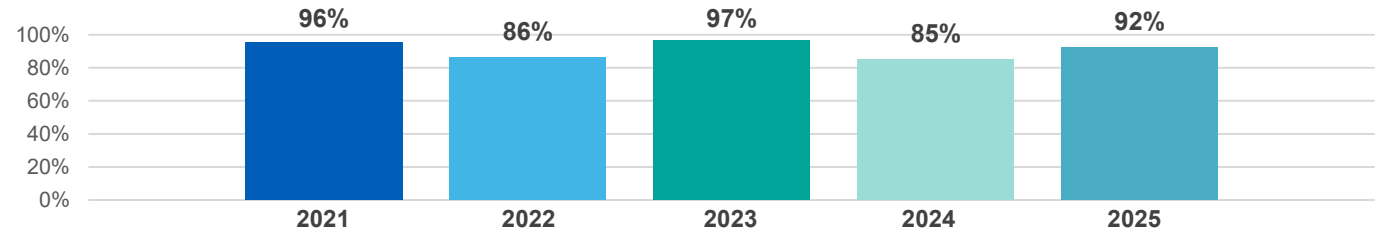
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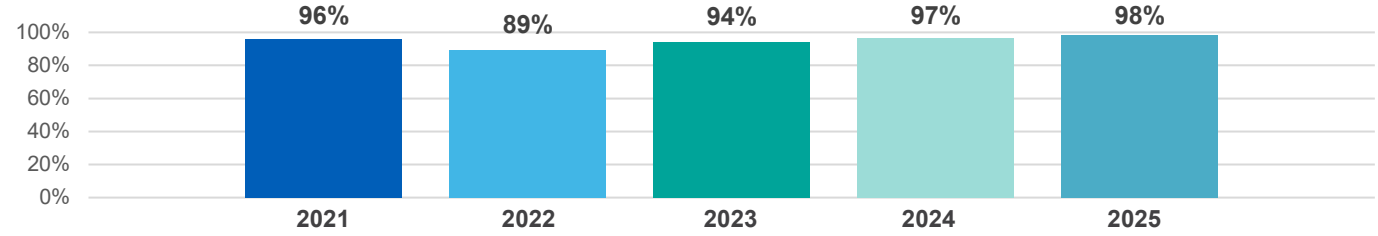
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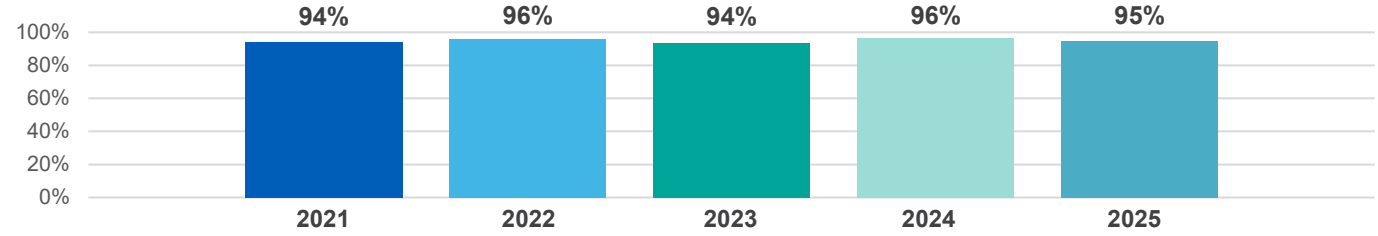
Q36. Hospital staff always did everything they could to help the patient control pain



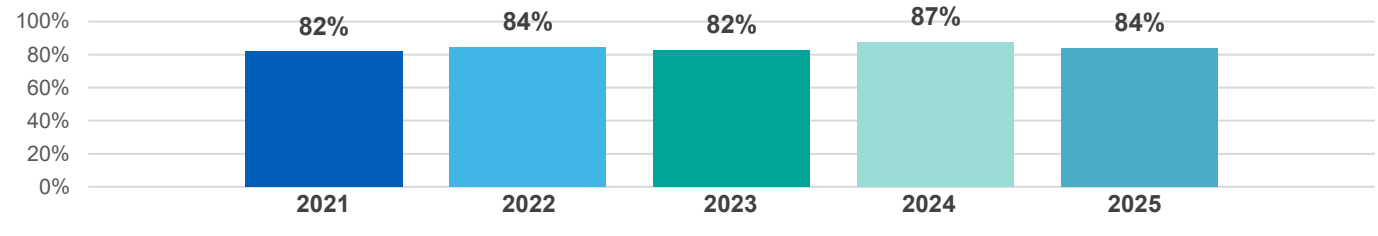
Q37. Patient was always treated with respect and dignity while in hospital



Q38. Patient received easily understandable information about what they should or should not do after leaving hospital

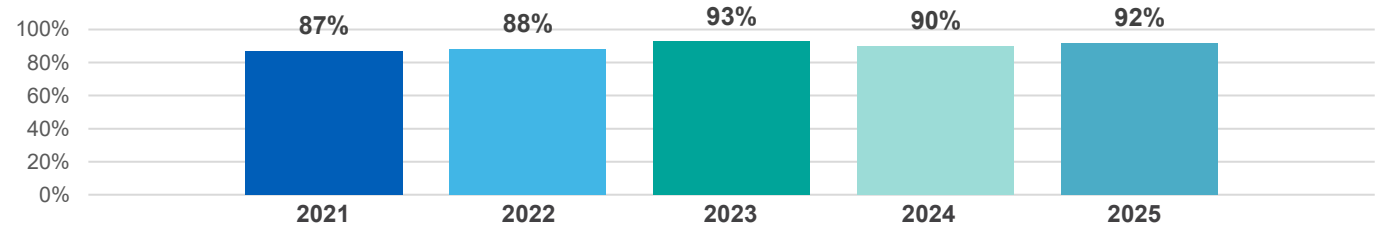


Q39. Patient was always able to discuss worries and fears with hospital staff while being treated as an outpatient or day case



YOUR TREATMENT

Q41_1. Beforehand patient completely had enough understandable information about surgery



Year on year charts

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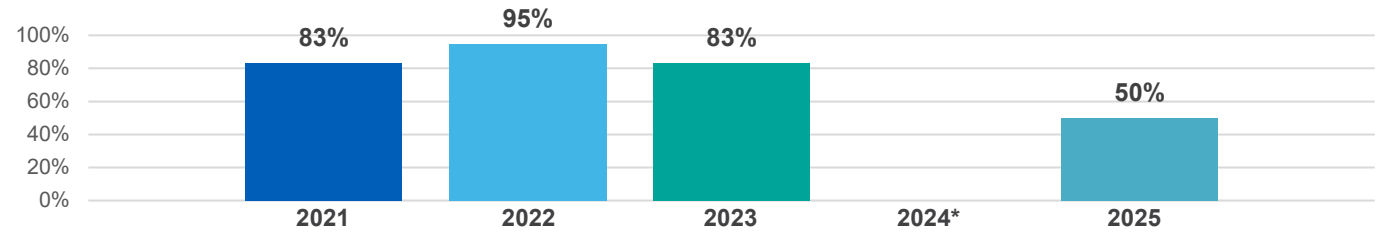
▲ or ▼ Statistically significant increase or decrease between 2024 and 2025

△ or ▽ Statistically significant increase or decrease from 2021 to 2025

Q41_2. Beforehand patient completely had enough understandable information about chemotherapy



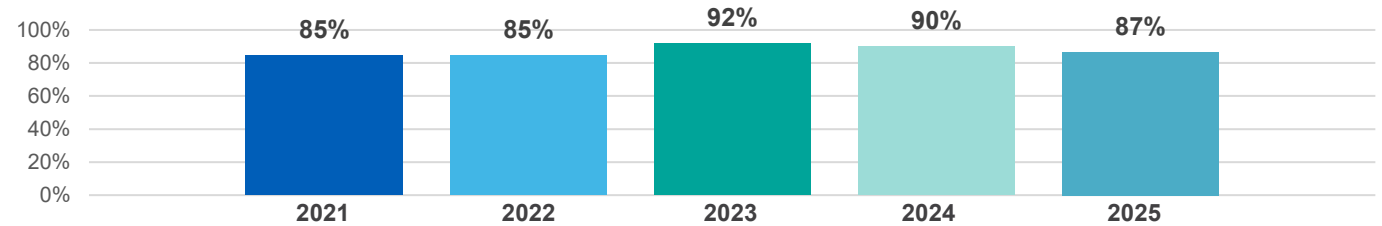
Q41_3. Beforehand patient completely had enough understandable information about radiotherapy



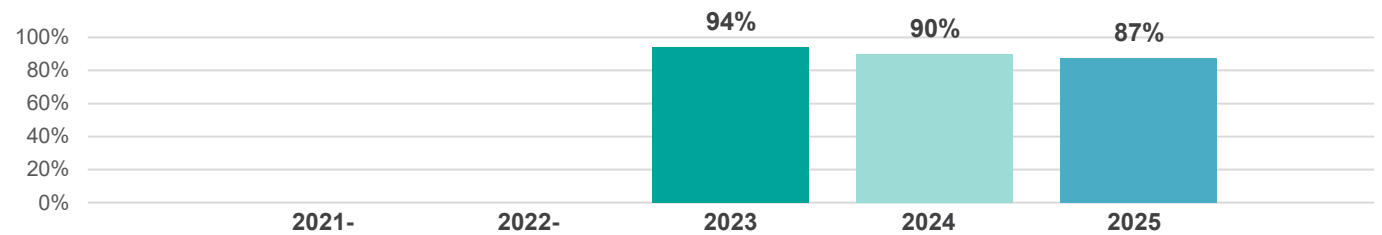
Q41_4. Beforehand patient completely had enough understandable information about hormone therapy



Q41_5. Beforehand patient completely had enough understandable information about immunotherapy



Q42_1. Patient completely had enough understandable information about their response to surgery



Year on year charts

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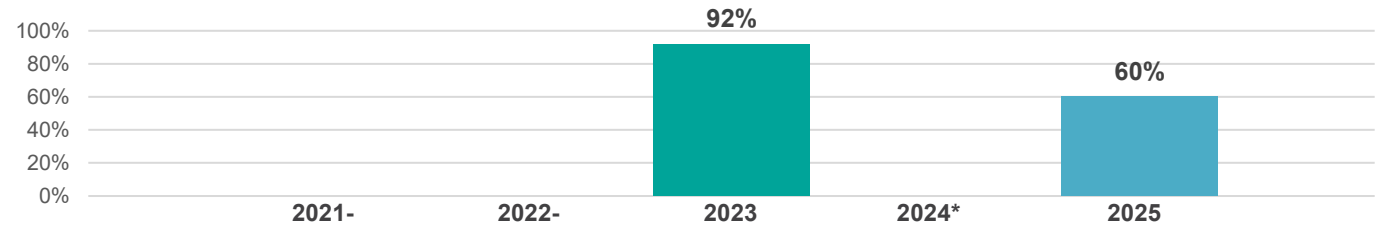
▲ or ▼ Statistically significant increase or decrease between 2024 and 2025

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Q42_2. Patient completely had enough understandable information about their response to chemotherapy



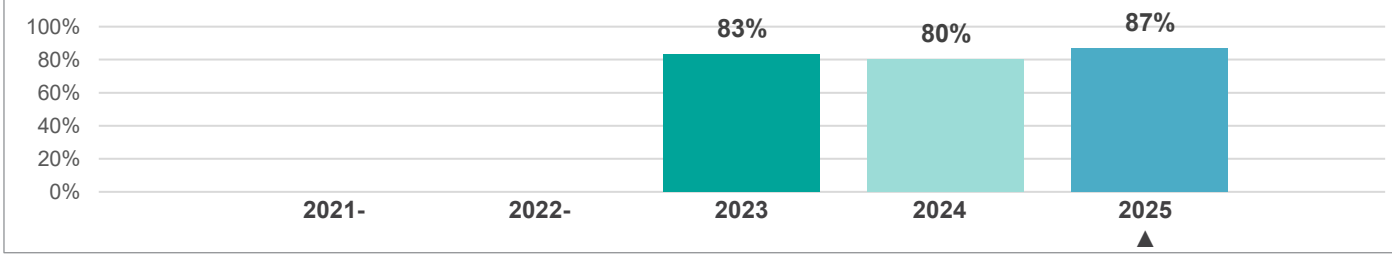
Q42_3. Patient completely had enough understandable information about their response to radiotherapy



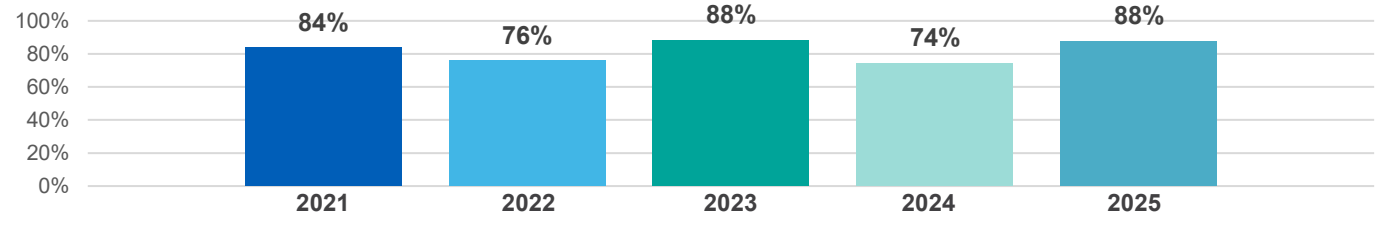
Q42_4. Patient completely had enough understandable information about their response to hormone therapy



Q42_5. Patient completely had enough understandable information about their response to immunotherapy



Q43. Patient felt the length of waiting time at clinic and day unit for cancer treatment was about right

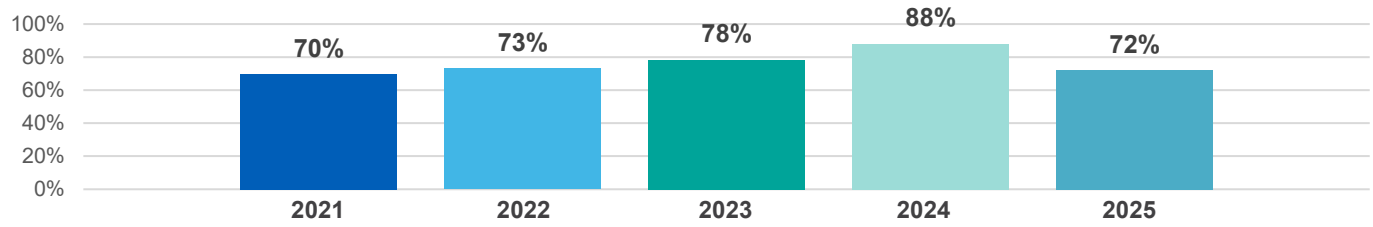


Year on year charts

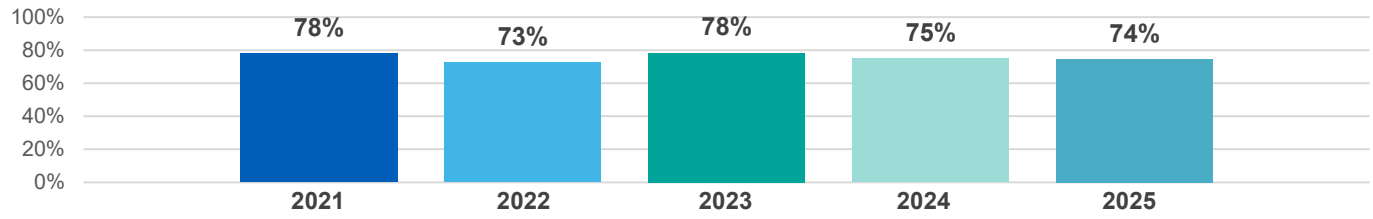
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IMMEDIATE AND LONG-TERM SIDE EFFECTS

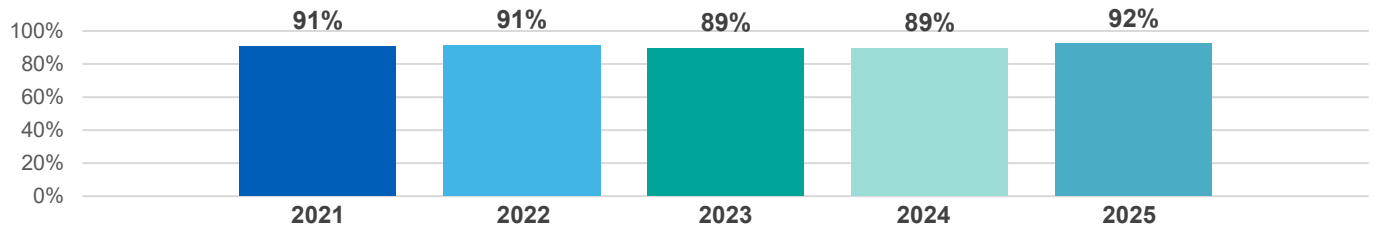
Q44. Possible side effects from treatment were definitely explained in a way the patient could understand



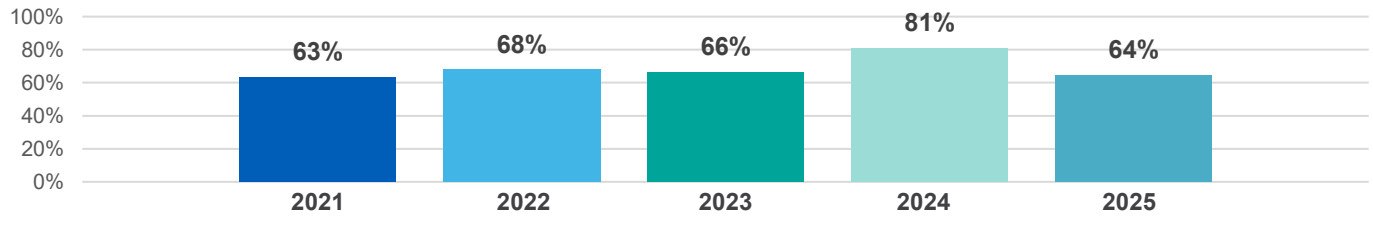
Q45. Patient was always offered practical advice on dealing with any immediate side effects from treatment



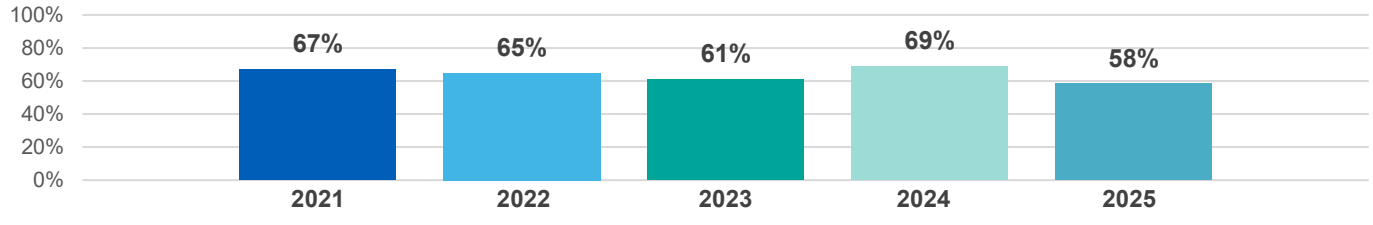
Q46. Patient was given information that they could access about support in dealing with immediate side effects from treatment



Q47. Patient felt possible long-term side effects were definitely explained in a way they could understand in advance of their treatment



Q48. Patient was definitely able to discuss options for managing the impact of any long-term side effects

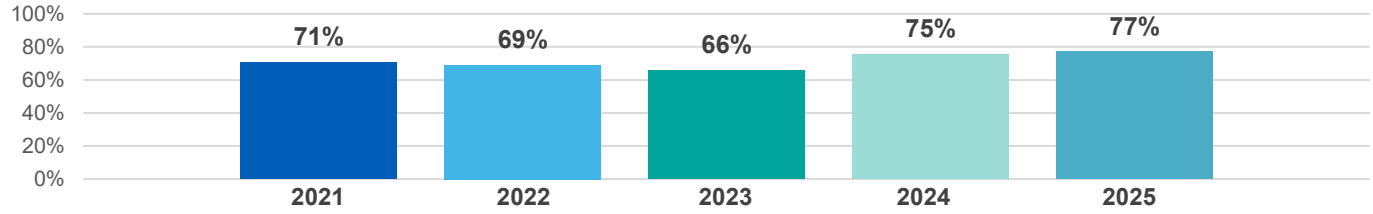


Year on year charts

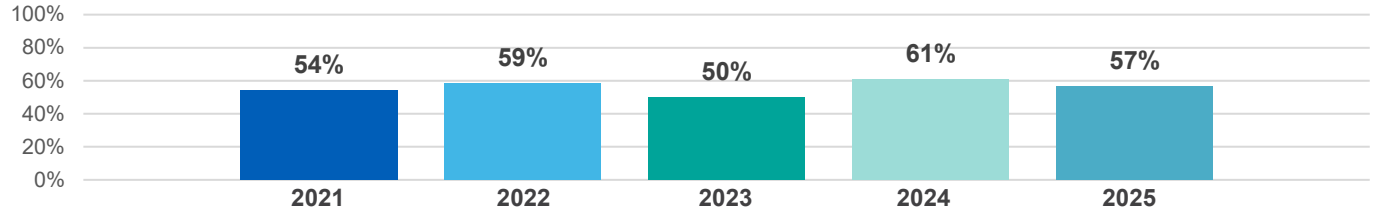
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SUPPORT WHILE AT HOME

Q49. Care team gave family, or someone close, all the information needed to help care for the patient at home



Q50. During treatment, the patient definitely got enough care and support at home from community or voluntary services



CARE FROM YOUR GP PRACTICE

Q51. Patient definitely received the help or support needed from their GP practice since their cancer diagnosis



Q52. Patient has had a cancer care review with someone from their GP practice (excluding patients who have not had a review but were diagnosed less than or around 12 months ago)

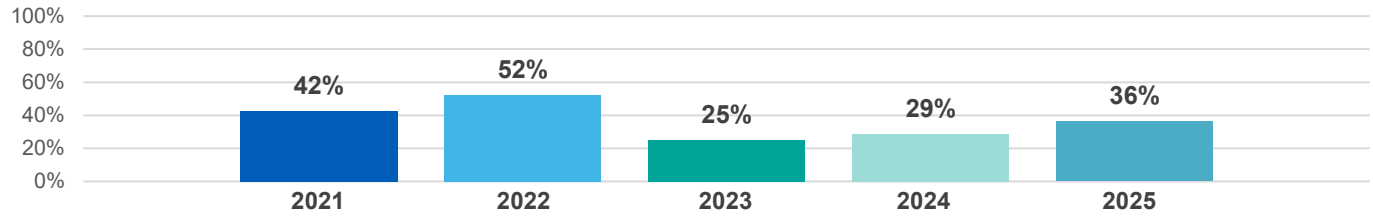


Year on year charts

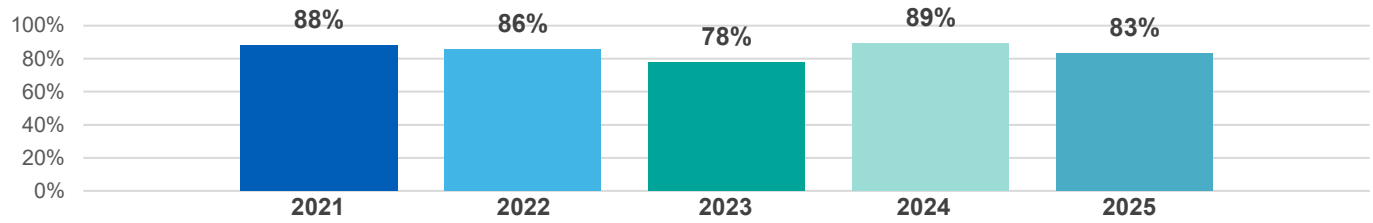
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LIVING WITH AND BEYOND CANCER

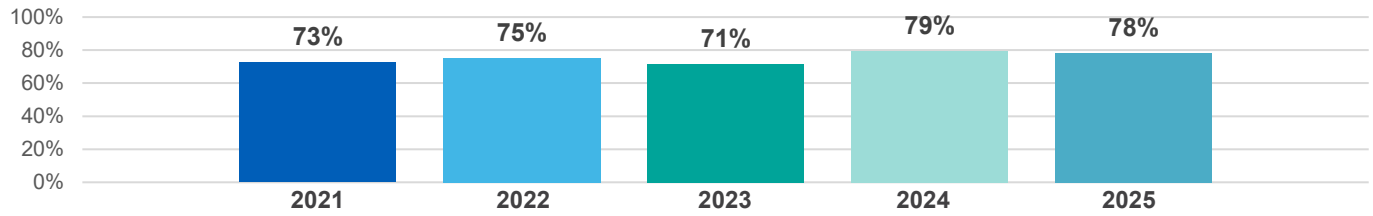
Q53. After treatment, the patient definitely could get enough emotional support at home from community or voluntary services



Q54. The right amount of information and support was offered to the patient between final treatment and the follow up appointment

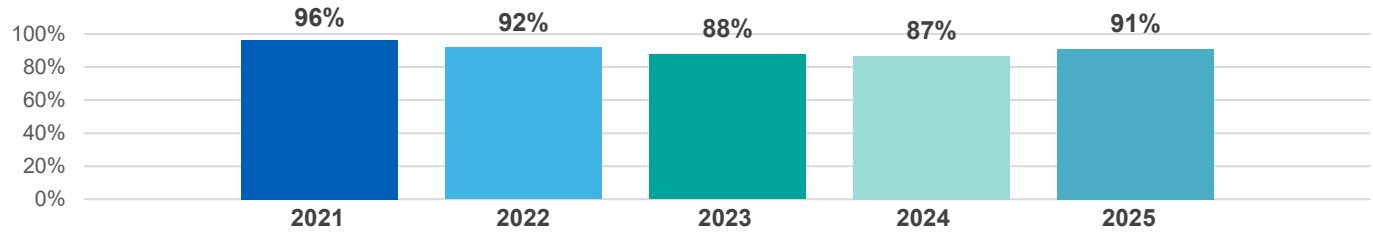


Q55. Patient was given enough information about the possibility and signs of cancer coming back or spreading

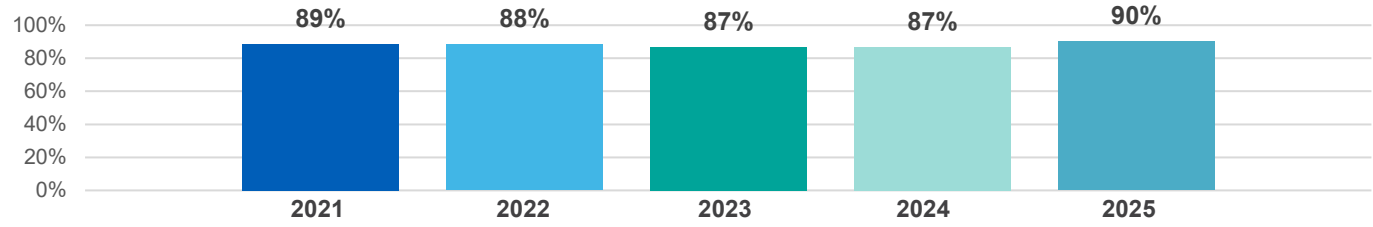


YOUR OVERALL NHS CARE

Q56. The whole care team worked well together



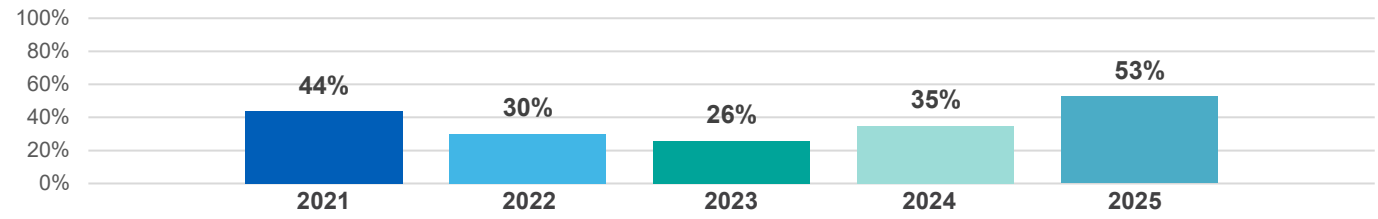
Q57. Administration of care was very good or good



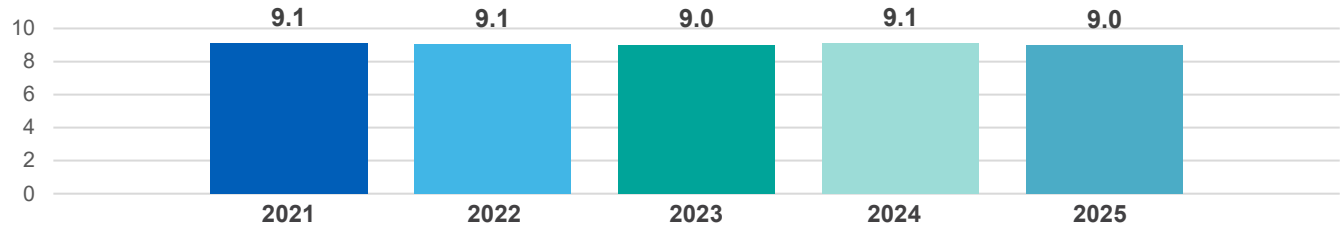
Year on year charts

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Q58. Cancer research opportunities were discussed with patient



Q59. Patient's average rating of care scored from very poor to very good



Report cover-page					
References					
Meeting title:	Board of Directors				
Meeting date:	16/09/26	**Agenda reference:**	**74-26**		
Report title:	Premises Assurance Model (PAM) - 2026				
Sponsor:	Helen Edmunds – Chief People Officer				
Author:	Melanie Tranmer – Compliance Manager (Estates)				
Appendices:	None				
Executive summary					
Purpose of report:	This report presents the results of the 2026 Estates Premises Assurance Model (PAM) self-assessment. It highlights areas of strength and identifies opportunities for further improvement, to inform future priorities of work and funding allocations.				
Summary of key issues	• PAM is a mandatory annual return that must be submitted to NHS England through the national portal by 28th September • The 2026 assessment uses a revised methodology based on three response options: Yes, No and Not Applicable (N/A) – with evidence needed for any positive responses • For 2026 there are 653 questions across five domains: Safety Hard, Safety Soft, Estate Competency, Patient Experience and Helipad (N/A for QVH) • 65% of subject areas were identified as areas of strength, while 28% highlighted opportunities to strengthen assurance and compliance arrangements • Strong performance was seen in Patient Experience, Leadership and Culture, Financial Controls and several key compliance areas • Most development priorities were within specialist engineering services where there are opportunities to improve records, asset information, resilience planning and governance arrangements • The findings provide a clear basis for future improvement activity and will help inform Estates and Facilities priorities, business planning and investment decisions during 2026/27				
Recommendation:	The Board are asked to **note** the content of the report and **approve** the submission of the PAM for QVH to NHS England.				
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:	Estates BAF				
Corporate risk register:	Various estates risks on the organisational risk register				
Regulation:	NHSE / CQC				
Legal:	None				
Resources:	Estates resources / capital resources / estates safety fund				
Assurance route					
Previously considered by:	Finance and Performance Committee				
	Date:	01/09/2026	Decision:	Present to the Board of Directors	
Next steps:	Submit PAM to NHSE and continue with programmes of work to strengthen areas requiring improvement tracked via action plan.				

Report to:	Board of Directors
Agenda item:	74-26
Date of meeting:	16 September 2026
Report from:	Helen Edmunds, Chief People Officer
Report author:	Melanie Tranmer – Compliance Manager (Estates)
Date of report:	3 August 2026
Appendices:	None

Premises Assurance Model (PAM) - 2026

Introduction

This report summarises the findings of the Premises Assurance Model (PAM) 2026 self-assessment, which is due for submission to NHS England (NHSE) by 28 September 2026. The updated version of PAM for 2026 contains 653 questions across five domains: Safety Hard, Safety Soft, Estate Competency, Patient Experience and Helipad. As the Trust does not operate a helipad, this domain has been excluded from the analysis.

In addition, there were 52 Facilities Management (FM) Maturity Level 1 and 2 questions, which assess how effectively Queen Victoria Hospital manages its Estates and Facilities services across integration, collaboration, compliance, strategy, and governance. The FM Maturity findings have been considered as part of the overall analysis; however, they are not assessed in the same way as the five PAM domains. These are assessed using a number scale 1 - 5 and not included in this report.

Some questions were not applicable to the services provided by the Trust and have therefore been recorded as Not Applicable (N/A).

The main benefits of PAM are to:

- Give assurance to patients, staff, commissioners, regulators and the Board that safe and effective systems are in place to manage premises and support services.
- Provide a consistent way of measuring compliance with legislation, national guidance and NHS standards.
- Identify areas of good performance as well as opportunities for improvement across estates and facilities services.
- Support investment decisions by helping organisations focus resources on areas of greatest risk and need.
- Improve governance, risk management and organisational assurance.
- Support wider NHS priorities, including sustainability, resilience, efficiency and the aims of the NHS 10 Year Health Plan.

Changes for 2026

Key changes to the 2026 Premises Assurance Model (PAM) include:

- The assessment methodology has changed significantly, with PAM now using a simplified response format of Yes, No and Not Applicable (N/A). This replaces the previous maturity-based scoring approach and means that results are now assessed primarily on compliance rather than levels of maturity.
- Several assessment sections have been revised, including updates to the Fire Safety (Safety Hard) and Sustainability (Estate Competency) domains. In addition, most HTM compliance and percentage questions have been removed, except for selected waste management questions.

- The question set has been updated and increased to reflect current legislation, guidance and operational priorities, including changes to the PSTN digital switchover section, revised Planned Preventive Maintenance (PPM) requirements and updates to supporting guidance to improve consistency of assessment and scoring.

Assessment Structure

The largest proportion of questions relate to **Safety Hard**, covering statutory compliance and the management of critical engineering systems such as fire safety, electrical systems, water safety, medical gases, ventilation, asbestos and business continuity.

Safety Soft focuses on non-clinical support services including catering, cleaning, laundry services, portering, pest control and decontamination.

The **Estate Competency** domain assesses governance, leadership, strategic planning, sustainability, financial management and performance monitoring and estate optimisation.

Patient Experience considers how estates and facilities services support patients, visitors and staff, including areas such as catering, transport, accessibility, privacy, dignity and the condition of the estate.

The fifth domain, **Helipad**, relates to organisations that operate helicopter landing facilities and was not applicable to the Trust.

The self-assessment requires contributions from a broad range of subject matter experts across Estates and Facilities, Health and Safety, Infection Prevention and Control, Clinical Services, Nursing and Corporate Services to ensure responses are supported by appropriate evidence and reflect the Trust's current level of compliance and assurance.

Accountability for PAM

The PAM is mostly completed and coordinated by the Estates Team but accountability for all the inputs and actions are shared across the executive and their respective teams.

Assurance Process

Responses were reviewed by the relevant subject matter experts to ensure they were accurate and supported by appropriate evidence.

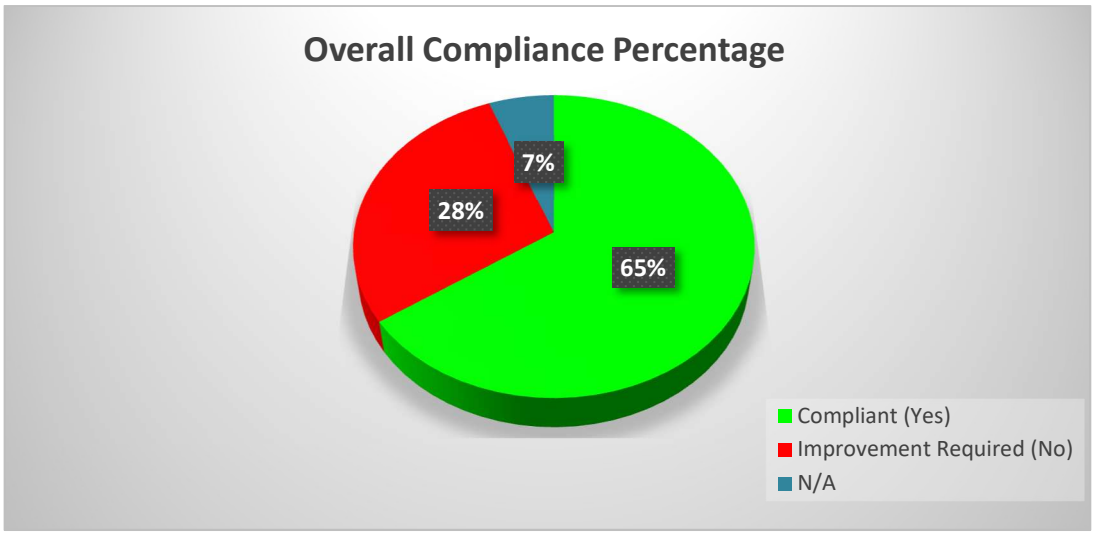
Limitations of PAM portal / responses

There are 10 questions that were not applicable to the Trust but could not be recorded as such within the PAM. For example, HVAP Electrical is not present on site; however, the portal would not allow a N/A response, resulting in a negative "No" score.

For PPM (planned preventative maintenance) compliance reporting the system does not recognise partial completion and only reflects 100% compliance. Many Trusts have noted this could present a misleading position within reports by implying poor performance when the vast majority of planned activities had actually been completed. This is the case for QVH across 10 PPMs. I

NHSE is aware of these system limitations affecting Trusts but currently there is no mechanism for amending them.

Overall PAM 2026 Scores

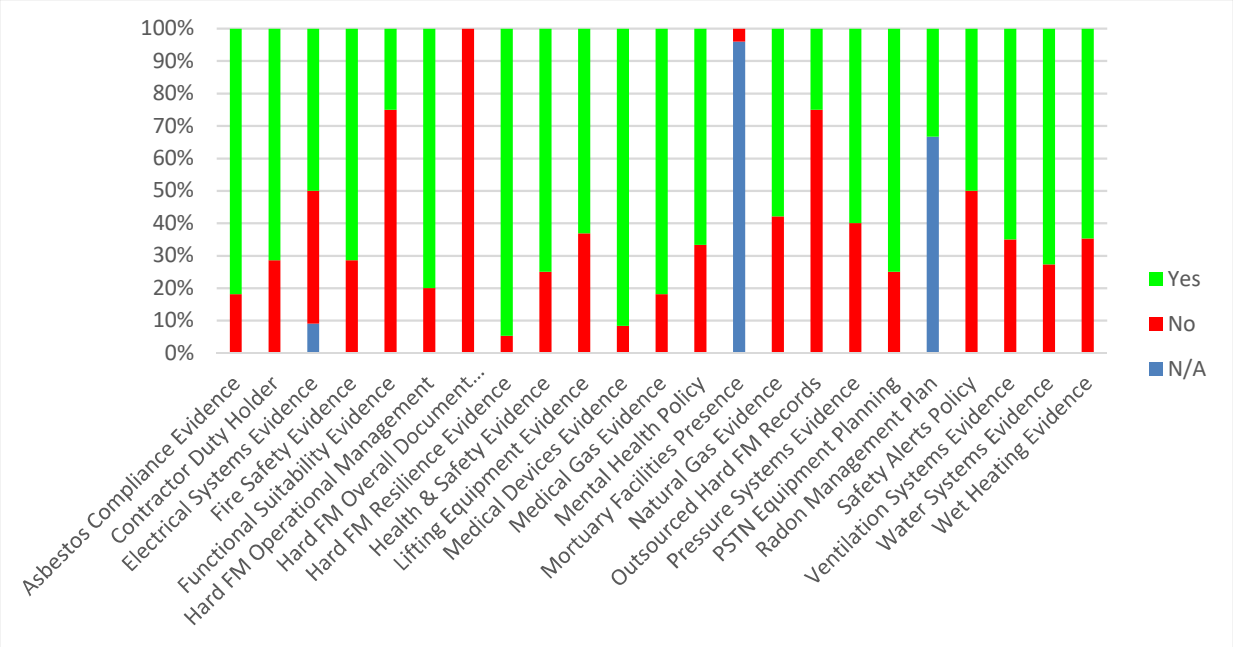


- The assessment demonstrates a mixed picture across the Trust's Estates and Facilities services, with areas of strong performance and opportunities for further improvement.
- 65% of assessed requirements were compliant, 28% require improvement, and 7% were not applicable to the Trust's services. A direct comparison to the submission from previous years isn't possible or meaningful due to the substantial nature of changes to questions (almost double the number of questions) and response options / report structure. Once the submission process has concluded and appropriate benchmarking information becomes available, the trust can consider its position against other Trusts.
- Strong performance was evidenced across Patient Experience, Leadership and Culture, Governance, Financial Controls, and a number of statutory compliance areas.
- The majority of improvement opportunities were identified within specialist engineering and Hard FM disciplines, including asset management, business continuity, risk assessments, training, records management, and assurance processes.
- The findings provide an improvement roadmap and support the Trust's commitment to delivering safe, effective, resilient, and well-managed Estates and Facilities services.

Safety Hard

Areas of Strength	Areas Requiring Improvement	Not Applicable
Health & Safety	Hard FM Operational Management	Radon Management
Asbestos Compliance	Functional Suitability	Mortuary Facilities
Medical Gas Systems	Hard FM Document Management	
Fire Safety	Natural Gas & Specialist Piped Systems	
Hard FM Resilience	Water Systems	
PSTN Equipment Planning	Electrical Systems	
Medical Devices & Equipment	Wet Heating Systems	
Safety Alerts Policy	Ventilation, Air Conditioning & Refrigeration Systems	
	Lifting Equipment	
	Pressure Systems	
	Outsourced Hard FM Records	
	Contractor Duty Holder	
	Mental Health Services	

Comparison of Yes VS No VS N/A – Safety Hard



Reasons for Non-Compliance – Safety Hard

- **Governance and assurance arrangements require further development.** Several services have not yet completed all required risk assessments, policies, audits and assurance processes, limiting the level of compliance evidence available. *Examples include Hard FM Operational Management risk assessments (SH1), Functional Suitability assessments (SH2), Natural Gas management policies and audits (SH7), Pressure Systems governance documentation and written schemes (SH14), Safety Alerts risk assessments (SH18), and Outsourced Hard FM procedures (SH19).*
- **Training, competency and authorised person arrangements are not consistently embedded across all specialist disciplines.** Gaps remain in workforce competency,

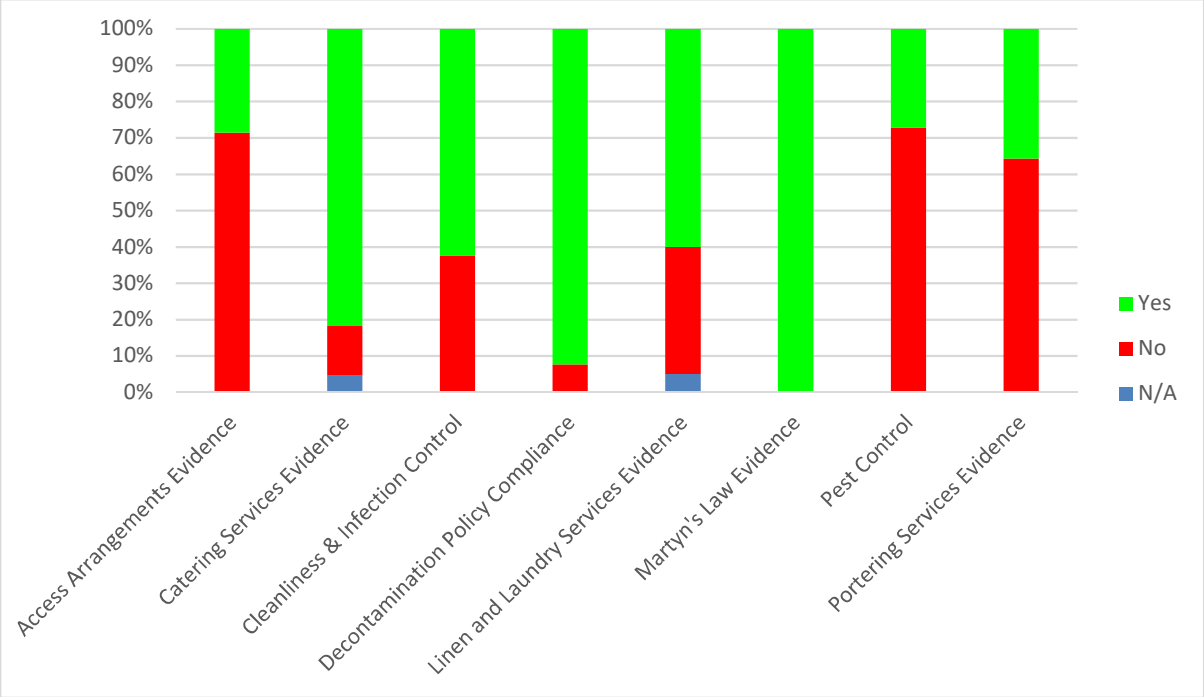
authorised person coverage and specialist training compliance, reducing assurance that services can be managed safely and effectively. *Examples include Natural Gas competency requirements (SH7), Electrical Systems competency and CP registers (SH10), Wet Heating training records (SH11), Ventilation Authorised Persons (SH12), Lifting Equipment Authorised Persons (SH13), Fire Safety management competency (SH15), Medical Devices training compliance (SH16), Contractor Management training (SH20) and Mental Health Services training requirements (SH21).*

- **Business continuity and resilience planning requires strengthening across a number of engineering systems.** Several disciplines could not demonstrate fully developed, tested or documented arrangements to maintain critical services during system failures or emergency situations*. Examples include Asbestos Compliance (SH5), Medical Gas Systems (SH6), Natural Gas Systems (SH7), Water Systems (SH9), Electrical Systems (SH10), Ventilation Systems (SH12), Lifting Equipment (SH13) and Pressure Systems (SH14).*
- **Asset information, technical records and document management arrangements need improvement.** Gaps were identified in asset registers, site plans and compliance records, training matrices, craftsperson registers and document control processes. These issues reduce the organisation's ability to demonstrate compliance and support effective operational management. *Examples include overall document management arrangements (SH3), Water Systems CP registers (SH9), Electrical asset registers and site plans (SH10), Wet Heating training matrices (SH11), Ventilation CP registers (SH12), and Fire Safety records and equipment plans (SH15).*
- **Several statutory assurance activities remain incomplete.** These include independent audits, maintenance compliance, action tracking, risk register management and planned preventative maintenance (PPM) compliance. *Examples include Medical Gas IEA/AE audits and risk assessments (SH6), Natural Gas audits (SH7), Water Risk Assessments and PPM compliance (SH9), Electrical Systems PPM compliance and risk assessments (SH10), Ventilation PPM compliance and action management (SH12), Lifting Equipment audits and risk assessments (SH13), Pressure Systems audits and governance arrangements (SH14), and Fire Safety PPM compliance and fire risk assessment action tracking (SH15). PPM compliance could only be assessed as compliant where completion was evidenced as 100%.*

Safety Soft

Areas of Strength	Areas Requiring Improvement	Not Applicable
Catering Services	Access Arrangements	N/A questions within individual sections
Decontamination	Linen and Laundry Services	-
Martyn's Law	Portering Services	-
Cleanliness & Infection Control	Pest Control	-

Comparison of Yes VS No VS N/A – Safety Soft



Reasons for Non-Compliance – Safety Soft

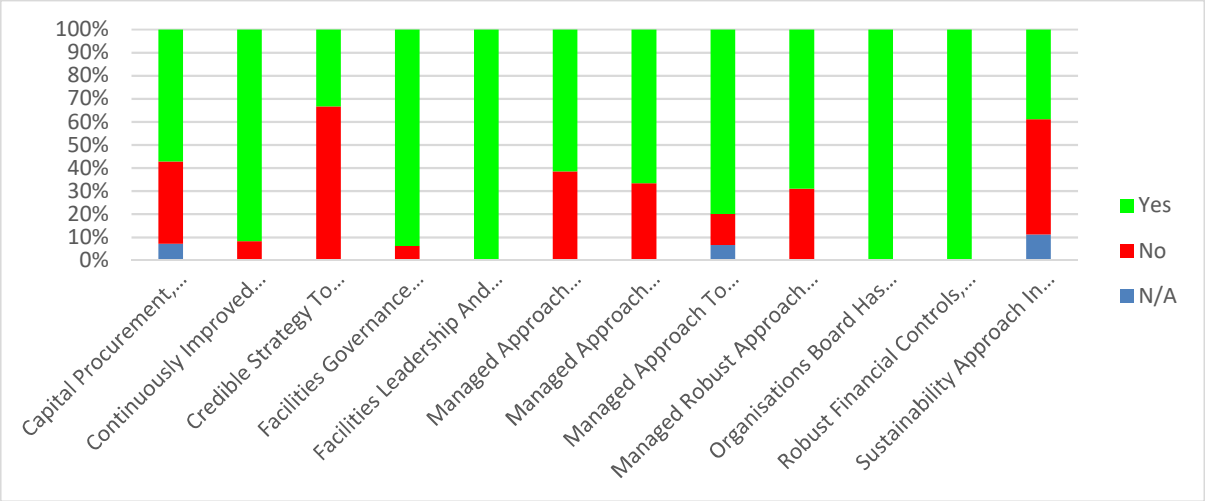
- **Policies, Procedures and Governance Require Further Development:** Some services do not yet have fully developed policies, supporting procedures, clearly defined responsibilities or robust governance arrangements in place. Opportunities were identified to strengthen policy compliance, governance documentation and responsible person arrangements across several services. *Examples: Portering Services policy (SS7), Pest Control policy and procedures (SS6), Linen & Laundry governance arrangements (SS4), Access Arrangements responsibilities (SS5), and Decontamination responsible person arrangements (SS2).*
- **Workforce Training, Competency and Role Clarity Require Strengthening:** Training records, competency frameworks, development plans and workforce assurance arrangements are not consistently established across all services. Some areas were unable to fully demonstrate that staff had received the required training or that competency records were complete and up to date. *Examples: Level 4 Food Hygiene training for Catering managers (SS1) (not an essential requirement), cleaning auditor training (SS3), Access Arrangements competency requirements (SS5), and Portering manual handling and medical gas training (SS7).*

- **Risk Assessment and Assurance Processes Need Strengthening:** Several services lack regular risk assessments, annual reviews, assurance processes, escalation arrangements and documented mitigation plans. This limits the ability to demonstrate that risks are routinely identified, monitored and managed effectively. *Examples: Cleanliness & Infection Control risk assessments and review processes (SS3), Linen & Laundry risk assessments (SS4), Access Arrangements risk assessments (SS5), and Pest Control risk assessments (SS6).*
- **Business Continuity and Resilience Arrangements Are Not Fully Developed:** Some services have not completed, tested or regularly reviewed business continuity, emergency response and escalation plans. Strengthening these arrangements will improve assurance that services can continue safely during disruption or service failure. *Examples: Catering Services resilience plans and testing (SS1), Cleanliness & Infection Control continuity testing arrangements (SS3), Linen & Laundry continuity plans (SS4), Pest Control contingency plans (SS6), and Portering service continuity exercises (SS7).*
- **Operational Controls, Monitoring and Maintenance Require Improvement:** Opportunities exist to strengthen service monitoring, compliance reviews, maintenance arrangements, contract oversight and operational assurance processes. Enhanced monitoring will support the safe, effective and reliable delivery of support services. *Examples: Cleanliness & Infection Control audit performance and review processes (SS3), Linen & Laundry operational procedures and equipment maintenance (SS4), Pest Control contract coverage and contingency arrangements (SS6), and Portering equipment maintenance arrangements (SS7).*

Estate Competency

Areas of Strength	Areas Requiring Improvement	Not Applicable
Performance Management	Credible Strategy to Deliver Good Quality Estates & Facilities Services	N/A questions within individual sections
Improved Efficiency in Running Estates & Facilities	Sustainability	-
Financial Controls, Procedures & Reporting	-	-
Continuous Improvement	-	-
Town Planning	-	-
Management of Land & Property	-	-
Facilities Governance Framework	-	-
Facilities Leadership & Culture	-	-
Professional Advice to the Board	-	-
Capital Procurement, Refurbishment & Land Management	-	-

Comparison of Yes VS No VS N/A – Estate Competency



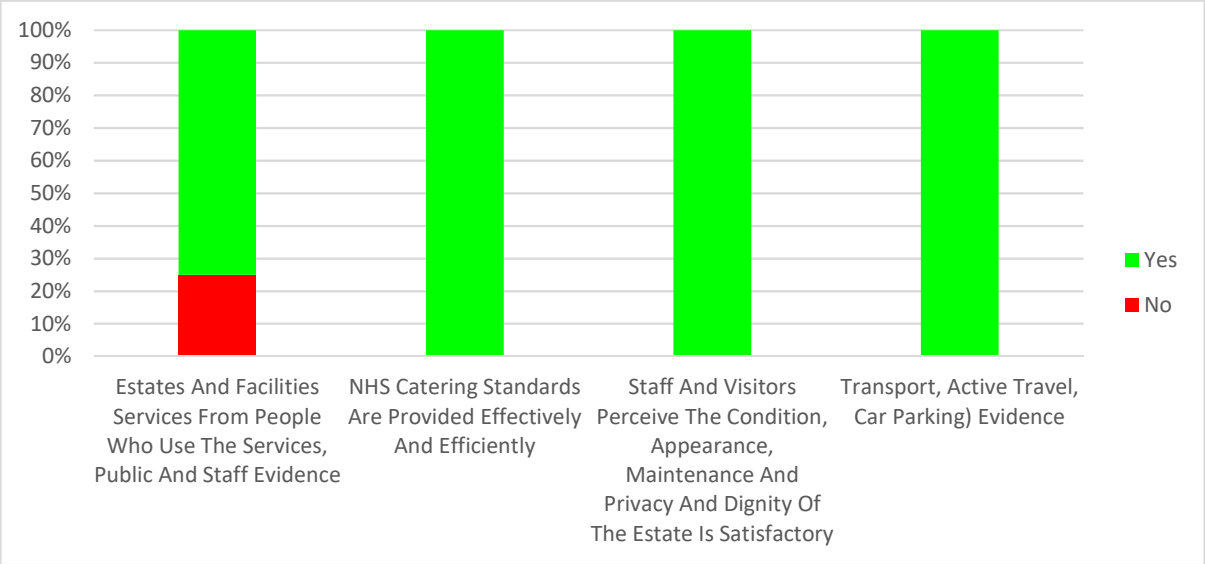
Reasons for Non-Compliance - Estate Competency

- **Strategic Planning and Performance Management Arrangements require further development**: Some key strategic and business planning processes are not yet fully established or evidenced.
  Examples: Estates Digital Maturity Assessment (C1), Estates and Facilities business planning process (C2), Estates Strategy and supporting documentation (C6), and analysis of whether services continue to meet organisational needs (C1).
- **Estate Planning, Asset Management and Property Information gaps**: Opportunities exist to strengthen estate utilisation, property records, master planning, and long-term estate planning arrangements.
  Examples: Property Asset Register (C8), space utilisation studies (C2), estate optimisation evidence (C8), estate masterplans (C8), and long-term estate strategy supporting clinical and financial objectives (C8).
- **Sustainability and Net Zero Planning Requires Further Maturity**: A number of sustainability, energy management, climate resilience and waste management requirements have not yet been fully implemented.
  Examples: Heat Decarbonisation Plans (C3), NHS Net Zero Carbon planning (C3), TM44 assessments (C9), Climate Change Risk Assessment (C9), Biodiversity Strategy (C9), HTM 07-01 and HTM 07-02 compliance (C9), and Energy Policy review (C9).
- **Stakeholder Engagement and Strategic Communication could be strengthened**: There is limited evidence that staff, stakeholders and partners are consistently involved in developing, delivering and monitoring estates strategies and plans.
  Examples: Staff understanding of the Estates Strategy (C6), stakeholder involvement in strategy development (C6), integration of stakeholder feedback (C6), monitoring progress through engagement activities (C6), and reference to ICS Infrastructure Strategy Guidance (C7).
- **Governance, Assurance and Continuous Improvement Processes require strengthening**: Some assurance mechanisms, audits, benchmarking activities and compliance monitoring processes are not fully embedded.
  Examples: Internal audit programme (C10), derogation management and clinical sign-off (C5), contract benchmarking and market testing (C2), independent sustainability audits (C9), KPI review meetings (C9), and DGSA reporting arrangements (C9).

Patient Experience

Areas of Strength	Areas Requiring Improvement	Not Applicable
Estates & Facilities Services from People Who Use Services, Public and Staff	None	None
Estate Condition, Appearance, Privacy & Dignity	-	-
Transport, Active Travel & Car Parking	-	-
NHS Catering Standards	-	-

Comparison of Yes VS No VS N/A – Patient Experience



Reason for Non-Compliance - Patient Experience

- **Limited evidence that patient, public and staff feedback is systematically used to inform preventative and corrective maintenance programmes.**
  Example: Leaders prioritising the participation and involvement of people who use services and staff through maintenance strategies (P1).

<u>Summary of Key Areas Requiring Improvement</u>

The PAM 2026 assessment identifies areas where compliance and supporting evidence can be improved. Most of the issues were identified within the **Safety Hard** and **Safety Soft** domains. Fewer issues were identified within **Estate Competency**, while **Patient Experience** showed strong overall performance.

Safety Hard

The main improvement areas relate to the management of engineering systems and statutory compliance:

- Some asset registers, site plans and system records need to be updated.
- Several areas require stronger risk assessments and clearer evidence of controls.
- Business continuity plans are not in place or fully developed for some services.
- Training and competency records need to be strengthened in a number of specialist areas.
- Document management arrangements require improvement to ensure key compliance records are easy to locate and review.
- Improvements are needed in contractor management and oversight of outsourced services.

Safety Soft

The main issues relate to policies, training and service resilience

- Linen and laundry services require updated training records and risk assessments.
- Portering services require improvements in training compliance and business continuity planning.
- Access arrangements need stronger governance and clearer supporting evidence.
- Pest control arrangements require improved contingency planning and contract oversight.
- Some areas of cleanliness and infection control need stronger assurance and record keeping.

Estate Competency

Two key areas require attention - Estates strategy and sustainability:

- The Trust needs a clearer long-term Estates Strategy.
- More evidence is required to show how staff and stakeholders contribute to planning and decision-making.
- Monitoring of strategic objectives could be strengthened.
- Further work is required to support the Trust's sustainability and net zero ambitions.
- Climate change and flood risk assessments need further development.
- Opportunities exist to improve energy management and sustainability training.
- Some environmental compliance requirements require additional evidence and monitoring.

Patient Experience

One area for improvement was identified around demonstrating how feedback from patients, visitors and staff is used to shape estates and facilities services and future improvements.

Common Themes across all Domains requiring improvement

Several common themes were identified across the assessment:

- Business continuity and emergency planning.
- Risk assessments and risk management processes.
- Asset registers and statutory compliance records.
- Training, competency and workforce development.
- Evidence management and document control.
- Sustainability and environmental planning.
- Strategic planning and governance arrangements.

These findings guide future improvement work and provide the basis for clear action planning and will support the prioritisation of resources, investment and compliance activities across Estates and Facilities services.

Strategic Focus Areas



Risks

The risk register for estates and facilities is currently being reviewed and updated. All known risks are actively managed, with appropriate controls and mitigations implemented within responsive and proportionate timescales when issues are identified.

At present, the PAM findings have not identified any new risks requiring escalation beyond those already known and managed by the Trust and have not affected any of the current risk scores.

Where emerging risks are identified, these are assessed and appropriate interim measures are put in place where required, rather than waiting for completion of the longer-term improvement programme. This provides assurance that patient, staff and visitor safety remains the priority while the identified improvement actions are progressed.

The position will continue to be monitored, and any material change in risk or inability to maintain appropriate mitigation will be escalated through the relevant governance route.

One of the areas requiring further assessment is the availability of appropriately qualified and competent staff to support the management and delivery of statutory and technical compliance requirements. This will include considering the level of qualified resource available against the Trust's operational and statutory requirements and identifying where additional controls or resources may be required.

The two areas of statutory compliance risk currently identified are electrical infrastructure and fire compliance. These are recognised risks and are being actively managed, with appropriate controls and mitigations in place, alongside programmes of work to improve compliance, to ensure patient and staff safety. These risks will continue to be reviewed through the Trust's risk and governance arrangements with improvement actions identified, prioritised and monitored.

Conclusion and next steps

The findings provide a framework for strengthening assurance, resilience and operational performance across the estate and will inform an action plan and timeline for improvements. By building on existing strengths and addressing identified priorities, the Trust can continue to enhance the safety, effectiveness and sustainability of its estates and facilities services.

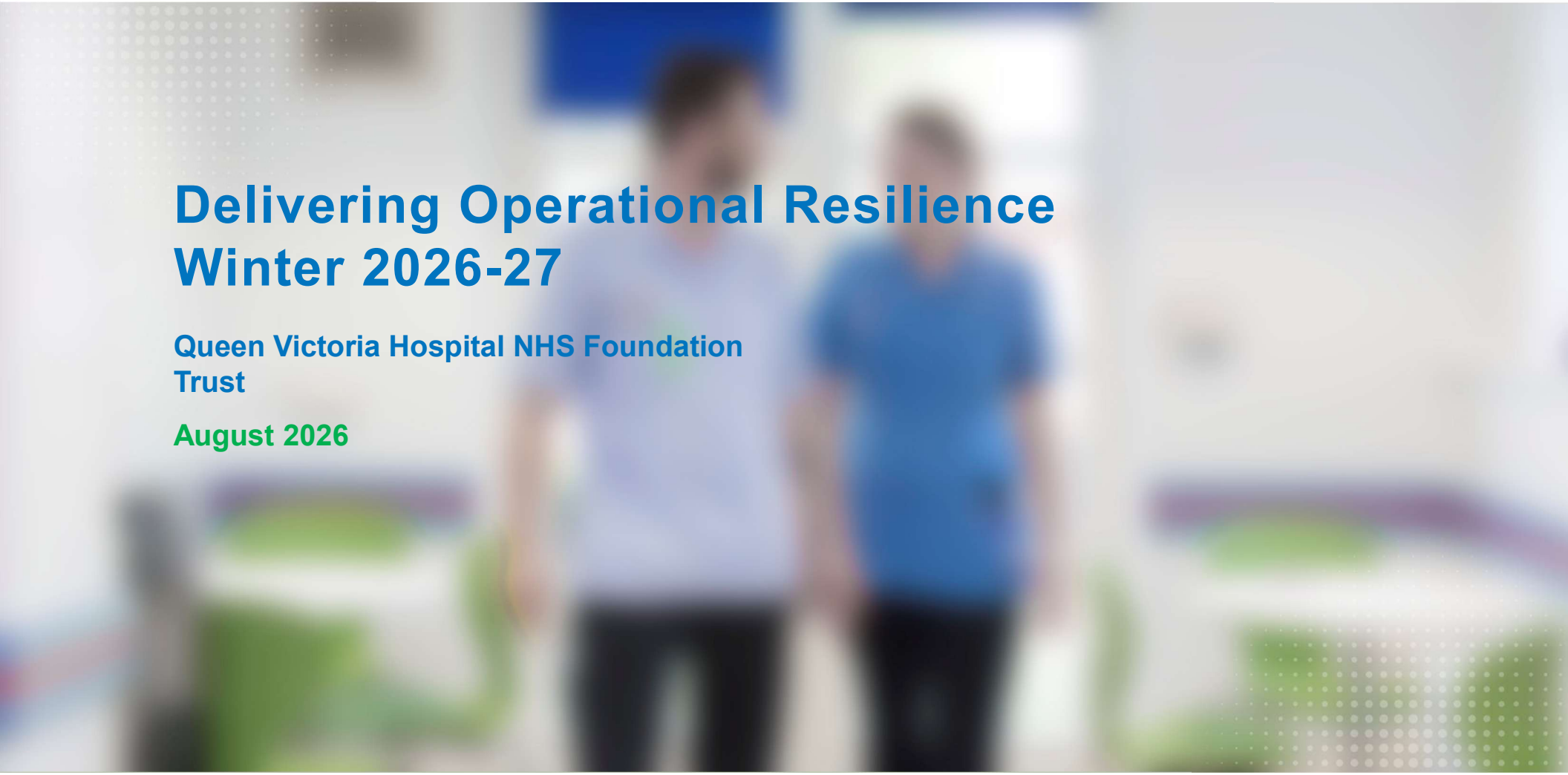
The estates compliance team will use the information from the PAM and priority areas identified to develop a formal action plan. This will enable the actions, responsible leads, priorities and timescales to be considered through the appropriate Estates and Facilities governance arrangements.

NHSE plan to review all submitted plans and use the information to prioritise national and regional areas of support.

Recommendation

The Board are asked to **note** the content of the report and **approve** the submission of the PAM for QVH to NHS England.

Report cover-page					
References					
Meeting title:	Board of Directors				
Meeting date:	16/09/2026	**Agenda reference:**	**75-26**		
Report title:	Winter Plan				
Sponsor:	Kathy Brasier, Acting Chief Strategy Officer				
Author:	Ashley Hunt, Deputy Chief Operating Officer				
Appendices:	Appendix 1 – Winter Planning Slides Appendix 2 – Board Approval Template				
Executive summary					
Purpose of report:	For the Board to approve the Trust's Winter Plans prior to submission to the Integrated Care Board (ICB) and NHS England (NHSE).				
Summary of key issues	The Winter Plan has been developed in line with NHS England and ICB requirements and sets out how QVH will maintain safe, effective and sustainable services throughout winter 2026/27 while supporting wider system resilience. As a specialist provider, QVH's focus is on maintaining elective and cancer activity, sustaining Minor Injuries Unit and Community Diagnostic Centre capacity, and delivering regional specialist burns, trauma and reconstructive services across Sussex, Surrey and Kent. The plan includes robust escalation and business continuity arrangements, workforce resilience measures, staff vaccination programmes and mitigations for key risks including respiratory outbreaks, workforce pressures, severe weather, PAS implementation and increased demand for specialist services.				
Recommendation:	The Board is requested to **approve** the Winter Plan for submission to the ICB.				
Action required	**Approval**	Information	Discussion	Assurance	Review
Link to key strategic objectives (KSOs):	**KSO1:**	**KSO2:**	**KSO3:**	**KSO4:**	**KSO5:**
	To deliver outstanding care	***To innovate and improve***	***To be an excellent employer***	***To deliver sustainable services***	***To collaborate with others***
Implications					
Board assurance framework:	BAF 1 – Access BAF 7 – Workforce BAF 10 – Sustainability and Strategy				
Corporate risk register:	N/A				
Regulation:	ICB, NHS England, CQC				
Legal:	None				
Resources:	None				
Assurance route					
Previously considered by:	ELT, Finance & performance committee				
	Date:	01/09/26	Decision:	Submission to Trust Board	
Next steps:	Submission to ICB and NHSE				



Delivering Operational Resilience Winter 2026-27

Queen Victoria Hospital NHS Foundation Trust

August 2026

NHS
Queen Victoria Hospital
NHS Foundation Trust

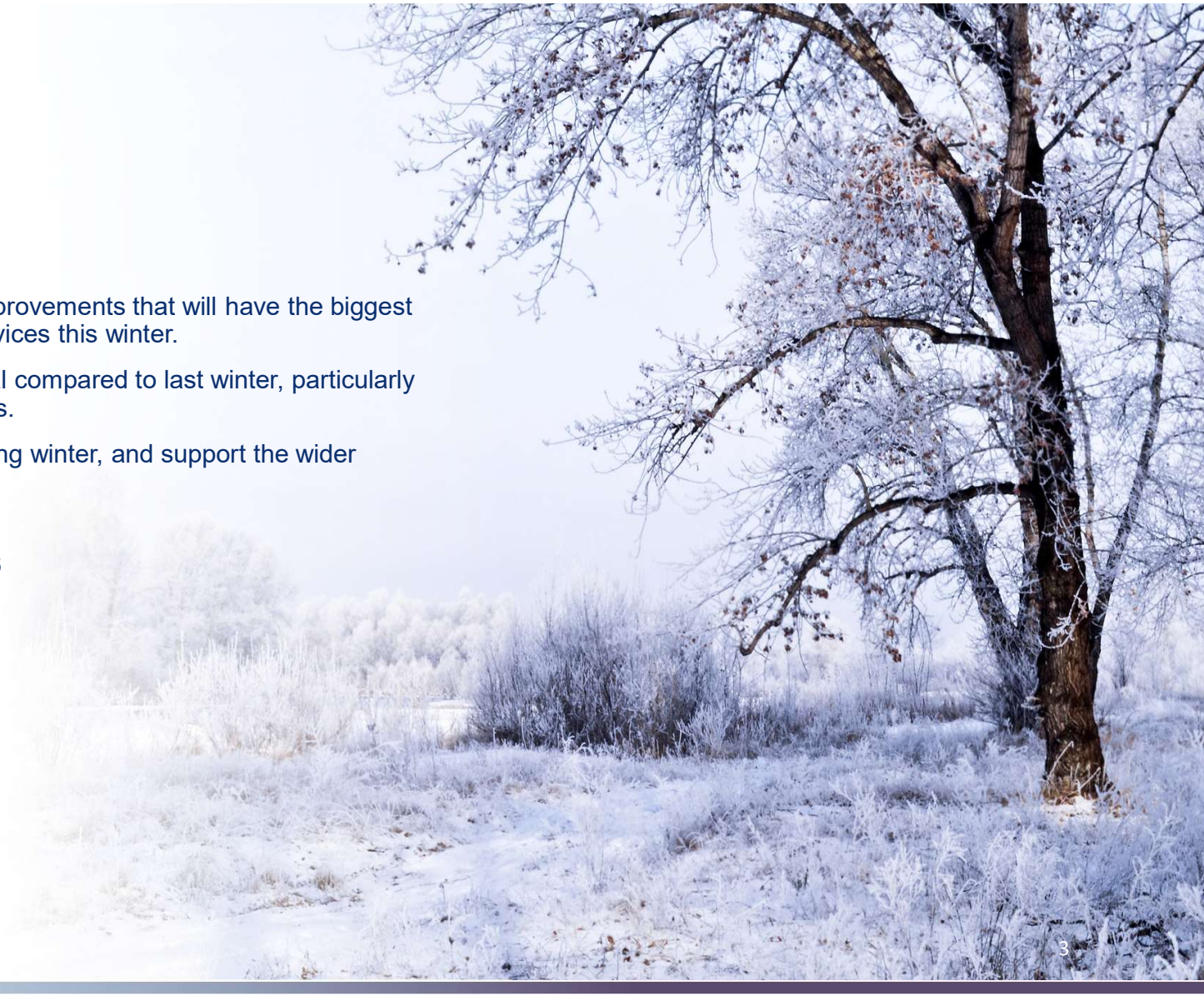
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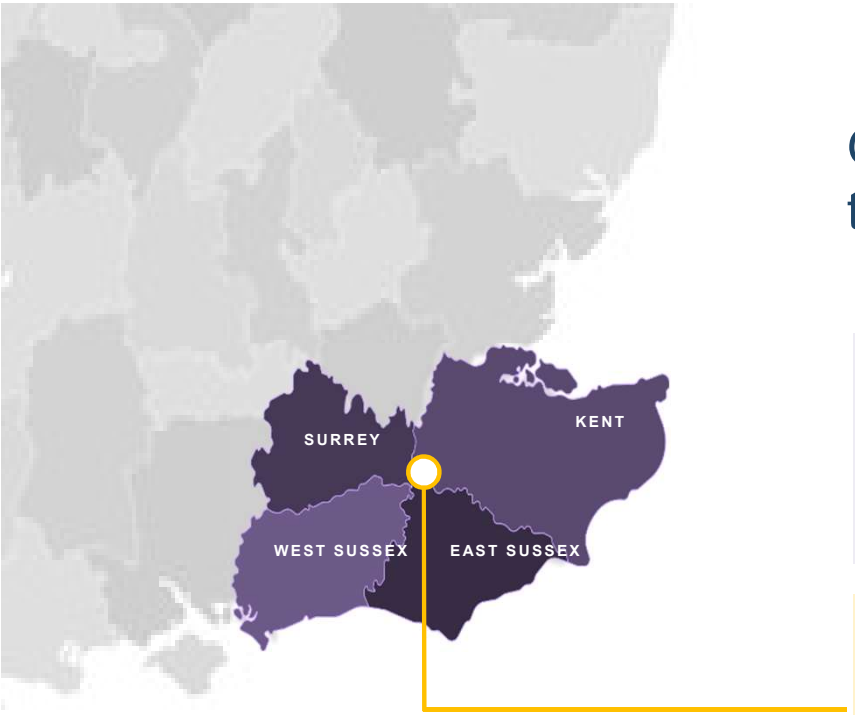
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2	QVH and System Support	Slide 5
3	How QVH contributes to the Surrey and Sussex system plan	Slide 6
4	Demand and capacity assumptions	Slide 7
5	Escalations, surge and business continuity arrangements	Slide 8
6	Workforce and staff wellbeing plans	Slide 9
7	Vaccination Programme	Slide 10
8	Key risks and mitigating actions	Slide 11
9	Delivery plans for the agreed winter priorities	Slide 12
10	Arrangements for maintaining elective recovery alongside winter resilience	Slide 13

Background

The Winter Plan is developed to

- Focus as a whole system on achieving improvements that will have the biggest impact on urgent and emergency care services this winter.
- increase services provided outside hospital compared to last winter, particularly through the development of CDC pathways.
- Maintain elective and cancer services during winter, and support the wider Sussex system where possible.
- The Winter Plan is underpinned by:
    - Applied learning from winter 2025/26





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

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



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



QVH and System Support

Queen Victoria Hospital plays an important role in supporting winter resilience across Sussex, Surrey and Kent through the delivery of specialist tertiary services, elective surgery, diagnostics and urgent care.

Unlike most acute providers, QVH does not operate an Emergency Department and does not routinely receive ambulance conveyances. Our contribution to winter resilience is therefore focused on maintaining elective productivity, reducing avoidable Emergency Department attendances through the Minor Injuries Unit, expanding diagnostic capacity and supporting wider system recovery.

As the regional specialist centre for maxillofacial trauma and reconstructive surgery, QVH provides a critical trauma service across Sussex, Surrey and Kent, supporting the wider urgent and emergency care system throughout the winter period. The Trust maintains 24/7 consultant-led trauma cover, ensuring timely assessment and treatment of patients with complex facial injuries and supporting neighbouring acute providers through specialist advice, transfer pathways and definitive care. Trauma activity is monitored closely throughout the winter to maintain patient safety, optimise theatre utilisation and balance urgent and elective demand.

During winter 2026/27, QVH will continue to provide a seven-day Minor Injuries Unit, serving more than 18,000 patients annually and offering an alternative pathway for appropriate patients who would otherwise attend an Emergency Department.

How QVH Contributes to the Surrey & Sussex Winter Plan

ICB Priority	QVH Contribution
Reduce pressure on Emergency Departments	MIU provides alternative pathway for appropriate injuries and minor urgent presentations
Improve ambulance flow	Indirect contribution through diversion of appropriate patients away from EDs, reducing demand across the urgent care pathway
Alternatives to hospital attendance	Community therapies, CDC pathways and outpatient management
Improve patient flow	High day-case model, low LOS and maintenance of inpatient capacity
Prevention and proactive care	Staff vaccination programme, community therapy services and diagnostics closer to home



Demand and Capacity Assumptions

Winter Demand Assumptions

Metric	Jan – Mar 2026 Actual	Jan – Mar 27 Assumption
MIU Attendances	3,648	3,832
Day Cases	3,367	3,629
Elective Admissions	829	872
Non-Elective Admissions	1,655	1,866
Diagnostics	7,402	7,481
First Outpatients	10,811	11,107
Follow-Up Outpatients	27,942	33,975
Outpatient Procedures	11,662	10,062

Escalation, Surge and Business Continuity Arrangements

OPEL Alignment
Aligned to system OPEL status, with a seperate status for Burns aligned to the Burns network.

Gold / Silver Command Arrangements
This is covered by the senior operational team, contactable via the Trust Switchboard. This is covered by staffing at Band 8C and above and executive colleagues rather than the traditional Gold / Silver structure due to the size of the Trust.

EPRR escalation structure
QVH has recently appointed a dedicated EPRR Lead who reports to the Chief Nursing Officer. There are clear escalation processes in place that align to the ICB EPRR processes.

All Business Continuity Plans are available on QNET should any service encounter any disruption.

System Co-Ordination Processes
QVH ensures there is senior presence at the system Partnership, Oversight and Assurance meetings. Any site concerns or escalations would be disussed at this meeting.

Key Escalation Triggers
- Significant staff absence.
- Respiratory outbreak.
- Critical care surge.
- Utilities/estates failure
- .PAS disruption.
- Major incident declaration.

Workforce and Staff Wellbeing Plans

Staffing Levels and Rostering

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

Annual Leave

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

Temporary Staffing

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

Sickness Management & Staff Wellbeing

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

Vacancy Rates

- The trust has reduced vacancy rates to 2.07% (from 5.9% this time last year). Work continues to focus on building resilience amongst our substantive workforce and reducing the requirement for temporary staffing options

Vaccination Programme

- The trust is focussed on improving vaccination rates by 5% or greater this year in comparison to last year.
- Flu campaign will commence in October 2026, offering three clinics per week through our Occupational Health provider on site.
- The trust is increasing the number of roaming vaccinators to provide support for vaccinations for clinical staff. Roaming vaccinators will have allocated times in departments to encourage more staff to take up the vaccine.
- Vaccinators have been identified to vaccinate the 65 years and over cohort of staffing.
- ‘Opt out’ forms are available on the intranet for those staff that do not wish to be vaccinated.
- Data is being gathered via our internal incident response email and is uploaded via NIVS.
- The trust will continue to submit data to Immform at the required frequency.
- Covid vaccine is provided through Alliance for Better Care, clinics operating on site in the run up to winter.
- Staff are encouraged to take up flu and covid vaccinations if offered by their primary care provider.
- Weekly updates on times on clinics are available in our internal communications via Connect.

Key Risks and mitigating actions

Risk	Impact	Mitigation
Respiratory outbreaks	Reduced workforce availability	Vaccination, IPC controls
Norovirus	Bed restrictions	Isolation processes
PAS implementation	Outpatient disruption	Enhanced command structure Robust planning with the clinical and operational teams ahead of go live.
Industrial action	Elective cancellations	Contingency rota planning
Severe weather	Access challenges	Estates and gritting plans
Workforce shortages	Reduced resilience	Bank and collaborative staffing arrangements
Burns capacity	Increased bed demand due to seasonal incidents	Flexible staffing model and established escalation processes through the burns network.

Arrangements for maintaining elective recovery alongside winter resilience

QVH's specialist elective model provides resilience against winter pressures and enables sustained delivery of elective activity throughout the winter period.

Activity plans have been developed using historic seasonal trends and account for reduced patient availability over Christmas and New Year.

The opening of the Community Diagnostic Centre in October 2026 will further increase diagnostic capacity available to local and regional patients while supporting pressure reduction across neighbouring acute providers.

Trauma activity will be reviewed weekly throughout the winter period to ensure appropriate balance between elective and non-elective demand.

Winter Planning 26/27
Section B: 26/27 Winter Plan checklist

This section provides a checklist on what Boards should assure themselves is covered by 26/27 Winter plans.
Board Assurance Statements should not be submitted until they have been tested during a regionally-led winter exercise programme.

Please complete these sections

Section B: 26/27 Winter Plan checklist			Confirm (Y/N)	Additional comments or qualifications (optional)	Blockers/Support requirements (optional)
Prevention					
1	1.1	The Board is assured there are plans in place to deliver a frontline healthcare worker (FHCW) flu vaccination programme that achieves the trust level uptake ambitions and demonstrates: •the offer is accessible to all frontline staff between 1 October – 31 March with the majority of vaccinations completed by 30 November; •that both walk-in and bookable appointments are available; •that all FHCW vaccination activity will be recorded on Record a Vaccination Service (RAVS); and •the FHCW flag has been applied to the ESR records of all clinical and non-clinical staff who are in direct contact with patients to ensure accurate reporting on FDP.	Yes		
	1.2	The Board is assured that frontline staff vaccination, respiratory virus prevention, and staff health measures are supported by targeted operational plans.	Yes		
	1.3	The Board is assured that plans are in place to offer vaccinations (flu and COVID-19) to long stay inpatients (21 days and above) and inpatients who are being discharged into a care home.	No	This is not applicable to QVH due to the nature of its services	
	1.4	The Board is assured that population health intelligence and risk stratification information are used in partnership with system colleagues to identify and support vulnerable patients and high-risk cohorts ahead of and during periods of winter pressure.	Yes		
Occupancy and discharge					
2	2.1	The Board is assured that a review of discharges across each pathway required to manage bed demand and occupancy has taken place ahead of winter with system partners. These have been developed jointly with local authority, Community Health Service Providers and system partners, including holiday-period arrangements.	Yes		
	2.2	The Board is assured that model discharge pathway requirements are in place to optimise discharge seven days a week across acute, community and social care services. This should include: • coordinated escalation, surge and extreme surge response arrangements, including bed escalation capacity, which have been tested and capable of safe activation to maintain patient flow, create additional capacity and support operational resilience during periods of increased demand. •executive-led governance arrangements to provide oversight of occupancy, the number of discharges required and delivered each day to support safe bed availability and flow, along with the number of patients who are NCTR by pathways 1 to 3 with monitoring of patients with long discharge delays. •targeted operational actions to reduce long discharge delays. •Discharge to Assess pathways that operate effectively with home first as the default and assessment taking place outside hospital wherever possible. These should be supported by integrated escalation arrangements with community and social care partners to maintain patient flow.	Yes		
	2.3	The Board is assured that pre-Christmas and holiday-period occupancy reduction plans will be implemented.	Yes		
	2.4	The Board is assured that Same Day Emergency Care (SDEC) and ambulatory emergency care pathways have been optimised to support admission avoidance.	No	This is not applicable to QVH due to the nature of its UEC services (MIU only)	
	2.5	The Board is assured that frailty pathways have been reviewed and are operating effectively to support avoidance of unnecessary admission.	No	This is not applicable to QVH due to the nature of its services	
Capacity					
3	3.1	The Board is assured that workforce resilience assumptions are evidenced and include safe staffing levels, appropriate skill mix, redeployment models and staff wellbeing support, with clear mitigations in place for sustained periods of increased demand.	Yes		
	3.2	The Board is assured that rotas have been reviewed to ensure consistent senior clinical decision-making capacity at times of peak pressure, including weekends, supported by clear escalation and supervision arrangements.	Yes		
	3.3	The Board is assured that elective and cancer delivery plans create sufficient headroom in Quarters 2 and 3 to mitigate the impacts of likely winter demand – including on diagnostic services.	Yes		
	3.4	The Board has reviewed its 4-hour and 12-hour, and RTT trajectories, and is assured that the Winter Plan will mitigate any risks to ensure delivery against the trajectories already signed off for 2026/27.	Yes		
	3.5	The Board is assured that there are effective operational actions in place to ensure urgent community capacity is prioritised for the sickest patients.	No	This is not applicable to QVH due to the nature of its services	
Flow					
	4.1	The Board is assured that emergency department crowding mitigations have been reviewed and implemented to actively eliminate corridor care as a patient safety priority. This should include implementation of relevant GIRFT recommendations, and with defined safety thresholds, clear escalation triggers, and routine Board level oversight of associated risks, including dignity, privacy and clinical harm.	No	This is not applicable to QVH due to the nature of its services	

4	4.2	The Board is assured that ambulance handover plans are deliverable and supported by appropriate operational arrangements and escalation processes.	**No**	This is not applicable to QVH due to the nature of its services	
	4.3	The Board is assured that escalation arrangements with system partners support timely transfer of care and patient flow.	**Yes**	This would be dicussed with system partners as the need should need arise based on appropriate clinical need.	
	4.4	The Board is assured that plans are in place to implement the Model ED and Model Discharge requirements ahead of winter.	**No**	This is not applicable to QVH due to the nature of its services	
Infection Prevention and Control (IPC)					
5	5.1	The Board is assured that plans, infrastructure, estates arrangements, IPC governance and operational capability are in place to enable the safe rapid reconfiguration of physical space, creation of additional clinical capacity and implementation of patient cohorting arrangements during periods of increased demand or infectious disease transmission, supported by appropriate environmental risk assessments and compliance with the Health and Social Care Act 2008: code of practice on the prevention and control of infections.	**Yes**		
	5.2	The Board is assured that IPC colleagues, including the Director of Infection Prevention and Control or nominated IPC Lead, have been engaged in the development of the winter plan, and are confident in the planned mitigations and actions.	**Yes**		
	5.3	The Board is assured that fit testing arrangements are in place for relevant staff, are appropriately recorded and monitored, and can be rapidly expanded during periods of increased respiratory disease and gastrointestinal viral transmission. Appropriate PPE supply, stock management and escalation arrangements are in place to support periods of increased demand.	**Yes**		
	5.4	The Board is assured, as encompassed by criterion 5 of the Health and Social Care Act 2008: code of practice on the prevention and control of infections, that a patient cohorting plan, including risk-based escalation, is in place that is understood by all staff and is ready to be activated by site management teams.	**Yes**		
Leadership and operational grip					
6	6.1	The Board is assured that on-call arrangements are in place and have been tested, and those on-call have access to medical and nursing leaders for urgent advice, and effective operational oversight to ensure urgent community capacity is prioritised for the sickest patients, where needed.	**Yes**		
	6.2	The Board is assured that plans are in place to monitor and report real-time pressures utilising the OPEL framework, with clear triggers for escalation and timely operational response.	**Yes**		
	6.3	The Board is assured that mutual aid arrangements have been reviewed and are capable of activation, if required.	**Yes**	This would be dicussed with system partners as the need should need arise based on appropriate clinical need.	
	6.4	The Board is assured that business continuity plans have been reviewed and tested where appropriate.	**Yes**		
	6.5	The Board is assured that severe weather and infrastructure disruption contingencies have been reviewed.	**Yes**		
	6.6	The Board is assured that industrial action contingencies have been reviewed where relevant.	**Yes**		
	6.7	The Board is assured that plans are in place to support staff welfare through periods of high demand.	**Yes**		
Specific actions for Mental Health Trusts					
7	7.1	The Board is assured that a plan is in place to ensure operational resilience of all-age urgent mental health helplines accessible via NHS 111, local crisis alternatives, crisis and home treatment teams, and liaison psychiatry services, including senior decision-makers.			
	7.2	The Board is assured that any patients who frequently access urgent care services and all high-risk patients have a tailored crisis and relapse plan in place ahead of winter.			
	7.3	The Board is assured that liaison psychiatry pathways and Section 136 arrangements remain resilient during periods of peak demand.			

Report cover-page					
References					
Meeting title:	Board of Directors				
Meeting date:	16/09/2026	**Agenda reference:**	**76-26**		
Report title:	NHS England Provider Capability Self-Assessment 2026				
Sponsor:	Abigail Jago, Acting Chief Executive				
Author:	Jamie O'Callaghan, Interim Company Secretary, exec leads				
Appendices:	Appendix One: Draft Provider Capability Self-Assessment 2026				
Executive summary					
Purpose of report:	To present the NHS England Provider Capability Self-Assessment 2026 and seek Board of Directors approval for submission to NHS England.				
Summary of key issues	NHS England requires all provider boards to complete an annual Provider Capability Self-Assessment and submit the approved return by 2 October 2026. The assessment has been developed using evidence from existing governance, performance, workforce and financial assurance processes and reflects the Trust's assessment of organisational capability. The assessment has been reviewed through the Trust's executive governance arrangements and by Non-Executive Directors. The Audit and Risk Committee has reviewed the assessment and recommended its approval by the Board of Directors prior to submission to NHS England.				
Recommendation:	The Board of Directors is asked to: • **approve** the NHS England Provider Capability Self-Assessment 2026; • **authorise** submission of the approved assessment to NHS England by 2 October 2026.				
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:	Provides assurance regarding the Trust's strategic, quality, workforce, operational and financial governance arrangements.				
Organisational risk register:	Reflects key strategic risks identified through existing governance and assurance processes.				
Regulation:	Supports compliance with NHS England's Provider Capability Assessment process.				
Legal:	None				
Resources:	None				
Assurance route					
Previously considered by:	ELT Huddle (18 Aug), ELT 24 Aug, Non-exec via email, Audit & Risk Committee				
	Date:	August 2026	Decision:	Assurance/ Recommendation	
Next steps:	Submission to NHSE				

NHS England Provider Capability Self-Assessment 2026

1. Background

NHS England requires all NHS provider boards to complete an annual Provider Capability Self-Assessment across six domains of organisational capability. The completed assessment must be approved by the Board of Directors and submitted to NHS England by 2 October 2026. The assessment is intended to support organisational self-awareness, demonstrate Board grip and capability, and inform NHS England's assessment of provider organisations.

The self-assessment considers the Trust's effectiveness across the six capability domains and draws upon evidence from existing governance arrangements, performance reporting, financial and workforce performance, the 2026 Well-Led Developmental Review and delivery of the Trust Strategy 2025-2030.

2. Development of the Assessment

The assessment has been developed through a collaborative process involving Executive Directors and senior leaders. The assessment seeks to provide an honest appraisal of organisational capability, recognising areas of strong performance whilst acknowledging the challenges that remain.

The assessment has been reviewed through the Trust's executive governance arrangements, including consideration at ELT Huddle and the Executive Leadership Team. Following executive review, the assessment was circulated to Non-Executive Directors by email to provide an opportunity for review, challenge and comment. Feedback received through these processes has informed the version presented to the Board.

The assessment reflects the significant progress made during 2025/26, including delivery against the Trust Strategy, improvements in governance and leadership arrangements, and ongoing work to address organisational sustainability, workforce and operational challenges.

3. Audit and Risk Committee Review

The Audit and Risk Committee reviewed the assessment and was assured that:

- the assessment had been developed through an appropriate governance process;
- the assessment is supported by evidence drawn from existing governance and performance processes;
- the assessment presents a fair and balanced view of organisational capability; and
- the proposed capability ratings are reasonable and consistent with the evidence available.

The Committee subsequently recommended that the Board of Directors approve the Provider Capability Self-Assessment 2026 for submission to NHS England.

4. Next Steps

The approval process to date has been:

- ELT Huddle review completed;
- Executive Leadership Team review completed;
- Non-Executive Director review completed via email; and
- Audit and Risk Committee review and recommendation completed.

Subject to Board approval, the assessment will be submitted to NHS England by 2 October 2026.

5. Recommendation

The Board of Directors is asked to:

- **approve** the NHS England Provider Capability Self-Assessment 2026;
- **authorise** submission of the approved assessment to NHS England by 2 October 2026.

Provider capability self-assessment template 2026

Providers should use the form and the supporting annex to rate themselves across each domain and, following Chair and CEO sign-off, submit to their regional oversight lead by **5pm Friday October 2**.

I. Strategy, leadership and planning

Capability statements	**Proposed domain rating**
	Amber-Green
1. The trust's strategy reflects clear priorities for itself as well as shared objectives with system partners	The Trust continues to deliver the *QVH Strategy 2025-2030*, which is aligned to the Sussex system strategy "Improving Lives Together". Progress against the strategy and Key Strategic Objectives is monitored through established governance arrangements, including the Board Assurance Framework and regular Board reporting. The Board's focus during 2025/26 has included delivery of the first year of the Strategy, improving organisational sustainability and developing a strategic partnership to secure the future resilience of services. The Trust successfully implemented its Electronic Patient Record during 2025/26, strengthening digital capability and supporting delivery of transformation objectives. The Annual Report identifies the Archie Electronic Patient Record as one of the most significant strategic programmes delivered during the year and a key enabler of future productivity, service improvement and sustainability. Governance and assurance arrangements have continued to mature during the year, culminating in the removal of the Trust's additional NHS Provider Licence conditions in March 2026. This represented an important milestone and recognised the progress made in leadership effectiveness, governance oversight and organisational capability since the conditions were imposed in 2021. The Board and Council of Governors have continued to strengthen their working relationship, supported by development work, regular engagement and revised governance arrangements. An independent Well-Led Developmental Review undertaken in 2026 found that the Trust had responded positively to previous organisational challenges through a comprehensive engagement exercise involving staff, patients, governors and stakeholders, resulting in a clear strategic vision and five key strategic objectives. The review concluded that the strategy is well understood and aligned to directorate planning arrangements, with ongoing oversight through Board and committee structures.
2. **If in breach of licence:** The trust is meeting and will continue to meet any requirements placed on it by ongoing enforcement action from NHSE	
3. The board has the skills and expertise to deliver its strategy in the context of the 10-Year Health Plan.	
4. The trust is working effectively and collaboratively with its system partners and provider collaborative for the overall good of	

the system(s) and population served	The Board has maintained clear executive accountability through a period of leadership transition. Interim leadership arrangements have ensured stability whilst the Trust progresses strategic partnership discussions with Ashford and St Peter's Hospitals NHS Foundation Trust and Royal Surrey NHS Foundation Trust group. The Board approved progression of this partnership following a structured appraisal process involving patients, staff, governors and stakeholders, recognising the importance of collaboration in supporting the long-term sustainability of specialist services. Substantive appointments are being progressed following the Board decisions for QVH to join the strategic partnership. During 2026/27, the Board's focus is on delivering the next phase of the Trust's strategy, including implementation of the strategic partnership arrangements, improving organisational sustainability, delivering productivity and financial improvement programmes, and maintaining high standards of quality and patient experience The Board has dedicated significant development time during 2025/26 to strategic planning, organisational sustainability and leadership development. Board seminars included formal Board development sessions, oversight of the Archie Electronic Patient Record implementation and extensive consideration of the Trust's long-term sustainability. Throughout the year, the Board reviewed strategic partnership options, the case for change, strategic risks, engagement plans, partner proposals, patient implications and future implementation arrangements. These sessions supported Board capability, informed decision-making and strengthened oversight of the Trust's strategic objectives and future direction. The Trust continues to play an active role within the Sussex provider collaborative and wider system partnerships. It works with neighbouring organisations to support elective recovery, cancer pathway improvements, diagnostic services and collaborative service development. The Board has recognised partnership working as a key strategic objective within the *QVH Strategy 2025-2030.* The Board has also strengthened oversight of digital and cyber risk during 2025/26. Cyber security is monitored through the Board Assurance Framework, Finance and Performance Committee and dedicated cyber reporting arrangements. The Trust has developed a Cyber Security Dashboard aligned to the Cyber Assessment Framework and Data Security and Protection Toolkit, providing assurance regarding cyber risks, compliance, controls, resilience and improvement activity. The Trust exceeded the national requirement for information governance and cyber security training compliance during 2025/26 and completed actions associated with its Data Security and
5. The trust has an effective cyber security strategy and uses digital technology to support organisational improvement	

	Protection Toolkit improvement plan. The Board receives regular reports regarding cyber risks and cyber resilience as part of its wider oversight of organisational risk management and resilience. The Well-Led Review also recognised opportunities to strengthen the articulation of strategic outcomes, measurable success indicators and benefits realisation arrangements, particularly in relation to the developing strategic partnership. The Board acknowledges these findings and is progressing work to further strengthen strategic planning, performance measurement and partnership governance arrangements. The Board recognises that organisational sustainability, workforce capacity, estates pressures and delivery of partnership benefits remain significant strategic challenges. However, it is satisfied that the Trust has a clear strategic direction, effective governance arrangements and appropriate oversight of the principal risks that may affect delivery of its strategic objectives.

II. Quality of care

Capability statements	Proposed domain rating
	Green
6. The organisation has regard to relevant NHS England guidance (supported by Care Quality Commission information, its own information on patient safety incidents, patterns of complaints and any further metrics it chooses to adopt).	The Board remains focused on ensuring the delivery of safe, effective and compassionate care through established governance arrangements, including the Quality and Safety Committee, Executive Committee for Quality and Risk, Integrated Quality and Performance Report and Board Assurance Framework. Quality performance, patient safety and clinical outcomes are regularly reviewed by the Board, alongside patient experience, workforce and operational indicators and the Premises Assurance Model. The Trust continues to deliver high-quality care and maintains a strong reputation for patient experience. In the Care Quality Commission Adult Inpatient Survey 2024, published during 2025/26, QVH achieved the highest overall patient experience score in England, with patients rating their care 9.4 out of 10 compared to the national average of 8.2. The Trust also continued to perform strongly in the National Cancer Patient Experience Survey, achieving top national scores in several domains, including involvement in care decisions and access to support from ward staff. The Trust was also recognised as the number one Trust nationally in the Children and Young People Survey 2024. The Trust has maintained a strong focus on patient safety and learning. Throughout 2025/26 there were no patient safety incidents resulting in severe harm or death attributable to Trust services. The Trust has fully implemented the Patient Safety Incident Response Framework (PSIRF), strengthening systems for learning from safety incidents, identifying themes and embedding improvements across services. Learning from incidents, complaints, claims and patient feedback is reviewed through established governance arrangements and informs quality improvement activity. The Trust continues to deliver improvement through its continuous improvement methodology, The QVH Way. Improvement huddles have been embedded across services and staff have been supported to develop quality improvement skills and capability. Improvement work during the year included initiatives to improve access, patient flow, patient experience and clinical outcomes.
7. The trust has, and will keep in place, effective arrangements for the purpose of monitoring and continually improving the quality of healthcare provided to its patients	
8. Systems are in place to monitor patient experience and there are clear paths to relay safety concerns to the board	

	The Trust maintains robust arrangements to monitor clinical outcomes, patient experience and compliance with evidence-based practice. Clinical audit, mortality review, clinical effectiveness programmes and participation in national audits provide ongoing assurance regarding quality of care. The Board receives regular reports on quality indicators and quality priorities through an integrated quality and performance framework. The Trust has continued to demonstrate good infection prevention and control performance. During 2025/26 there were no hospital-attributable MRSA, MSSA or Klebsiella bacteraemia cases. One case of hospital-acquired Clostridioides difficile was reported and deemed unavoidable. Infection prevention and control performance remains subject to regular monitoring and review. An independent Well-Led Developmental Review completed during 2026 identified a strong commitment to quality, patient-centred care and continuous improvement across the organisation. The review recognised the positive quality culture that exists within QVH and the Board's ongoing focus on quality and patient outcomes. It also identified opportunities to further develop quality metrics, benefits realisation and organisational learning processes to support delivery of strategic objectives. The Board recognises that challenges remain in relation to elective access, workforce pressures and maintaining performance in an increasingly demanding operating environment. However, the Board is satisfied that quality governance arrangements remain effective, that patient safety risks are appropriately managed and that the Trust continues to deliver high-quality care and positive outcomes for patients.

III. People and culture

Capability statements	Proposed domain rating
	Amber-Green
9. Staff feedback is used to both improve the quality of care provided by the trust and monitor and improve staff experience	The Board recognises that a skilled, engaged and supported workforce is fundamental to the delivery of high-quality patient care and achievement of the Trust's strategic objectives. Workforce governance arrangements support oversight of staff experience, wellbeing, equality, inclusion, workforce development and organisational culture, with regular reporting through established committee structures, the Integrated Quality and Performance Report and the Board Assurance Framework. The Trust continues to demonstrate high levels of staff commitment to patient care. In the 2025 NHS Staff Survey, 82% of staff reported that care of patients and service users is the Trust's top priority and 90% stated they would be happy with the standard of care provided if a friend or relative required treatment. Survey participation remained strong at 56%, exceeding the average for specialist trusts and demonstrating continued staff engagement with organisational improvement activity. The Trust continues to perform well in inclusion, diversity and team working. Staff survey results demonstrated strengths in compassionate and inclusive culture, diversity and equality, team working and staff pride in making a positive difference for patients. Improvements were also seen in indicators relating to bullying, harassment, discrimination and workplace violence, with ethnically diverse colleagues continuing to report strong engagement and positive workplace experiences. The 2026 Well-Led Developmental Review independently described the Trust's culture as positive, supportive and collaborative, with strong staff commitment, pride in the organisation and widespread recognition of leadership behaviours that promote openness and inclusion. The review highlighted positive relationships across the organisation and recognised significant investment in staff development, leadership programmes and organisational culture initiatives. During 2025/26, the Trust continued to invest in workforce development, leadership and organisational culture. Initiatives included implementation of the behavioural framework, manager development programmes, leadership workshops, wellbeing initiatives, equality and inclusion programmes and delivery of The QVH Way continuous improvement programme. Staff have continued to receive improvement training and support to
10. Staff have the relevant skills and capacity to undertake their roles, with training and development programmes in place at all levels	
11. Staff can express concerns in an open and constructive environment	

	contribute directly to service improvement and organisational development. The Trust provides a range of development opportunities for staff. Mandatory and statutory training compliance remained strong and exceeded national requirements in several key areas. Apprenticeship investment increased during the year and a dedicated management development programme was established for Bands 6-8a, focusing on leadership skills, speaking up, staff wellbeing and managing difficult conversations. Workforce planning processes remain aligned to annual business planning and strategic objectives. The Trust remains committed to maintaining an open and transparent culture in which staff feel able to raise concerns. A range of mechanisms are available, including Freedom to Speak Up arrangements, People Pulse surveys, the NHS Staff Survey, Ask Abigail, Tell Liz and local engagement forums. Freedom to Speak Up reporting demonstrates increasing staff engagement with speaking up mechanisms and active Board oversight of themes, learning and organisational responses. The review concluded that Freedom to Speak Up arrangements are well established and supported by active Board oversight, with increasing levels of staff engagement with speaking up mechanisms. However, it also recognised that psychological safety is not yet experienced consistently across all teams and that continued focus is required to address cultural variation and support staff confidence in raising concerns. The Board receives assurance that staff feedback is actively used to shape organisational improvement. Staff Survey findings have informed targeted actions including wellbeing initiatives, leadership visibility programmes, culture development work, equality and inclusion initiatives and support for teams with lower levels of engagement. Whilst acknowledging significant activity to support equality, diversity and inclusion, the Well-Led Review identified opportunities to strengthen the measurement of outcomes and impact, improve engagement with staff networks and further increase visible diversity within leadership positions. The Board recognises that the 2025 Staff Survey identified areas requiring continued focus. Compared with 2024, staff engagement and morale declined, with increased reports of fatigue, workload pressures and reduced advocacy for the organisation as a place to work. Staff with long-term conditions also reported lower levels of involvement, motivation and morale. These issues are recognised within governance

	arrangements and have informed workforce priorities for 2026/27. Workforce indicators remained broadly stable during the year. The Trust reported a rolling turnover rate of approximately 11%, sickness absence averaging 4% per annum and continued reductions in agency expenditure. The Board continues to monitor workforce sustainability, recruitment and retention through established governance arrangements. The Board remains committed to creating a positive organisational culture, supporting the wellbeing and development of staff, and ensuring colleagues are empowered to contribute to organisational improvement and delivery of high-quality patient care.

IV. Access and delivery of services

Capability statements	Proposed domain rating
	Amber-Green
12. Plans are in place to improve performance against the relevant access and waiting times standards	The Board maintains oversight of operational performance through the Integrated Quality and Performance Report and recognises that, whilst performance remains strong in some areas and services, challenges remain in relation to the delivery of certain elective access standards. Improvement plans are in place and performance is monitored through established governance arrangements, including the weekly Executive led Performance Oversight Meeting, the Executive Access and Responsiveness Meeting, and the Finance and Performance Committee. These forums maintain a focus on reducing long waits, improving pathway management and ensuring safe and timely access to services. The Trust continued to improve elective access and reduce long waits during 2025/26. The start of 2026/27 has been more challenging for some services, particularly in relation to RTT and cancer performance. Key drivers include a material increase in referrals to the Sleep, Skin and Oral and Maxillofacial Surgery (OMFS) services. Recovery plans are in place, supported by additional Chief Executive level oversight of challenged areas to ensure appropriate grip and oversight. Urgent and Emergency Care (UEC) performance remains strong with the Trust MIU consistently exceeding the constitutional four-hour standard. The Board recognises that recovery of elective and cancer performance in some challenged services will take time given the scale of demand growth experienced during 2026/27. Recovery plans are in place and subject to enhanced oversight, with a focus on delivering sustainable improvements in access, waiting times and patient outcomes. The Board recognises the importance of addressing inequalities in access, experience and outcomes. During 2025/26, the Trust continued delivery of its Health Inequalities Strategy and strengthened its ability to identify variation through the development of a Health Inequalities Dashboard. Ethnicity data completeness improved from 79.8% to 83.9%, supporting a better understanding of inequalities across patient pathways and services. Analysis of waiting times, cancellations and Did Not Attend (DNA) rates by age, ethnicity, gender and deprivation has enabled the Trust to identify areas of potential inequity in access to care. Early findings suggest that patients from more deprived
13. The trust can identify and address inequalities in access/waiting times to NHS services across its patients	
14. Appropriate population health targets have been agreed with the ICB	

	communities and some demographic groups experience higher levels of non-attendance and longer waits for treatment. The Trust is using these insights to inform future improvement priorities and targeted interventions. The 2026 Well-Led Developmental Review recognised significant progress in improving demographic data quality and developing a better understanding of inequalities within the Trust's patient population. The review concluded that further work is required to demonstrate measurable improvements in patient outcomes and evidence the impact of health inequalities initiatives. Addressing this remains a key priority within the Trust's improvement programme. The Trust continues to work collaboratively with Sussex system partners, Cancer Alliances, provider collaboratives and neighbouring organisations to support elective recovery, improve access standards and strengthen service resilience. This partnership working is expected to contribute further to pathway resilience and service sustainability in future years. The Board recognises that further work is required to improve performance against some elective standards and to demonstrate measurable reductions in health inequalities. However, it is satisfied that operational risks are well understood, credible recovery plans are in place, and appropriate action is being taken to improve access while maintaining patient safety and the quality of care.

V. Productivity and value for money

Capability statements	Proposed domain rating
	Amber-Green
15. Plans are in place to deliver productivity improvements as referenced in the NHS Model Health System guidance, the Insightful board and other guidance as relevant	The Board recognises the importance of improving productivity and maximising value from available resources whilst maintaining quality of care, patient experience and staff wellbeing. Productivity and efficiency performance is monitored through established governance arrangements, including Executive Access and Responsiveness Sub-Committee, the Finance and Performance Committee, Integrated Quality and Performance Report, Board reporting and delivery of the Trust's efficiency and improvement programmes. The Trust has continued to strengthen its approach to continuous improvement through The QVH Way, its organisation-wide improvement methodology. The approach is embedded through improvement huddles, structured problem-solving and staff-led improvement activity, enabling teams to identify inefficiencies, improve patient pathways and support sustainable service improvements. The Well-Led Developmental Review identified The QVH Way as a significant organisational strength and recognised the Trust's investment in continuous improvement capability through Lean Six Sigma methodologies, improvement training and departmental huddles. The review found evidence of successful local improvement initiatives and increasing staff engagement in service improvement activity. Work continues to ensure that the processes are fully embedded. During 2025/26, the Trust delivered a range of productivity and service improvement initiatives. These included pathway redesign, improvements to diagnostic services, optimisation of cancer pathways, strengthened theatre and outpatient productivity initiatives and implementation of digital solutions to support more efficient ways of working. The Trust also continued to expand virtual models of care, with approximately 24% of outpatient appointments delivered virtually during the year, improving convenience for patients and reducing unnecessary travel. Digital transformation has been a key enabler of productivity improvement. During 2025/26, the Trust successfully implemented the Archie Electronic Patient Record and continued optimisation activity to improve clinical workflows, operational reporting, information accessibility and organisational efficiency. The Trust also progressed development of its Community

	Diagnostic Centre and digital innovations supporting integrated pathways and multidisciplinary working. The Trust has demonstrated the effective use of innovation to improve both productivity and patient outcomes. For example, implementation of the Bleepa platform within the breathlessness pathway supported secure multidisciplinary working across primary and secondary care, has reduced waiting times for patients, enabling patients to be managed without the need for a face-to-face specialist appointment. This approach received national recognition through the HSJ Partnership Awards. The Board continues to support productivity through investment in staff capability, leadership development and improvement training. Continuous improvement capability has been strengthened across clinical and corporate services, supporting delivery of local and organisational priorities and creating greater ownership of improvement activity amongst staff. Recognising the challenges associated with organisational scale, the Trust has agreed a strategic partnership with Ashford and St Peter's Hospitals NHS Foundation Trust and Royal Surrey NHS Foundation Trust Group. Following a period of shared planning and assurance, moving towards the implementation phase of the programme. Partnership workstreams include governance, leadership, financial alignment, clinical collaboration and corporate services, with the intention of improving resilience, reducing duplication and supporting financial sustainability. The Board ensures that productivity initiatives are considered alongside quality, workforce and patient experience impacts. Established governance arrangements, including quality impact assessments and integrated performance reporting, support oversight of the relationship between efficiency, productivity and quality outcomes. The Board recognises that further opportunities remain to improve productivity, strengthen benchmarking and increase transformation capacity. However, it is satisfied that the Trust has established a strong foundation for continuous improvement and is taking appropriate action to improve productivity whilst maintaining high standards of patient care and staff experience.

VI. Financial performance and oversight

Capability statements	Proposed domain rating
	Amber-Green
16. The trust has a robust financial governance framework and appropriate contract management arrangements	The Board maintains oversight of financial performance through established governance arrangements, including the Finance and Performance Committee, Audit and Risk Committee, Board reporting, the Board Assurance Framework and regular review of the Trust's financial position, financial risks and delivery of cost improvement plans. Financial, operational, workforce and quality information is routinely reviewed through the Integrated Quality and Performance Report, supporting effective triangulation of performance and decision-making. During 2025/26, the Trust delivered its financial plan and maintained financial stability despite a challenging operating environment. The Trust achieved a breakeven position after adjusting for additional deficit support funding and improved its underlying financial position compared with previous years. The Trust also maintained a strong cash position and continued investment in strategic programmes, including the Electronic Patient Record, Community Diagnostic Centre and critical infrastructure improvements. The Trust has continued to strengthen financial governance and assurance arrangements. The Finance and Performance Committee reported improvements in financial control, forecasting and financial planning during 2025/26 and was able to provide assurance to the Board regarding delivery of the Trust's financial plan. Financial risks, cost improvement programmes, workforce pressures, activity performance, capital expenditure and major transformation programmes are subject to routine committee scrutiny and Board oversight. The Trust maintains robust arrangements for contract management, procurement and financial controls. Audit and Risk Committee reporting demonstrates oversight of contracts, waivers, retrospective orders and compliance with the Trust's Standing Financial Instructions and procurement requirements. Review of governance arrangements during 2025/26 provided assurance that actions implemented following previously identified weaknesses have strengthened the internal control environment and improved compliance.
17. Financial risk is managed effectively, and financial considerations (for example, efficiency programmes) do not adversely affect patient care and outcomes	
18. The trust engages with its system partners on the optimal use of NHS resources and supports the overall system in delivering its planned financial outturn	

	Financial risk management remains a key Board focus. Strategic risks relating to financial sustainability, ageing estate infrastructure, efficiency delivery and long-term organisational resilience are monitored through the Board Assurance Framework and reviewed regularly through governance structures. Financial risks are considered alongside workforce, operational and quality risks to support balanced organisational decision-making. The Trust delivered £7.5 million of efficiency savings during 2025/26 and has established governance arrangements to oversee delivery of future efficiency requirements. The Board recognises the need to continue improving productivity and delivering recurrent efficiencies whilst maintaining quality of care and workforce wellbeing. An executive-led Efficiency Steering Group oversees delivery and risk management associated with the Trust's improvement and efficiency programmes. The Board seeks assurance that financial decisions do not adversely affect patient care, operational delivery or workforce wellbeing. Financial performance is reviewed alongside quality, operational and workforce indicators, and established governance arrangements ensure that risks associated with efficiency programmes and transformation initiatives are appropriately assessed and managed. The Trust continues to engage proactively with system partners to support the effective use of NHS resources. The Trust participates in the Provider Collaborative and meets weekly to work with Chief Finance Officer (CFO) partners across the system to collaborate on the best use of resources. Strategic partnership discussions with Ashford and St Peter's Hospitals NHS Foundation Trust and Royal Surrey NHS Foundation Trust Group include financial alignment, governance review and identification of opportunities to improve resilience, efficiency and long-term sustainability. The Trust has also implemented a shared CFO arrangement as part of these developments. The 2026 Well-Led Developmental Review highlighted strong levels of Board challenge, accountability and financial scrutiny, noting evidence of improving financial control, forecasting and governance arrangements. The review concluded that governance structures provide effective oversight of financial performance and strategic

	risks and recognised successful delivery of the 2025/26 financial plan. Independent assurance provides further confidence in the effectiveness of the Trust's financial governance arrangements. External Audit proposed an unmodified audit opinion on the 2025/26 financial statements and identified no significant weaknesses in the Trust's arrangements for securing economy, efficiency and effectiveness. Internal Audit concluded that there is a sound system of internal control and governance, with Financial Management, Key Financial Controls and Board Assurance Framework arrangements receiving Reasonable Assurance opinions. The Well-Led Review also noted that future financial sustainability remains a significant strategic challenge for the Trust, given the requirement for recurrent efficiency savings, estate pressures and wider NHS financial constraints. The Board recognises that successful delivery of productivity improvements, transformation programmes and strategic partnership benefits will be important factors in maintaining long-term financial resilience. The Board recognises that the financial environment during 2026/27 remains increasingly challenging. Delivery of the Trust's financial plan requires significant efficiency improvements through the Better Value programme and associated productivity initiatives. Robust governance arrangements are in place to oversee delivery, monitor associated risks and ensure that financial improvement actions are implemented in a way that protects patient safety, quality of care and workforce wellbeing. The Board is satisfied that appropriate governance, financial controls, assurance arrangements and risk management processes are in place and that financial risks are actively monitored and managed. However, it recognises that delivery of the 2026/27 financial plan, including Better Value programme requirements, and the Trust's longer-term financial sustainability remain key strategic challenges requiring active management and partnership working.

Signed on behalf of the Board of Directors

Chair: _____

Signature: _____ Date: _____

Signed on behalf of the Board of Directors

Chief Executive: _____

Signature: _____ Date: _____

Annex: Using a RAG-rating approach to derive the rating – guidance for providers

The table below sets out the approach providers should take to assess themselves across the six domains. Providers should set out, in their return template, a commentary covering the rationale behind each domain's rating, the evidence referenced in their return and improvements made since the last submission in 2025.

Note that regions will take their own views of capability across the board and will not have the level of detail that providers have – while the evidence here supports the rating it should not be considered automatic or algorithmic in every instance, rather it sets a general benchmark around different levels of capability taking account of the statements.

<table>
<tr><td colspan="2">Leadership and strategy</td></tr>
<tr><td colspan="2">Overarching expectation: the trust's board is working well as a unit to oversee the provider and has effective relationships with system partners and stakeholders. The board demonstrates the skills to oversee the delivery of safe, sustainable services, plans effectively and receives the right information to oversee performance and plan delivery as well as monitoring internal and external risk factors.</td></tr>
<tr><td>Capability statements</td><td>Indicative evidence</td></tr>
<tr><td>1. The trust's strategy reflects clear priorities for itself as well as shared objectives with system partners

2. If in breach: The trust is meeting and will continue to meet any requirements placed on it by ongoing enforcement action from NHSE
3. The board has the skills and expertise to deliver its strategy in the context of the 10-Year Health Plan.

4. The trust is working effectively and collaboratively with its system partners and provider collaborative for</td><td>The following are indicative aspects of each level of capability but should not be seen as exhaustive

Green
• Strategy is coherent, measurable, aligned with provider's objectives and system priorities.
• If in breach: all undertakings being delivered; regulatory confidence restored and trust on track to compliance
• Board has requisite range of skills; development plans active; succession plans in place; no vacancies > 3 months; no interims > 6 months.
• Strong collaboration with local partners; joint planning; shared outcomes delivered.
• Regular board reporting on cybersecurity matters, cyber built into Board Assurance Frameworks; digital strategy embedded.
Amber-Green
• Strategy mostly aligned with the provider's objectives but lacks depth or consistent delivery.</td></tr>
</table>

the overall good of the system(s) and population served 5. The trust has an effective cyber security strategy and uses digital technology to support improvement	• **If in breach:** On track to compliance with credible plans; minor slippage only. • Skills mostly adequate; some gaps recognised and being addressed. • Good relationships with system partners but inconsistent joint delivery. • Cybersecurity is mostly well-managed, but some areas lack maturity or consistency. • Concerns from independent board governance reviews or CQC well-led findings in past 6 months that are in hand **Amber-Red** • Strategy unclear, outdated, or inconsistently applied. • **If in breach:** Behind trajectory on return to compliance; repeated slippage; weak assurance. • Significant capability gaps at board level; weak development; over-reliance on individuals. • CQC well-led 'requires improvement' • Patchy collaboration; strained relationships; siloed behaviour. • Outdated systems; weak cyber assurance; limited digital use. **Red** • No credible strategy; board direction fragmented. • **If in breach:** persistent non-compliance; enforcement actions escalating; board grip absent. • Board lacks a number of core skills; no development; unsafe capability. • CQC well-led 'Inadequate' • Board isolated; system relationships dysfunctional. • No credible cyber strategy; repeated material incidents.
Quality oversight	
Overarching expectation: the trust's board is set up for effective oversight of the quality of care it provides, monitoring safety, patient experience and using insights from third parties as appropriate. This is evidenced by robust information going to boards, a track record of high-quality care and an open, curious and enquiring approach on quality issues from executives and non-executives alike.	
Capability statements	**Indicative evidence**

6. The organisation has regard to relevant NHS England guidance (supported by Care Quality Commission information, its own information on patient safety incidents, patterns of complaints and any further metrics it chooses to adopt). 7. The trust has, and will keep in place, effective arrangements for the purpose of monitoring and continually improving the quality of healthcare provided to its patients 8. Systems are in place to monitor patient experience and there are clear paths to relay safety concerns to the board	*The following are indicative aspects of each level of capability but should not be seen as exhaustive* **Green** • Guidance is used effectively to drive improvements in quality of care. • Established quality governance arrangements in place; confidence in early warning systems; systems of triangulation identify issues before they become critical • Patient experience embedded in discussions around quality; concerns reach board quickly. **Amber-Green** • Mostly compliant with guidance and it is generally used to improve care; • Some gaps in the effectiveness of quality oversight e.g. escalation approaches or learning from close calls. Triangulation is used in places. • Systems in place to monitor patient experience but aren't always used consistently to escalate. **Amber-Red** • Guidance applied inconsistently • Board tends to be reactive to quality issues and actions to address issues are not consistently effective. • Limited insight into patient experience; slow escalation; weak or non-existent triangulation. **Red** • No regard for guidance; blind spots in safety and complaints. • Quality governance failing; evidence from third parties that serious risks are unmanaged. • No reliable patient experience monitoring.
People and culture	
Overarching expectation: the board has an accurate, evidence-based view of the trust's culture and improves the organisation as a place to work. This is evidenced by: staff input being collected, valued and used in board decisions; staff being able to speak up where they have concerns; and staff have access to training and other opportunities to carry out their roles as well as possible.	
Capability statements	**Indicative evidence**

9. Staff feedback is used to both improve the quality of care provided by the trust and monitor and improve staff experience 10. Staff have the relevant skills and capacity to undertake their roles, with training and development programmes in place at all levels 11. Staff can express concerns in an open and constructive environment	*The following are indicative aspects of each level of capability but should not be seen as exhaustive* **Green:** • Evidence that staff feedback drives improvement; strong culture indicated by high scores in staff survey, and Staff Standards measures. • Workforce plans credible; training embedded across the organisation; safe staffing levels in place and reviewed regularly. • Strong speaking-up culture. **Amber-Green** • Feedback collected but not consistently acted on. • Staff skills are mostly adequate but there may be gaps/insufficient depth in key areas. • Generally open culture; some pockets of concern in specific areas of the staff survey. **Amber-Red** • Feedback intermittently collected or when reported is out of date; limited impact on care or management actions. • Persistent gaps in skill levels in key areas; weak/ineffective training; • Evidence that staff groups indicate fear of speaking up; insufficient insights at board level. • Persistently lowest quartile in NHS staff survey **Red** • Persistent lowest 10% in NHS staff survey • Staff feedback ignored; culture deteriorating. • Unsafe staffing; no development in staff. • Evidence of a toxic culture; concerns suppressed.
Access and delivery of services	
Overarching expectation: the board understands the drivers of delivery of core national access standards and uses this to optimise the trust's performance. The Board has extracted the maximum reasonable performance from the resources, workforce and authority available to it, and does all it can to mitigate the impact of external factors.	
Capability statements	**Indicative evidence**
12. Plans are in place to improve performance against the relevant	*The following are indicative aspects of each level of capability but should not be seen as exhaustive*

access and waiting times standards 13. The trust can identify and address inequalities in access/waiting times to NHS services across its patients 14. Appropriate population health targets have been agreed with the ICB	**Green** • Generally delivering on trajectory vs plans. • Clear knowledge/awareness of access and care levels across local geography and demographics in order to identify and address inequalities; can demonstrate measurable improvement. • Targets aligned with system partners; joint delivery plans in place where necessary (e.g. with provider collaborative partners). **Amber-Green** • Plans credible but inconsistent delivery. • Inequalities in access/care identified; actions underway but not yet fully addressing issues. • Targets aligned with system partners; joint delivery plans in place as necessary (e.g. provider collaborative) but not fully implemented or delivering desired outcomes. **Amber-Red** • Under-delivery or deterioration in performance but board cannot demonstrate a credible plan to address it; • Underperforming local peers with no evidence of mitigating factors • Known variation in the quality of and access to services but little or no evidence of addressing them. • Limited engagement across system partners to deliver access standards. **Red** • Behind trajectory on multiple access measures with no credible plan to address. • No insights into inequalities by demographic. • No engagement with rest of system
Productivity and value for money	
Overarching expectation: the board understands how workforce, estate, asset utilisation, activity and provision of care interact at the trust to drive productivity. This is evidenced by a track record of improvements in productivity that are delivered within the wider context of quality of care and patient experience.	
Capability statement	**Indicative evidence**

15. Plans are in place to deliver productivity improvements as referenced in the NHS Model Health System guidance, the Insightful board and other guidance as relevant	*The following are indicative aspects of each level of capability but should not be seen as exhaustive* **Green** • Board understands drivers of productivity and can use them to improve use of resources; provider in top 25% vs peers • Productivity improvements are discussed in the context of quality of care, patient experience and staff wellbeing **Amber-green** • Board has good insights and credible plans but has not fully extracted efficiencies • Performance vs peers flat/declining <12 months **Amber-red** • Board is aware of poor productivity and associated symptoms but has been unable to address them • Declining productivity vs peers >12 months **Red** • Board cannot explain the drivers behind poor productivity, quantify the upside or deliver improvement • Persistent bottom quartile in benchmarks vs peers
Financial performance and oversight	
Overarching expectation: the trust's board demonstrates a good financial understanding and literacy, leads the forecasting and risk management process and has a track record of overseeing the delivery of financial plans and efficiencies and offers strong challenge and insight. There is effective triangulation of workforce, activity and finance in both forward planning and in-year oversight.	
Capability statements	**Indicative evidence**
16. The trust has a robust financial governance framework and appropriate contract	*The following are indicative aspects of each level of capability but should not be seen as exhaustive:* **Green**

management arrangements 17. Financial risk is managed effectively, and financial considerations (for example, efficiency programmes) do not adversely affect patient care and outcomes 18. The trust engages with its system partners on the optimal use of NHS resources and supports the overall system in delivering its planned financial outturn	• Track record of delivering financial plans 'without surprises'; cost improvement programmes are generally delivered • Executives and Non-Executives understand the drivers of the trust's financial position and the board links finance discussions to quality of care, operational demand and workforce • Financial risks are reviewed regularly at board level; • Strong links between trust and system planning functions; supports system outturn. Impact of external factors outside the board's control are minimised **Amber-Green** • Occasionally off-plan, but generally returns to plan over time and by year-end • Cost improvement programs are delivered, but below forecast • Minimal reliance on one-off mitigations to hit plans **Amber-Red** • Understands headline numbers but struggles to explain or control how underlying drivers affect financial performance. • Unplanned reliance on agency/bank staff • Has recurring forecasting inaccuracies and missing planned performance – may rely on one-off mitigations to ameliorate under-performance • Shows weak linkage between workforce, activity levels, quality of care and financial performance. **Red** • Persistent plan under-delivery, with frequent unexpected in-year deterioration in performance vs plan, and little confidence in forecasts. Consistently misses savings targets. • Unplanned reliance on agency/bank staff • Board cannot clearly articulate factors behind the organisation's financial position; weak board-level financial governance, poor scrutiny of financial information and the factors behind performance • Track record of reliance on external support, regulatory intervention or year-end bailouts; little

	connection with system partners on financial planning and investment

Report cover-page					
References					
Meeting title:	Board of Directors				
Meeting date:	16/09/2026	**Agenda reference:**	**77-26**		
Report title:	Board Assurance Framework (BAF)				
Sponsor:	Jamie O'Callaghan, Interim Company Secretary, Executive risk leads				
Author:	Jamie O'Callaghan, Interim Company Secretary				
Appendices:	Appendix one- BAF summary, Appendix two- BAF				
Executive summary					
Purpose of report:	To present the Board Assurance Framework (BAF) for review, providing oversight of the principal strategic risks to delivery of the Trust's strategic objectives and an assessment of the actions most likely to reduce strategic risk exposure.				
Summary of key issues	• The BAF comprises ten strategic risks following the inclusion of Cyber as a standalone strategic risk in July 2026. • The highest-rated risks remain Estates, Finance and Leadership Capacity (all scoring 16), with Sustainability & Strategy scoring 15. • Nine of the ten strategic risks remain outside their agreed risk appetite. Workforce remains the only strategic risk operating within appetite. • Assurance ratings remain largely stable, with nine risks rated Amber and Quality rated Green. • No strategic risk scores have changed since the previous Board review. • Executive Directors have introduced collective BAF review sessions to strengthen oversight of interdependencies between risks and identify the actions most likely to reduce overall strategic risk exposure. • The actions expected to have the greatest impact on reducing risk relate to implementation of the strategic partnership programme, leadership stability, recurrent financial improvement, estates infrastructure investment, operational recovery and organisational resilience. Access remains a key area of Board focus, particularly in relation to cancer performance and long waiting patients				
Recommendation:	The Board is asked to: 1. Review the Board Assurance Framework and confirm that it appropriately reflects the principal strategic risks facing the Trust. 2. Provide any comments or direction on the strategic risks, assurance gaps and risk reduction priorities identified within this report.				
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:	ELT, Board sub-committees				
	Date:		Decision:		
Next steps:					

Board Assurance Framework (BAF)

1. Introduction

The Board Assurance Framework (BAF) sets out the principal strategic risks that may impact delivery of the Trust's strategic objectives. It provides the Board with oversight of the effectiveness of controls and assurances and supports identification of areas where further action or assurance may be required.

The BAF was last reviewed by the Board on 9 July 2026 and has subsequently been reviewed through the relevant committee structure during July and August 2026. Committees have reviewed risk ratings, controls, assurances, action plans and alignment with risk appetite.

The BAF comprises ten strategic risks, including Cyber, which was approved as a standalone strategic risk in July 2026 to provide enhanced visibility and oversight of cyber security and organisational resilience risks.

2. Strengthening Executive Oversight of Strategic Risk

Since the previous Board review, the Executive Leadership Team has introduced dedicated BAF review sessions, enabling strategic risks to be considered collectively rather than solely through individual executive ownership.

This approach has strengthened discussion of interdependencies between risks, improved challenge regarding assurance and risk appetite, and enabled greater focus on those actions most likely to reduce overall strategic risk exposure. Initial feedback from Executive Directors has been positive, particularly in relation to understanding the links between Sustainability & Strategy, Leadership Capacity, Finance and Estates.

The Executive Team intends to continue this approach as part of the ongoing development of the Trust's risk management and assurance arrangements.

3. Strategic Risk Overview

The Board last reviewed the BAF on 9 July 2026. Since that review, there have been no changes to strategic risk scores and the overall strategic risk profile remains broadly unchanged.

The highest-rated risks continue to be:

- Estates (16)
- Finance (16)
- Leadership Capacity (16)

Sustainability & Strategy remains a significant strategic risk with a score of 15. Access, Cyber, Digital and Regulation score 12, whilst Workforce and Quality score 9.

Nine of the ten strategic risks remain outside their agreed risk appetite. Workforce remains the only strategic risk operating within appetite.

The overall assurance position remains stable, with nine risks rated Amber and Quality remaining Green.

At the last meeting in on 1 September, the Quality and Safety Committee considered whether the current residual risk score of 9 continues to accurately reflect the level of control and assurance in place, noting progress in strengthening governance and assurance arrangements. The Committee suggested that the current score may warrant further review against the target score of 6 and requested further consideration by the Executive Leadership Team.

The Executive Team's collective review of the BAF identified that the Trust's overall strategic risk profile is increasingly driven by a small number of interconnected risks, principally Sustainability & Strategy, Leadership Capacity, Finance and Estates. In addition, Access remains a key area of Board focus due to the ongoing challenges associated with cancer performance, long waiting patients and delivery of national operational standards. Whilst not among the Trust's highest-scoring strategic risks, Access remains one of the most important risks from a patient, performance and regulatory perspective and will therefore continue to receive enhanced executive oversight.

4. Heat Map

The Board's strategic risk profile is illustrated in the heat map below. Whilst there have been no changes to risk scores since the previous review, the heat map demonstrates the relative concentration of risk across the ten strategic risks and highlights those areas that continue to require the greatest Board attention. The Executive Team's collective review of the BAF confirmed that a small number of interconnected risks continue to drive the majority of the Trust's overall strategic risk exposure

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

The heat map demonstrates that the Trust's principal risk exposure remains concentrated within Estates, Finance, Leadership Capacity and Sustainability & Strategy. These risks are closely interconnected and continue to have the greatest influence on the Trust's overall risk profile. Progress in these areas is also expected to support reductions in several other strategic risks, including Access, Digital, Cyber and Regulation. Whilst no risk scores have changed since the previous review, Executive discussion concluded that these higher-scoring risks remain the key determinants of

the Trust's ability to deliver its strategic objectives and achieve longer-term sustainability.

5. Actions Most Likely to Reduce Strategic Risk

As part of the enhanced Executive review process, consideration was given not only to the current level of strategic risk but also to the actions most likely to result in a meaningful reduction in risk exposure. Whilst each strategic risk has an associated action plan, Executive discussion identified a small number of cross cutting priorities that are expected to have the greatest impact on reducing the Trust's overall strategic risk profile during the remainder of 2026/27.

Strategic Priority	Key Action	Risks Most Impacted
1. Strategic Partnership and Leadership	Deliver partnership implementation and future leadership arrangements	Sustainability & Strategy, Leadership Capacity, Finance, Workforce, Regulation
2. Operational Recovery	Improve cancer performance and reduce long waits	Access, Quality
3. Financial Sustainability	Deliver recurrent savings and financial recovery plan	Finance, Sustainability & Strategy, Workforce
4. Infrastructure Resilience	Deliver estates investment programme and reduce backlog maintenance	Estates, Quality
5. Organisational Resilience	Strengthen cyber resilience, digital continuity and infrastructure resilience	Cyber, Digital, Estates

These actions are expected to have the greatest influence on the Trust's overall strategic risk profile as they address the highest-scoring risks and support improvement across multiple strategic risk domain.

6. Overall Assurance

The Board Assurance Framework continues to provide an appropriate reflection of the principal strategic risks facing the Trust and demonstrates active oversight through the Board and committee structure.

Whilst the overall risk profile remains largely unchanged, progress continues across a number of strategic programmes, including the strategic partnership, estates investment programme, cyber resilience agenda and financial recovery initiatives.

The Executive Team's collective review of the BAF has reinforced that the Trust's future risk profile will be most significantly influenced by progress in relation to strategic partnership implementation, leadership stability, financial sustainability, organisational resilience and operational recovery

7. Recommendation

The Board is asked to:

- Review the Board Assurance Framework and confirm that it appropriately reflects the principal strategic risks facing the Trust.
- Provide any comments or direction on the strategic risks, assurance gaps and risk reduction priorities identified within this report

Board Assurance Framework Summary - Updated 11 August 2026

Ref	Strategic Risk	Score			Trajectory	Assurance rating	Risk appetite	Board Commentary
		Inherent	Current	Target				
1	**Access** *Failure to deliver against the operational plan and national access standards*	16	12	8	⟷	Amber (monitor and address)	Outside of risk appetite. Risk appetite for this area is cautious (4-6)	• Ongoing challenges remain in relation to cancer performance, long waiting patients and delivery of operational standards. Recovery plans remain in place and Access continues to be a key area of Board focus due to its direct impact on patients and external scrutiny.
2	**Cyber** *Major cyber security incident impacting service delivery*	16	12	8	⟷	Amber (monitor and address)	Outside of risk appetite. Risk appetite for this area is seek (15-20)	• Cyber risk remains focused on legacy infrastructure, asset visibility and organisational resilience. Progress continues through delivery of DSPT/CAF improvements, infrastructure upgrades and development of the Information Asset Register.
3	**Digital** *Failure to deliver clinical, operational and financial objectives through digital transformation*	20	12	12	⟷	Amber (monitor and address)	Outside of risk appetite. Risk appetite for this area is seek (15-20)	• The principal risks relate to sustaining digital transformation, securing future funding and strengthening resilience arrangements following successful EPR implementation
4	**Estates** *Estate deterioration impacting safe and sustainable service delivery*	20	16	12	⟷	Amber (monitor and address)	Outside of risk appetite. Risk appetite for this area is minimal (1-3)	• Estates remains one of the highest-rated risks within the BAF. Whilst additional funding has been secured, delivery of the funded programme and reduction of backlog maintenance remain critical to reducing risk.
5	**Finance** *Failure to achieve financial sustainability*	20	16	12	⟷	Amber (monitor and address)	Outside of risk appetite. Risk appetite for this area is minimal (1-3)	• Delivery of recurrent efficiencies and achievement of a sustainable financial position remain the principal challenges. Progress continues through implementation of the recovery plan and further development of the medium-term financial plan.
6	**Leadership capacity** *Insufficient leadership capacity to deliver strategic objectives and key projects*	20	16	8	⟷	Amber (monitor and address)	Outside of risk appetite. Risk appetite for this area is minimal (1-3)	• Leadership transition and implementation of future partnership arrangements remain the principal drivers of this risk. Progress continues in developing future leadership and governance arrangements.
7	**Workforce** *Workforce sustainability and culture*	15	9	6	⟷	Amber (monitor and address)	Within the range of risk appetite. Risk appetite for this area is open (8-12)	• Workforce remains the only strategic risk operating within appetite. Key workforce indicators remain stable, although staff experience, morale and organisational culture continue to require close oversight during organisational change.
8	**Quality** *Failure to consistently deliver safe, high-quality care*	20	9	6	↓	Green (controls are effective)	Outside of risk appetite. Risk appetite for this area is minimal (1-3)	• Quality continues to have the strongest assurance position within the BAF and remains the only Green-rated strategic risk. Safe staffing, patient experience and quality governance arrangements remain strong.
9	**Regulation** *Failure to meet regulatory requirements*	20	12	8	⟷	Amber (monitor and address)	Outside of risk appetite. Risk appetite for this area is minimal (1-3)	• Regulatory assurance remains stable, supported by positive internal and external assurance and continuing improvements in governance and policy compliance.
10	**Sustainability and strategy** *Failure to secure long-term organisational sustainability*	20	15	10	⟷	Amber (monitor and address)	Outside of risk appetite. Risk appetite for this area is open (8-12)	• Sustainability & Strategy remains a significant strategic risk. Successful implementation of the strategic partnership programme and delivery of anticipated benefits will be critical to reducing risk.

BAF001 - ACCESS

KSO1	KSO2	KSO3	KSO4	KSO5	Overall Assurance Rating (RAG)	Q3- 2025/26	Q4- 2025/26	Q1- 2026/27	Q2- 2026/27		
✓			✓	✓							

BAF

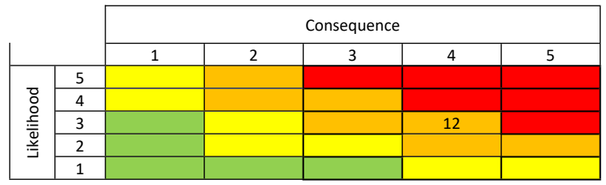
Risk description
Risk:
There is a risk that the Trust will not deliver against its operational plan and national access standards
Caused by:
Rise in waiting lists; increased demand; national changes;
Resulting in:
Patients waiting longer than we would like for treatment; potential patient harm/ poor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

Responsible committee	Finance and performance committee	**Date Risk Added:**	13 November 2025		
Principal Exec – Risk Owner	Chief operating officer	**Date Risk last reviewed:**	6 August 2026		
Risk Handler(s)	Deputy Chief operating officer	**Date Risk last formally discussed:**	9 July 2026	**Group**	Trust Board

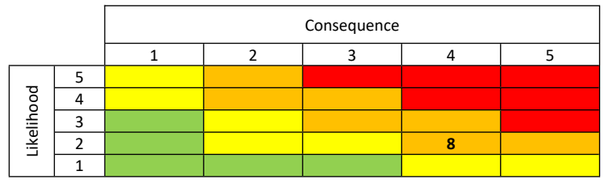
Inherent Score



Current Score



Target Score



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

Controls (what are we doing about risk)	Assurances and RAG rating (how do we know if it's working)	Gaps in assurance (what additional assurance is needed)
Monitoring against the operational plan 2025/26 weekly internally and externally with action plans for improvements	1st line: Review of cancer action plan by Cancer Board monthly. QVH has worked with the Surrey and Sussex Cancer Alliance to map the skin cancer pathway. A revised action plan incorporating QVH and SSCA actions was presented to Cancer Board in April 2026. We have a Cancer Project Manager that is due to start Aug/Sept 2026 to support pathway redesign. Overall cancer position is challenged. Improvements in FDS and 62 day performance are anticipated by September 2026 and further work is required on 31 days. August, 2026 Amber Updated recovery plans are in place to address performance challenges driven by increased demand, capacity challenges demand in Sleep, Skin and Oral and Maxillo Facial Surgery services, capacity constraints within Plastic Surgery and the need to strengthen operational grip and control across some care pathways. Enhanced operational oversight is making progress, supported	Non-RTT waits oversight and reporting – this is being reported on from M11 2025/26 and will continue in 2026/27. NHSE strategic review of breast reconstruction- the Trust has indicated wanting to be a key player within this. Breast is still challenged due to the national capacity constraints.

	by strengthened leadership and a clear focus on improving patient access and recovering performance, August 2026 Amber / Red 2nd line: Monthly reporting and monitoring through the IQPR demonstrates ongoing challenges with 65 week waits, 52 week waits and 18 week wait performance. For cancer, FDS 62 day and 31 day are currently challenged. August 2026 Amber/ Red (see action 2 and 8) 3rd line: Internal audit on faster diagnosis standards demonstrates reasonable assurance with a good control framework in place. The 2026 audit is on skin cancer 62 day is in progress. August 2026, Green LUNA Data Quality Assessment demonstrates high confidence levels at 99.6%, August 2026, Green National Oversight Framework rating by NHSE. The Trust was rated 42/ 134 trusts for performance overall for Q4 2025/26, June 2026 (fall in performance). Amber	
Governance and oversight incl. weekly tracking list meeting, weekly operational performance meeting, system planned care meeting, monthly access and performance meeting. Weekly focused recovery assurance meetings for sleep and plastics	2nd line: Monthly alert, assure, advise reporting to the ECQR from the Access and Responsiveness executive sub-committee demonstrates grip and control, appropriate oversight and escalation, August 2026, Green Independent review of waiting list management and governance carried out in March/April 2026, with recommendations highlighting key areas for improvement required in some services. August 2026. Amber (See Action 11)	
Clinical harm review process with CMO reviewing patients over 78 weeks. Metrics and learning on harm from delays in cancer pathways shared at Cancer Board	1st line: Weekly review of long waiting cancer patients in place. No confirmed moderate or greater than moderate harm confirmed, but noting longer wait impact for patient experience, June 2026, Amber (see action 4) Process established within cancer care pathways for harm from delays to be clinically evaluated resulting in targeted action and shared learning reported to Cancer Board. Reporting through Quality Committee to ECQR and by exception to Quality & Safety Committee demonstrates targeted action and shared learning, Amber (see action 4)	Clinical Lead for Cancer has responsibility and oversight of progress in this metric. As at April 2026 there are 39 patients on a skin pathway awaiting a clinical harm review, and 14 on a head and neck pathway awaiting a clinical review.
Health inequalities priorities improving data collection around ethnicity and processes for patients under the mental capacity act	1st line: Annual report to Board on addressing health inequalities demonstrated improvement in ethnicity data capture, priorities and key risks including resource constraints. Key assurance still required is related to the impact for patients, September 2025, Amber (see actions 3, 6 and 7) Paper on health inequalities discussed at quality and Safety Committee in Q4 2025/26 with progress on developing a HI dashboard.	Data for patients with other protected characteristics due to patient administration system. Impact on health inequalities work for patients.

	HI Focus Areas identified doe progression relating to Deprivation / DNA impact in regard to both PTL reporting and targeted review for Medway spoke site patients. Amber (See Action 11)	
Access policy, booking policy, training manual for appointments staff, EPRR policies in place	2nd line: Internal review of policies demonstrates the majority of operational policies are in date and have been reviewed against most recent guidance Green EPRR annual assurance to Board demonstrates Substantial compliance. Next update due September 2026. Green 3rd line: Internal audit on faster diagnosis standards demonstrates reasonable assurance with a good control framework in place. The 2026 audit is on skin cancer 62 day is in progress. August 2026, 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	In progress, conversations with NHSE have commenced. Paced impacted by NHSE restructures
3. Use the Health Inequalities Task and finish Group to continue to prioritise ethnicity recording, and to work through actions to reduce inequalities where these are known, e.g children with long waits.	February 2026	CNO	Complete
4. Completion of clinical review of harm for cancer patients with long waits	January 2026	CMO	Complete
5. Develop oversight and reporting for non-RTT waits	April 2026	COO	Complete
6. Health inequalities data for patients with protected characteristics	February 2026	CNO	Complete
7. Provide assurance about the impact on health inequalities work completed to date and yet to be completed for patients	February 2026	CNO	Complete
8. Revisit action plans to address issues with 65 week waits to address any internal pathway challenges	~~May 2026~~ September 2026	COO	Action plans in place, revised trajectories for non-breast patients (0 by Sept 2026)
9. Revisit action plans to improve cancer performance to meet 2026/27 plan	May 2026	COO	Complete – will be subject to monthly review and update
10. Delivery of recovery action plan	In line with plan for review in September 2026	COO	Ongoing – in progress
11. Further review of actions required for 8 to incorporate waiting list review recommendations	June 2026	DCOO / COO	Complete
12. Targeted HI work programme	September 2026	CNO	On track

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

BAF002 - CYBER

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

BAF

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

Responsible committee	Audit and risk committee	**Date Risk Added:**	03 June 2026		
Principal Exec – Risk Owner	Tamara Everington, Chief medical officer	**Date Risk last reviewed:**	03 June 2026		
Risk Handler(s)	Bill Gordon, Chief digital information officer	**Date Risk last formally discussed:**	09 July 2026	**Group**	Trust Board

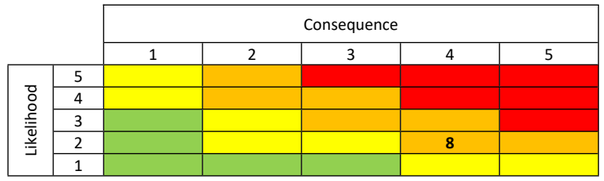
Inherent Score



Current Score



Target Score



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

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

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

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

Links to Organisational Risk Register	Digital risk register / BAF

BAF003 - DIGITAL

KSO1	KSO2	KSO3	KSO4	KSO5	Overall Assurance Rating (RAG)	Q3- 2025/26	Q4- 2025/26	Q1- 2026/27	Q2- 2026/27		
✓	✓		✓	✓							

BAF

Risk description

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

Responsible committee	Finance and performance committee	**Date Risk Added:**	13 November 2025		
Principal Exec – Risk Owner	Tamara Everington, Chief medical officer	**Date Risk last reviewed:**	17 August 2026		
Risk Handler(s)	Bill Gordon, Chief digital information officer	**Date Risk last formally discussed:**	9 July 2026	**Group**	Trust Board

Inherent Score



Current Score



Target Score



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

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

BAF003 - DIGITAL

Organisational resilience in the event of digital systems failure	1st line: Regular review / refresh as needed of business continuity plans to ensure ongoing service provision in the event of system failure Red 2nd line: Scheduled EPRR simulation events to test resilience. Lessons learnt with actions following unplanned outage. Red	Systematic process aligned to Information Asset review to be developed to ensure assets, especially essential system assets have an in date BCP. Review lessons learnt from unplanned outage. Plan EPRR simulation events.
Horizon scanning for digital funding with NHSE incl. commissioning intentions	1st line: Discussion with NHSE about medium term planning- no confirmation about future funding, bids submitted to Frontline Productivity and Wayfinder calls May 2026, Green 3rd line: Commissioning intentions for 2026/27 demonstrate a continued commitment to driving digital transformation and plans to address duplication in digital infrastructure with opportunities to share costs and functions across the system for implementation from 1 April 2026, ongoing discussions with new ICB Lead, Amber	Trust reliant on external funding to progress. Internal funding agreed until 31 December 2026. Engagement with ICB Digital Strategic Commissioning Enablement Lead.
Workforce with specialist digital and technical skills to support digitisation	1st line: Core Trust IT require further development of specialist technical skills. Contractors and internal staff on secondment to support Digital Transformation Programme programme internally funded until December 2026 with some stepdown from June 2026. Amber 2nd line: Outsourced functions to 3rd party providers through managed service contracts. Contract monitoring processes in place, Green	Time limited resource with no confirmation of long-term funding. Internal funding agreed until December 2026. Management of change to include identification of skills requirements for specific roles by October 2026.

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

BAF004 - ESTATES

KSO1	KSO2	KSO3	KSO4	KSO5	Overall Assurance Rating (RAG)	Q3- 2025/26	Q4- 2025/26	Q1 2026/27	Q2 2026-27		
✓			✓								

BAF

Risk description
Risk:
There is a risk that the Trust's estate deteriorates to the point where it is no longer safe
Caused by:
Ageing estate; poor quality of previous work completed; limited capital resource to address critical infrastructure challenges; maintenance and repair backlog; estates team resource challenges; lack of compliant ventilation
Resulting in:
Harm to individuals; Potential impact on service delivery; services no longer being delivered from the QVH site; financial loss; reputational damage.

Responsible committee	Finance and Performance committee	**Date Risk Added:**	10 November 2025		
Principal Exec – Risk Owner	Chief People officer	**Date Risk last reviewed:**	6 August 2026		
Risk Handler(s)	Interim Director of Estates and Facilities	**Date Risk last formally discussed:**	9 July 2026	**Group**	Trust Board

Inherent Score



Current Score



Target Score



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

Controls (what are we doing about risk)	Assurances and RAG rating (how do we know if it's working)	Gaps in assurance (what additional assurance is needed)
Estates policies and processes in place to support compliance with statutory requirements	1st line: Regular reporting on the Trust's estate to the Finance and Performance committee demonstrates that works are completed are in line with statutory requirements, July 2026, Green 2nd line: Regular report regarding out of date policies to the ECQR. Following the E&FSC meeting on 26th March, estates up to date on policies. August 2026 June 2026, all policies up to date Green (see action 6)	Planned backlog works to be completed including fire and heating systems multi-year plans and the schemes added following the receipt of £2.8m of additional estates safety funding. June 2026 – funding still to be received from NHSE. July 2026 – estates safety fund for 2026/27 confirmed for £2.4m An updated detailed six facet survey is in progress and contract has been awarded. Commencing 6 August 2026 to be completed by September 2026. Authorised engineer (AE) for electrical appointed and review on electrical compliance to be completed. June 2026 – AE report outstanding, has been followed up with AE. August 2026 – report received and being reviewed at electrical safety group

	Policy log demonstrates that key estates policies are in place to support compliance with statutory requirements, March 2026. June 2026 Policies are all in date. Green (see action 6) Premises Assurance Model (PAM) completed annually and reported to the Finance and Performance committee and the Board demonstrates significant improvement from the previous year with action planning for further improvements underway, New digital collection system is in the process of being launched March 2026. June 2026, PAM has been updated for 2026, with additional questions and evidence of compliance requirements. August 2026, PAM completed, reporting to Finance and Performance Committee 1 September 2026 ahead of NHSE Submission. Submission is by 28 September 2026. Amber. 3rd line: Authorised engineer (AE) review on water compliance was completed in September 2025 and the report is being actioned. August 2026 – new water AE appointed Authorised engineer (AE) review on ventilation compliance was completed in December 2025 and the report is being actioned. August 2026 – AE report reviewed by the ventilation group	Histology water action plan to be completed. June 2026, being reviewed as part of overall estates compliance plan and work planned for 2026/27.
Estates capital funding plan to ensure prioritisation of works in line with risks	1st line: Regular reporting on the Trust's estate to the Finance and Performance committee demonstrates limited funding available to appropriately address critical infrastructure risks, March 2026, Amber (see action 2). Receipt of the additional £2.8m of estates safety funding in 2025/26 and £3.6m in 2026/27 required to support estates critical infrastructure work. June 2026 – funding not yet received from NHSE for 2026/27. July 2026 – funding confirmed Green 2nd line: Review of estates budget by management accountant demonstrates that the directorate is overspent on its allocated budget at this stage of the year due to unplanned and unforeseen issues, March 2026, Amber (see action 2). June 2026, capital budget is limited for 2026/27, awaiting estates safety funds for 2026/27 to support delivery of essential maintenance. July 2026 – funding confirmed Green Regular reporting on financial performance through the IQPR demonstrates that the estates capital budget fully spent at March 2026, Green (see action 7) August 2026 – regular reporting via Finance and Performance Committee – on track to utilise all capital funds - Green 3rd line: £2.8m of estates safety funding received in November 2025, Green (see action 2) August 2026 - £2.4m of estates safety funding confirmed in July 2026 Green	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

BAF004 - ESTATES

Business continuity plans for dealing with a range of issues, for example critical infrastructure failure	2nd line: EPRR annual assurance to Board demonstrates full compliance, Green	Lack of EPRR lead There is a need to review estates specific business continuity plans. June 2026, review underway, with specific actions to ensure plans are in place. There are limited mitigations regarding emergency plant in the event of a critical failure as there is no in-built resilience. There is no normal load plus one for critical plant which is not in line with HTM guidance Reliance on key individuals to enact business continuity plans. June 2026, on-call arrangements and business continuity plans to be supported by contractors whilst there remains gaps in the estates establishment. August 2026 – key roles have been recruited to
Asbestos management plan in place to meet the statutory requirement of CAR 2012 (Control of Asbestos Regulations)	1st line: Regular review of Management Plan by estates leadership incl. visual inspection of asbestos areas demonstrates a requirement to remove certain asbestos contained roofing materials (ACM's) within six months. Amber. June 2026, work has been completed on a replacement roof for the estates building. 3rd line: The Management Plan is reviewed annually by an external specialist contractor. Review undertaken in November 2025. Green Regular testing (refurbishment and demolition surveys) to identify asbestos prior to any building or repair works being undertaken, demonstrates no works to be undertaken in unsafe environment, November 2025, Green	Assurance from annual review of Asbestos Management Plan D Additional roofing actions have now been prioritised and funded.
Estates team and key roles with appropriate qualifications to manage the Trust's estate	1st line: Review of team demonstrates that key roles are in place including Associate Director of Estates and Facilities, Project managers and Compliance Manager, however there are gaps in expertise relation to electrical and mechanical, March 2026. June 2026, Fire Safety Officer, Waste Compliance Manager and Compliance Co-ordinator roles have been appointed / have started in their roles. Mechanical and electrical specialist roles remain unfilled, with reliance on contractors due to these gaps. Amber (see action 4).August 2026 – electrical engineer appointed.	Lack of qualified persons in roles incl authorised persons such as electrical and mechanical. June 2026 – Authorised engineer in place for electrical. Ongoing recruitment to vacant roles underway. August 2026 – recruitement into key roles has been achieved Partnership opportunities and solutions to be explored.

BAF004 - ESTATES

Actions	Timescale	Lead	Status (complete, on track, off track, not yet started)
1. Statutory Fire advisor role to be recruited to	31 March 2026	ADEF	Successful candidate started May 2026 - completed
2. Seeking additional funding from NHSE for funding for critical infrastructure risks	30 June 2026	DEF	Notification on 10 June funding approved - complete
3. Arrange for a six facet survey to be completed	31 July 2026	DEF	Contract awarded
4. Appointment of replacement authorised engineers (AE) to be completed	31 October 2026	DEF	Replacement of AEs being undertaken by DEF. Work ongoing – replacement of water and medical gas engineers
5. Review of estates specific business continuity plans	30 September 2026	ADEF	Underway – reviews of plans / updates being undertaken by ADEF / DEF
6. All estates policies to be updated in line with requirements	31 March 2026	ADEF	Completed
7. Continued oversight of estates capital spend to support year end position	31 March 2026	CFO	Completed
8. Complete Estates Bench marking compliance review	30 September 2026	DEF	On track
9. Compliance report for electric, water, ventilation, fire to be produced	30 September 2026	DEF	On track
Links to Organisational Risk Register	153 (spread of fire), 139 (electrical fire), 47 (failure of electrical systems), 48 (fire alarm), 49 (fire dampers), 53 (heating and hot water)		

BAF005 - FINANCE

KSO1	KSO2	KSO3	KSO4	KSO5	Overall Assurance Rating (RAG)	Q3- 2025/26	Q4- 2025/26	Q1- 2026/27	Q2- 2026/27		
✓	✓	✓	✓	✓							

BAF

Risk description

Risk:

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

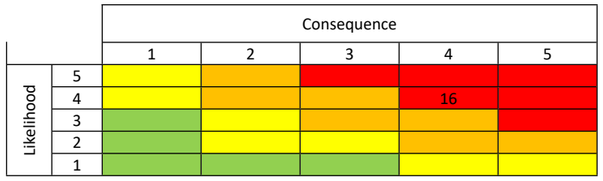
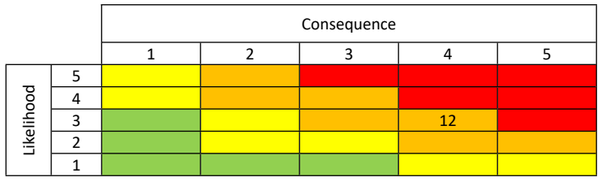
Caused by:

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

Resulting in:

The Trust not being financially sustainable for the future.

Responsible committee	Finance and performance committee	**Date Risk Added:**	13 November 2025		
Principal Exec – Risk Owner	Chief Finance Officer	**Date Risk last reviewed:**	10 August 2026		
Risk Handler(s)	Deputy Chief Finance Officer	**Date Risk last formally discussed:**	9 July 2026	**Group**	Trust Board

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

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

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

BAF005 - FINANCE

	Report to ELT on the business planning approach for 2027/28 along with learning from the previous years planning process, October 2026, Green 2nd line: Fortnightly review of business planning progress by business planning group worked well and will be continued in the 2027/28 planning and will be used again to monitor delivery and triangulation of plans Will need to be further developed for 2027/28, June 2026, Amber	

Actions	**Timescale**	**Lead**	**Status** (complete, on track, off track, not yet started)
1. Continued identification of cost improvement programmes and conversion of non-recurrent to recurrent schemes	Ongoing	CFO	Ongoing
2. Develop Governance handbook to support staff across organisation	30 September 2026	CS	First draft Complete
3. Medium term financial plan development following 1st year of the plans	Q3/Q4 2026/27	CFO	Plan for year 2 to be updated and refreshed for 2027/28 planning.
4. Dashboard for financial assurance within the Audit and Risk committee to facilitate the compliance review	Q3/Q4 2026/27	DCFO	On track – draft has been created for comments
5. To compile and implement an in-year recovery plan to achieve breakeven at 31 March 2027	31 August 2026	CFO	On track
Links to Organisational Risk Register	161 (cash balance), 148 (CIP), 149 (ERF assumptions), 144 (delivery of breakeven plan)		

BAF006 – LEADERSHIP CAPACITY

KSO1	KSO2	KSO3	KSO4	KSO5	Overall Assurance Rating (RAG)	Q3- 2025/26	Q4- 2025/26	Q1- 2026/27	Q2- 2026/27		
✓	✓	✓	✓	✓							

BAF

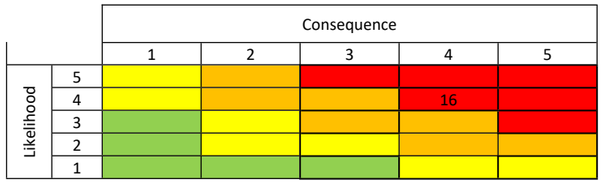
Risk description
Risk:
There is a risk that there will not be leadership capacity to deliver the strategic partnership, key strategic objectives and key projects
Caused by:
Four interim executive roles including Chief executive officer; turnover in Board level roles and organisational memory loss; three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

Responsible committee	Strategy and culture committee	**Date Risk Added:**	13 November 2025		
Principal Exec – Risk Owner	Chief executive officer	**Date Risk last reviewed:**	10 August 2026		
Risk Handler(s)	Chief executive officer	**Date Risk last formally discussed:**	09 July 2026	**Group**	Board

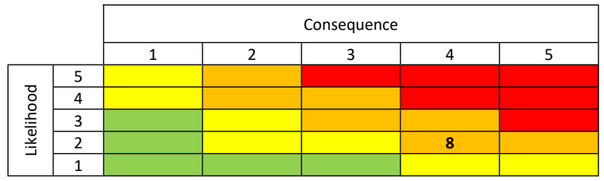
Inherent Score



Current Score



Target Score



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

Controls (what are we doing about risk)	Assurances and RAG rating (how do we know if it's working)	Gaps in assurance (what additional assurance is needed)
Key Board level roles being filled incl. executive portfolios covering all areas of operational business	1st line: Review of Board roles demonstrates all roles currently filled with some executive roles being filled by interims to ensure the required level of experience required. An interim Chair is now in post until October 2026, Amber Board succession plan presented to the Nomination and remuneration committee in March 2025 demonstrates a limited succession pipeline for key roles, March 2025, Red (see action 2) Chief strategy officer role has been filled on an interim basis, April 2026, Green 3rd line: Recruitment process started for shared Chair and CEO being in post by October 2026, Green	Board skills and maturity matrix to be reviewed in October 2026 Acting CEO to leave QVH in early October. Managing Director appointment process currently ongoing in August 2026. Group Chair, Group CEO and QVH processes started and due to commence in late September 2026.
Programme of work to deliver strategic partnership incl. timeline	1st line: MoU now signed by all ASPH/RSFT/QVH, Green	

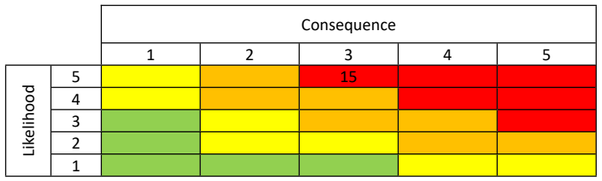
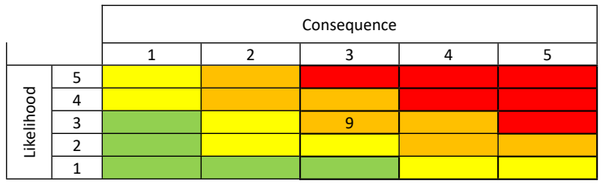
	Reporting to the Strategy and Culture committee outlining the timeline demonstrates that the Trust is meeting milestones, Green Transition and implementation plan was shared with Strategy and culture committee in February 2026, demonstrates commencement of workstreams and finance and governance reviews,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

Actions	**Timescale**	**Lead**	**Status** (complete, on track, off track, not yet started)
1. Shared Chair and CEO to be in post by October 2026	~~March 2026~~ October 2026	CEO	On track- Appointment process started July 2026.
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
6. Board skills and maturity matrix to be reviewed	~~June 2026~~ October 2026	Interim Chair, CS	On track
7. Confirm Chief finance officer cover from June 2026	May 2026	CEO	Complete- shared interim CFO with RSFT
8. Confirm and action revised leadership arrangements from October 2026	October 2026	CEO	On track
Links to Organisational Risk Register	11 (relationship between Board and Council of Governors)		

BAF007 - PEOPLE

KSO1	KSO2	KSO3	KSO4	KSO5	Overall Assurance Rating (RAG)	Q3- 2025/26	Q4- 2025/26	Q1- 2026/27	Q2- 2026/27		
		✓									
BAF	**Risk description** Risk: There is a risk that the Trust is unable to fulfil its commitment to being an excellent employer and may not have a workforce fit for the future Caused by: Significant organisational change; uncertainty; the Trust's significant cost improvement target; requirement for corporate service cost reduction; leadership capacity and managers capability Resulting in: Staff turnover; single points of challenge and lack of resilience; challenges with recruitment and retention; challenges with organisational culture; a negative effect on staff wellbeing and motivation; non-delivery of key strategic objectives and projects; impact on quality										

Responsible committee	Strategy and culture committee	**Date Risk Added:**	13 November 2025		
Principal Exec – Risk Owner	Chief people officer	**Date Risk last reviewed:**	10 August 2026		
Risk Handler(s)	Deputy Chief people officer	**Date Risk last formally discussed:**	9 July 2026	**Group**	Board

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

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

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

	and an improving trajectory. Appraisals out of date by more than 3 months is decreasing, May 2026. Appraisal rates have improved to 85% August 2026 Amber Employee relations team weekly review of employee relations cases, demonstrates focus points for specific support and interventions required, October 2025. May 2026 – weekly review meetings continue, with thematics from cases triangulated with other data Green (see action 1) 2nd line: Organisational cultural assessment undertaken to be presented to the Board in November 2025, demonstrates that there are micro cultures and ongoing focus required to embed behavioural framework. Presented to Board in November, with ongoing work to support culture development (December 2025). Update on areas of consideration and next steps presented to Strategy and Culture Committee in March 2026 . V2 of the report will be presented to the Strategy and Culture committee in Q2 2026/27 and will compare to V1 Green	
Mechanisms in place for staff to provide feedback incl. Staff Survey, Quarterly People Pulse Surveys, Freedom to Speak Up Service, 'Tell Liz', 'Ask Abigail'	2nd line: 2024 Staff survey results published in March 2025 with a 57% response rate, demonstrate disabled staff have a less positive experience than non-disabled staff and staff do not always feel confident action will be taken if they speak up. 2025 staff survey results published in March 2026, with a 56% response rate and a small decline in some areas for speaking up, and increase in some areas, with focussed work underway to prioritise areas of decline. Update paper being taken to the Strategy and Culture Committee in September 2026 Amber People Pulse Survey for Q2 was responded to by 14% of staff which demonstrated a decline in mood and motivation. People Pulse Survey for 2025/26 (up to January 2026) was responded to by 474 staff. In Q4 139 (10.7%) staff completed the People Pulse Survey. The Q4 results demonstrated an improvement in mood and motivation. Pulse survey is currently live for completion during April 2026. The Q1 People Pulse Survey results will be presented to the Strategy and Culture Committee in August 2026 Amber 3rd line: FTSU Guardian report presented to the Board in July 2025 demonstrated that more staff are speaking up but some staff still wishing to stay anonymous due to concerns about the consequence. FTSU report and Raising concerns report presented to the Board in February 2026, with some staff still wishing to stay anonymous. Updated report presented to the Board in April 2026. Update presented to the Board in July 2026. Green	Ongoing action plans from staff survey. Once 2025 staff survey results are available in March 2026 (once embargo is lifted), specific action plans will be worked on with departments March 2026 – staff survey results published with reports sent to departments. Workshops in place for supporting managers to understand results and work with their teams on areas of focus. May 2026 – staff survey results presented to Strategy and Culture Committee and Board. Further analysis to be undertaken where there are significant deteriorations in results. Directorates and corporate departments are presenting their priority areas to executive directors on 27 May 2026. Follow up paper to be taken to the Strategy and Culture Committee in September 2026. To note, turnover hasn't increased in 2026/27

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

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

BAF008 - QUALITY

KSO1	KSO2	KSO3	KSO4	KSO5	Overall Assurance Rating (RAG)	Q3- 2025/26	Q4- 2025/26	Q1- 2026/27	Q2- 2026/27		
✓	✓		✓								

BAF	Risk: There is a risk that the Trust may be unable to consistently deliver high quality, safe care Caused by: Pressures on workforce capacity, increasing patient demand, variation in clinical practice, infrastructure limitations or less effective governance arrangements Resulting in: Patient harm, poor patient experience, regulatory action, financial impact and reputational damage

Responsible committee	Quality and safety committee	**Date Risk Added:**	13 November 2025		
Principal Exec – Risk Owner	Chief medical officer / Chief nursing officer	**Date Risk last reviewed:**	10 August 2026		
Risk Handler(s)	Deputy Chief nursing officer	**Date Risk last formally discussed:**	9 July 2026	**Group**	Board

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

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

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

BAF008 - QUALITY

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

	Six monthly report to Board demonstrates procedures are in place and inpatient staffing levels are safe, and have been reviewed in line with cost improvement plans, January 2026, Green 3rd line: NHSE Oversight of safer staffing processes and compliance, Green	
Digital transformation - Archie EPR implementation included extensive clinical engagement which must continue through transition to Archie PAS and other digital transformation priority programmes	1st line: CNIO in post with clinical safety capability supporting maintenance of hazard log and clinical safety case, further Clinical Safety Officers (CSOs) trained and supporting this work. CCIO in place and supporting improvement in end user experience, Green 2nd line: Third party vendor provided independent clinical safety assessment for Archie EPR to ensure areas of non-compliance with DCB1060 highlighted prior to go live, remaining actions completed by Archie EPR Programme Team. Internal CSOs trained and collaborating to support further digital transformation including PAS supported with mentorship from the third-party vendor, Green	Funding constraint in ongoing support for the digital transformation programme including clinical safety for 26/27
Clinical Governance reporting framework established	1st line: Dedicated clinical governance staff time to ensure consistent recognition and evaluation of quality and safety metrics, Green 2nd line: Quality and safety sub-committee of Board and executive sub-committee for quality in place with oversight of quality and safety matters, November 2025, Green Reporting through revised Quality, Safety and (clinical) Risk infrastructure to regularly evaluate achievement against metrics and learning from triangulated data, Green 3rd line: Report from Well-led review pending, due July 2026, Amber	Reflection on clinical governance structure and processes will be required on receipt of the Well-led review report.
Staff Training – Designated leadership in clinical professional learning. Electronic and face to face training environments.	1st line: Line manager oversight of training compliance through ESR, Green 2nd line: MAST training compliance monitored and acted upon through Quality committee, Green 3rd line: Provider assurance framework includes oversight of training data, Green	
Clinical Risk Management – drives understanding and action on identified risk to quality and safety.	1st line: Inphase risk management system in place to manage risk, Green 2nd line: Quality and safety sub-committee of Board and executive sub-committee for quality in place with oversight of quality and safety matters, November 2025, Green IQPR, ECQR and local clinical governance meetings where risk evaluation takes place, Green	Lack of robust process for risks to be escalated and approved to the risk register. Limited ability to triangulate risk with other clinical governance data due to recording in separate systems (eg. Inphase/Datix). Ensure external audit of risk management completed

	3rd line: External auditing of risk management	

Actions	Timescale	Lead	Status (complete, on track, off track, not yet started)
1. Evidence of actions following staff survey address deficiencies in staff confidence to speak up needs to be addressed through behavioural framework initiatives and evidenced in regular reports	31 March 2027	CPO, CNO, CMO	In progress / ongoing
2. Quality and Equality Impact Assessment Policy being revised to incorporate QIA, EIAs and ongoing monitoring / assurance	31 August 2026	CNO, COO, CMO, CIP Leads	In progress
3. Review PSIRF policy and ensure resource in place to maintain effective and timely management of incidents following completion of the working group addressing historical incidents	31 October 2026	CNO, Head of Safety & Patient Experience	In progress
4. Biannual Raising concerns paper identified a reduction in 'Tell CNO' enquiries which may be linked to lack of anonymity, to review and monitor for next paper	31 July 2026	CNO, Head of Safety & Patient Experience	Pending
5. Weekly meeting between the CNO, Deputy CNO and Head of Quality & Compliance to review CQC preparedness	31 March 2027	CNO, Dep CNO, Head of Quality & Compliance	Ongoing
6. Reconfiguration of nursing staff and review of the impact on quality once in place to include care of patients in outpatient environment	31 October 2026	CNO	Complete
7. Funding applications submitted to NHSE to support ongoing digital transformation programme, result awaited	31 August 2026	CDIO, CMO	Pending
8. Reflection on clinical governance structure and processes will be required on receipt of the Well-led review report.	31 September 2026	CNO, CMO	Pending
9. Exploration of quality management systems to enable triangulation of intelligence.	31 October 2026	CMO, Head of Quality and Compliance, Company Secretary	In Progress
10. Senior leaders to dedicate time for visibility within services to enable learning, support and improvement.	31 September 2026	Executives & Senior Leaders	Complete

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)

BAF009 - REGULATION

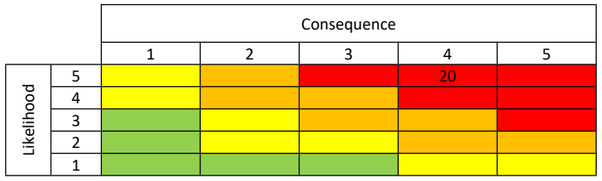
KSO1	KSO2	KSO3	KSO4	KSO5	Overall Assurance Rating (RAG)	Q3- 2025/26	Q4- 2025/26	Q1- 2026/27	Q2- 2026/27		
✓	✓	✓	✓	✓							

BAF

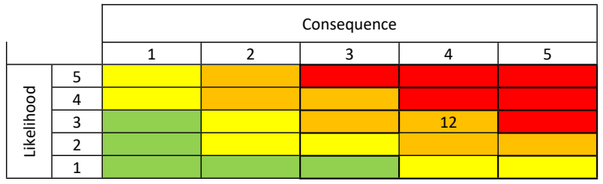
Risk description
Risk:
There is a risk that the Trust may not be able to meet its regulatory requirements
Caused by:
Scale; cost improvement plans; corporate savings; turnover at Board level; non-compliance; leadership capacity; national changes to requirements
Resulting in:
Damage to reputation; non-removal of additional licence conditions; regulatory intervention

Responsible committee	Audit and Risk committee	**Date Risk Added:**	13 November 2025		
Principal Exec – Risk Owner	Chief executive officer	**Date Risk last reviewed:**	11 August 2026		
Risk Handler(s)	Company secretary	**Date Risk last formally discussed:**	9 July 2026	**Group**	Trust Board

Inherent Score

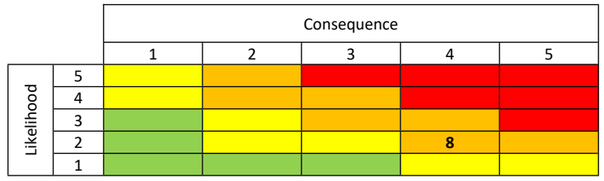


Current Score



Direction of travel since last review	⟷

Target Score



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

Controls (what are we doing about risk)	Assurances and RAG rating (how do we know if it's working)	Gaps in assurance (what additional assurance is needed)
Key Trust policies in place aligned to statutory and regulatory requirements	1st line: Reporting to the ECQR demonstrates that a revised 'policy for policies' is in place and has been disseminated to staff. The revised policy for policies seeks to ensure consistency for policy management across the Trust, however further assurance is required to demonstrate improvements with policy management, July 2025, Amber (see action 1) Reporting to the ECQR demonstrates that a robust process is in place to ensure that policy owners are made aware when policies are expiring incl the deadline and process for updating them, December 2025, Green Oversight dashboard in place as of Q4 2025/6. Policies at 92% compliance as of June 30 2026, Green 2nd line:	Assurance that the 'policy for policies' has been embedded and driving improvements in policy management Assurance that progress is being made in updating out of date policies or taking them out of circulation if they are deemed to be duplicative/ no longer required

	Reporting to the ECQR on out of date policies demonstrates that of 239 active policies, 19 are out of date which is an decrease since the last review. No key corporate policies are out of date, June 2026, Green (see action 2) 3rd line: Internal Audit reported that 28 actions arising in 2025/26 had been implemented, including all high-priority actions, with remaining actions monitored through Audit & Risk Committee. June 2026, Green	
Governing documents in place including Trust Constitution, Scheme of delegation and reservation of powers, Standing financial instructions aligned to statutory and regulatory requirements	1st line: Reporting to the Audit and risk committee regarding compliance demonstrates no known breaches since Q4 2024/25, June 2026, Green 2nd line: Approved Annual Governance Statement conclusion for 2025/26 demonstrates no significant control issues. This is aligned to the Head of Internal Audit opinion, June 2026, G Green 3rd line: Head of Internal Audit Opinion 2025/26 concluded that there are areas with a generally sound system of internal control designed to meet the Trust's objectives and that controls are generally being applied consistently, although some improvements can be made, June 2026, Green The Trust received confirmation in March 2026 that its additional licence conditions have been removed due to the Trust's work on its strategy and strategic partnership and the strong relationship between the Board and Council of Governors, March 2026, Green	
Annual Provider Capability Assessment demonstrating Board awareness of gaps against key lines of enquiry from the Insightful Provider Board guidance	1st line: Provider capability assessment undertaken by the Board demonstrates a confirmed rating for quality of care and people and culture and a partially confirmed rating for other areas. The submission demonstrated action being taken to address gaps. An update on the progress against the gaps was taken to Audit & Risk committee in June 2026. June 2026, Amber (see action 5) 3rd line: Review of Provider capability assessment undertaken by NHSE and QVH received a rating of Amber/Green which is aligned to the Trust's own assessment, March 2026, Green	Review of progress against actions to address gaps- scheduled for June 2026
Code of Governance for NHS Provider trusts	2nd line: Annual review of compliance against the Code of Governance for NHS provider trusts to Board demonstrates one area of non-compliance during 2025/26, related to NED pay. This is compared to multiple areas of compliance being reported in previous years. March 2026, Green	

Actions	**Timescale**	**Lead**	**Status** (complete, on track, off track, not yet started)
1. Review of effectiveness of 'policy for policies'	~~July 2026~~ September 2026	CS, executive team	On track
2. Continued oversight of management of out of date policies incl. priority areas	Ongoing	Policy owners	On track

BAF009 - REGULATION

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	Completed – June Audit & RIsk committee update paper
Links to Organisational Risk Register			

BAF010 – SUSTAINABILITY AND STRATEGY

KSO1	KSO2	KSO3	KSO4	KSO5	Overall Assurance Rating (RAG)	Q3- 2025/26	Q4- 2025/26	Q1- 2026/27	Q2- 2026/27		
✓	✓	✓	✓	✓							

BAF	**Risk description** Risk: There is a risk that the Trust will not secure long-term sustainability Caused by: Inability to progress the strategic partnership; Potential delays in progressing the partnership; Challenges with progression of partnership implementation and associated decision making; a potential breakdown in relationship between the Board and the Council of Governors; leadership capacity and resilience challenges; changes to the commissioning of services; changes to service specifications; staff morale; time constraints Resulting in: Sustainability challenges for patient services/ site; priority shift of QVH Strategy 2025-2030; regulatory intervention; reputational damage; non-delivery of recurrent annual financial, productivity and efficiency savings

Responsible committee	Strategy and Culture Committee	**Date Risk Added:**	13 November 2025		
Principal Exec – Risk Owner	Acting Chief Strategy Officer	**Date Risk last reviewed:**	10 August 2026		
Risk Handler(s)	Acting Chief Strategy Officer	**Date Risk last formally discussed:**	9 July 2026	**Group**	Board of Directors

Inherent Score

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

Current Score

Likelihood \ Consequence	1	2	3	4	5
5					
4					
3					15
2					
1					

Target Score

Likelihood \ Consequence	1	2	3	4	5
5					
4					
3					
2					10
1					

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

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

	Lead Governor visit to RSFT May 2026, Green Further walk in workshop planned for staff and volunteers June 2026, Green	
Engagement with key stakeholder's incl. NHSE and ICB- regarding potential partnership arrangements and option appraisal process incl. staff, patients, members, Council of Governors, primary care partners	1st line: Reporting to the Strategy and Culture committee demonstrates wide ranging engagement undertaken internally and externally from September 2025, Green Communication and engagement plan post Board approval has been agreed between partners from August 2026, Amber Shared lines of communication for the phase Aug 26 – March 27 is in development across all three partners, 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: Progress continues across programme workstreams, with commencement of workstreams and finance reviews from NHSE and RSFT CFO completed, Green 2nd line: ASPH/RSFT agreed for QVH to join the expanded group (following on QVH decision in December 2025). Green ASPH/RSFT/QVH signed MoU in July 2026. Green 3rd line: Continued engagement with NHSE demonstrates alignment with key timelines, May 2026, Green QVH well-led review now completed and action plan being developed, Green	Contingency planning in the event of a delay in implementing the senior leadership in October 2026.
Governance and oversight - Oversight by the Strategy and culture committee (SCC) and Board including input from Council of Governors and Strategic assurance group. Strategic direction by NHSE and ICB	2nd line: Ad-hoc Strategic Assurance Group (SAG) made of up internal key stakeholders in place to ensure critical decision making is appropriate and transparent, May 2026, Green 3rd line: Monthly QVH internal Partnership Steering Group in place from March 2026, Green Weekly Partnership working group between QVH and RSFT/ASPH in place from March 2026, Green	
Partnership implementation plan- incl. six key workstreams: Programme management, Corporate governance, Communication and engagement, Leadership and culture, Financial and planning alignment 2026/27, Clinical and corporate alignment	1st line: Reporting to Strategy and culture committee demonstrates that implementation plan is in place and progressing from February 2026, Green Governance structure for first 6 months (From October 2026) has been defined, Green 2nd line: Six key workstreams have assigned executive senior responsible officers and risks have been identified with mitigations, March 2026, Green 3rd line:	Benefits realisation for partnership to be further developed Proposed governance structure for partnership April 27 onwards not yet defined

BAF010 – SUSTAINABILITY AND STRATEGY

	Financial governance review of QVH undertaken by NHSE demonstrates no concerns. Recommendations will be monitored by the Partnership steering group, March 2026, Green Review of financial documents undertaken by partners Chief finance officer demonstrates no significant concerns, March 2026, Green Awaiting outcome of QVH Well-Led governance review July 2026, Amber	

Actions	**Timescale**	**Lead**	**Status** (complete, on track, off track, not yet started)
1. Continued shared 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. RSFT/ASPH Stakeholder analysis to be completed	~~July 2026~~ September 2026	Acting CSO	On track
8. Arrangements to be made for QVH to join partners Transformation committee	~~August 2026~~ November 2026	Acting CSO	On track
9. QVH well led review of leadership and governance	July 2026	CS	Complete
10. Benefits realisation for partnership draft to be shared with FPC	~~August 2026~~ September 2026	Acting CSO	On track
11. Contingency planning in the event of a delay in implementing the partnership	July 2026	Board	Complete
12. Contingency planning in the event of a delay in the CoG decision in September around senior leadership	October 2026	CSO/CoSec	On track
13. Board sign off of partnership MoU across all three Trusts	July 2026	Board	Complete

Links to Organisational Risk Register	132 (delivery of QVH Strategy 2025-2030), 189 (long term sustainability of key services), 208 (shared chair and ceo timeline), 223 (leadership capacity during partnership transformation), 224 (staff uncertainty and resistance to change), 225 (reduced leadership presence and visibility across QVH), 226 (finance and benefits), 234 (stakeholder confidence)

Report cover-page					
References					
Meeting title:	Board of Director				
Meeting date:	16/09/2026	**Agenda reference:**	**78-26**		
Report title:	Committee Terms of Reference				
Sponsor:	Jamie O'Callaghan, interim Company Secretary				
Author:	Jamie O'Callaghan, interim Company Secretary				
Appendices:	Appendix 1 - Finance & performance terms of reference Appendix 2 - Strategy & culture committee terms of reference				
Executive summary					
Purpose of report:	To present the amended Finance & performance and Strategy & culture committee terms of reference to the Board for approval.				
Summary of key issues	• Following recent changes to Board composition, the number of Non-Executive Directors serving on the Board has reduced from five to four. The committee's membership requirements therefore need to be amended to reflect the current Board structure. • The proposed amendments are intended to ensure that the Terms of Reference remain accurate, achievable and aligned with the Trust's governance arrangements. No changes are proposed to the committee's purpose, duties, delegated authority, reporting arrangements or quorum requirements. • Additional minor amendments are proposed to the Terms of Reference for the Strategy & Culture committee to ensure they are accurate and up to date. • The committee terms of reference were reviewed by the committees at their meetings in September 2026 and are recommended to the Board for approval.				
Recommendation:	The Board is asked to **approve** the changes to the Finance & performance and Strategy & culture committee Terms of Reference.				
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:	Standing orders Code of governance for NHS provider trusts Constitution				
Legal:	None				
Resources:	None				
Assurance route					
Previously considered by:	Finance & performance committee, Strategy & culture committee				
	Date:	September 2026	Decision:	Recommend for approval	
Next steps:	New terms of reference to come into effect on Board approval.				

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~~ Two 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.
***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.

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:

- Provide oversight and direction regarding the development of the Trust's strategic and sustainable future model
- Provide oversight and direction regarding the delivery of the QVH strategy 2025-2030, clinical ambitions and key enablers in the national context.
- 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

To fulfil its purpose, the Committee will:

- Maintain oversight of the effective management of Board Assurance Framework and organisational risks appropriate to the committee's remit
- Identify the key strategic issues, risks and opportunities requiring discussion or decision by the Board of Directors
- Advise on appropriate mitigating actions

Duties and responsibilities

Duties

Sustainability

- Detailed oversight of the development of the Trust's strategic sustainable future model
- Inform proposals related to partnerships and strategic collaborations and making recommendations to the Board
- 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~~ 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.

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~~ Two 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.

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.