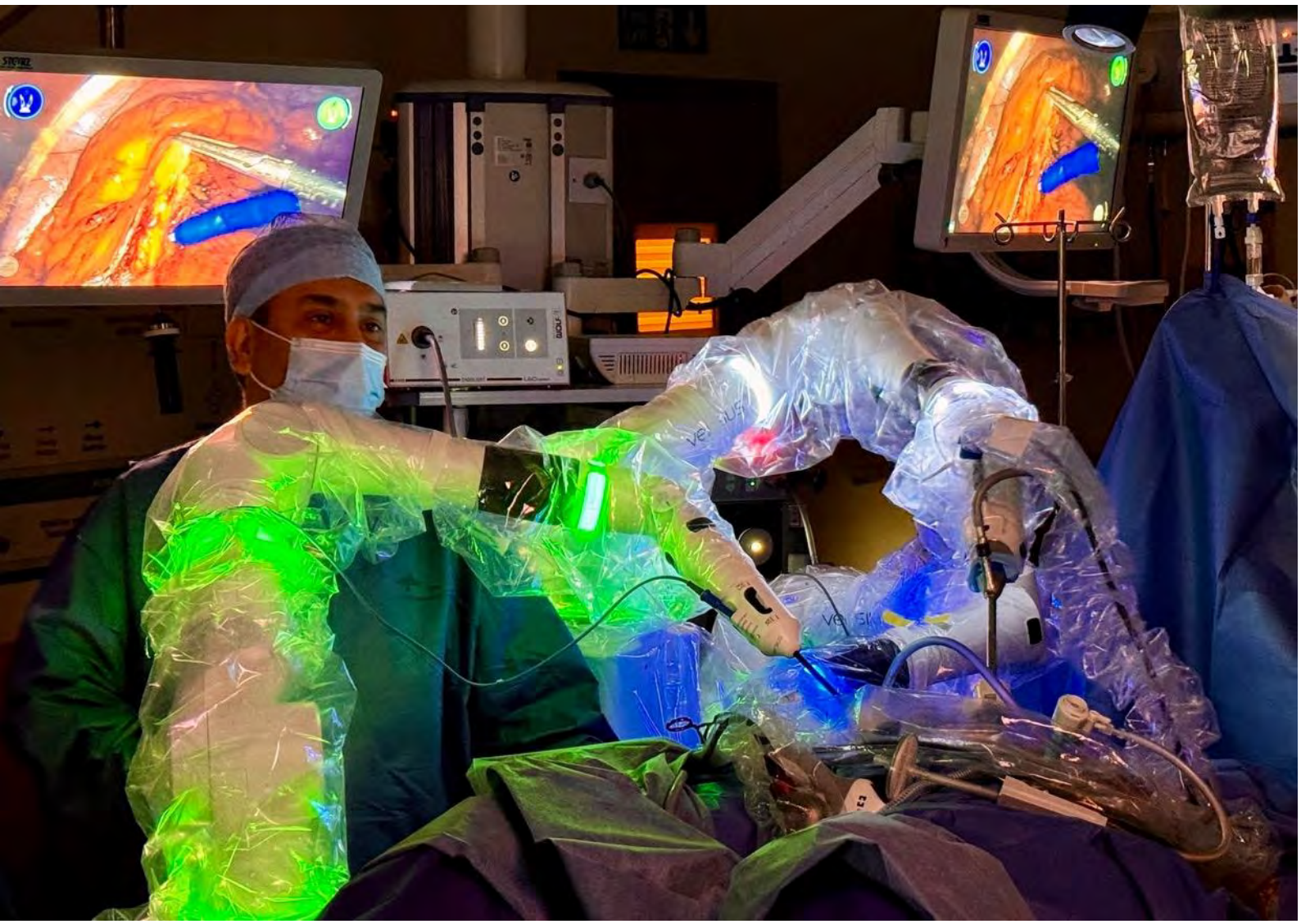
The Queen Elizabeth Hospital King's Lynn
NHS Foundation Trust

Annual Report and Accounts

2024/25



The Queen Elizabeth Hospital King's Lynn NHS Foundation Trust

Annual Report and Accounts 2024/25

For the period 1 April 2024 to 31 March 2025

Presented to Parliament pursuant to Schedule 7, paragraph 25 (4) (a) of the National Health Service Act 2006.

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This publication is available at www.qehkl.nhs.uk.

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Performance Report

This section of the report is intended to give an overview of how we did against the priorities we set ourselves for 2024/25 and describe our areas of focus for the year to come, reflecting on the Trust's Corporate Strategy and the direction of travel for the wider health and social care system in Norfolk and Waveney.

Statement from the Chair and Chief Executive

As we reflect on the past year, we do so with a deep sense of pride both in improvements that have been made this year and the dedication demonstrated by all of those who are part of the team at The Queen Elizabeth Hospital King's Lynn NHS Foundation Trust (The QEH).

Despite the wider challenges facing the healthcare sector, we have witnessed exceptional accomplishments across our Trust. Every member of staff at The QEH, regardless of their role, has contributed meaningfully to our shared mission of providing safe, high-quality and compassionate care. The dedication, professionalism and collaboration demonstrated throughout the organisation have made a tangible impact on patient outcomes and staff experience alike.

Among the highlights of the year was the announcement of His Majesty King Charles III's patronage of the Trust – an honour that recognises the excellence of our services and the dedication of our staff. We were also proud to receive a 'Good' rating for our maternity services from the Care Quality Commission (CQC), affirming our ongoing commitment to continuous improvement and the delivery of safe, person-centred care.

Significant strides have been made in the development of our estate and infrastructure for patients that need our care now. Our Estates team delivered a £66 million Capital Programme, including the installation of steel failsafe roof panels through the Reinforced Autoclaved Aerated Concrete (RAAC) Programme. We also received £1.5 million in backlog maintenance, one way in which we used this funding was to and improve energy efficiency with site-wide LED lighting upgrades. Additional capital investments include a newly refurbished resuscitation area and the installation of a new Gamma Camera – enhancements that support the delivery of safe, modern healthcare.

In line with our strategic priorities, the launch of the Community Diagnostic Centre (CDC) and the Peddars Way Unit represent key milestones in expanding access and improving patient pathways. Our commitment to digital innovation has also been demonstrated through the successful implementation of a new Electronic Observation system, which captured over 200,000 patient observations in its first year. This development has been instrumental in improving patient safety and clinical effectiveness. The introduction of Martha's Rule and the increased use of the NHS App further illustrate our focus on empowering patients and their loved ones.

We continue to be inspired by the dedication and compassion shown by our volunteers and staff. The introduction of Ted, a therapy dog on West Dereham Ward, exemplifies our holistic approach to care. In addition, The QEHKL Charity raised £80,000 to support dementia care, enabling the introduction of comfort-enhancing measures such as noise-cancelling headphones, reclining chairs, and all-weather buggies. Most notably, the charity funded a £1 million robotic-assisted surgery system, which is set to transform surgical outcomes.

Other achievements include the opening of the Butterfly Garden, a tranquil space for families who have experienced baby loss, and recognition of our Endoscopy Unit at the Building Better Healthcare Awards for its innovative design. The Grand East Anglia Run (GEAR) also raised significant funds in support of our services, reflecting strong community engagement.

One staff member we are particularly proud of is Jenifer Saravanan, Collaborative Patient Participation Lead, who received the Unsung Hero Award at the British Indian Nurses Association Awards – a testament to the remarkable dedication within our team. Our own awards, The 2024 QEH Staff Awards also celebrated the exceptional contributions of our colleagues, teams and external partners.

Our focus on education and workforce development has remained strong. The QEH Education Faculty was shortlisted for two national awards, reflecting our commitment to nurturing the future NHS workforce. Our successful Nurse Recruitment Open Days and Job Centre Takeovers have contributed to our ability to attract and retain skilled professionals.

A pivotal moment in our Trust's history came in May 2023, when the government formally included The QEH in the New Hospital Programme (NHP). This followed sustained local advocacy and political support. In January 2025, the government reaffirmed the priority status of RAAC hospital replacements. We are now progressing through the early stages of planning for a new hospital in King's Lynn – a facility that will serve our community for generations to come.

As we look ahead, we remain committed to continuous improvement. The formation of the Norfolk and Waveney University Hospital Group – comprising The QEH, Norfolk and Norwich University Hospitals (NNUH), and James Paget University Hospitals (JPUH) – marks a significant strategic development. This collaboration will strengthen our ability to deliver high-quality, sustainable healthcare across the region.

As we begin a new financial year a new Group Model with JPUH and NNUH, we do so with renewed focus and ambition. We are confident that The QEH will meet future challenges with professionalism, compassion and determination.

We extend our sincere thanks to our more than 4,000 staff, volunteers, and Governors, as well as to our Trust members, local communities and partners. The achievements of the past year are a testament to what we can accomplish together. We look forward to continuing this journey with you in the year ahead.

Signed

Mark Friend
Interim Group Chair

Professor Lesley Dwyer
Group Chief Executive

Our year in numbers

Purpose and activities of the Foundation Trust

The QEH provides acute hospital services to the residents of King's Lynn and West Norfolk, as well as parts of Cambridgeshire. Lincolnshire, North Norfolk, and Breckland.

Due to the geographical location and population that The QEH serves the Trust is commissioned by Integrated Care Boards (ICBs) across Norfolk, Cambridgeshire and Lincolnshire, with NHS Norfolk and Waveney ICB acting as the lead commissioner. The Trust works collaboratively with the Norfolk and Waveney, Cambridgeshire and Peterborough, and Lincolnshire Integrated Care Systems (ICS).

In alignment with our Clinical Strategy and the Norfolk and Waveney Acute Hospital Collaborative Acute Clinical Strategy, we are developing integrated pathways to ensure long-term service sustainability and improved patient outcomes.

The QEH provides a range of acute district general hospital services across multiple sites including:

- The QEH site in King's Lynn
- North Cambridgeshire Hospital
- Swaffham Cottage Hospital
- St Augustine's Surgery (King's Lynn)
- Downham Market Midwifery Hub
- Wells Community Hospital

In 2025/26, we will expand our footprint further with the completion of the King's Lynn Health Hub, which will become an additional service delivery site.

Specialist services

- Acute Medicine (including Same Day Emergency Care)
- Anaesthetics
- Audiology
- Breast Surgery
- Cardiology
- Cardio-respiratory
- Clinical Psychology
- Colorectal
- Critical Care
- Dermatology
- Diabetes and Endocrinology
- Dietetics
- Emergency Medicine
- Ear, Nose and Throat
- Gastroenterology
- General Medicine (including Treatment and Investigation Unit)
- Haematology and Anti-coagulation
- Integrated Care of the Older Person (ICOP)
- Mortuary
- Nephrology
- Neurology
- Neurophysiology
- Obstetrics and Gynaecology
- Oncology*
- Ophthalmology
- Oral Surgery
- Orthodontics
- Paediatrics
- Pain Services
- Palliative Medicine
- Pharmacy
- Phlebotomy
- Radiology (MRI, X-ray, CT, Ultrasound, Nuclear Medicine and Bone Density scanning)†
- Respiratory
- Rheumatology
- Stroke
- Speech and Language
- Therapies
- Trauma and Orthopaedics
- Upper GI
- Urology‡
- Vascular§

* Our Oncology service is supplemented by additional facilities in Cambridge.
† Our radiology service is supplemented by additional facilities at the Norfolk and Norwich University Hospitals NHS Foundation Trust (NNUH).
‡ Urology services are delivered by The QEH with NNUH providing Consultant and Specialist Nursing staff
§ Thoracic, Vascular and Plastic Surgery services are provided by NNUH.

About us

The QEH is a district general hospital, employing over 4,000 staff and volunteers. We serve a population of approximately 375,000 and provide care for patients from West and North Norfolk, Breckland, Cambridgeshire, and South Lincolnshire. We are united in our commitment to delivering high-quality, safe and compassionate care.

Authorised as a Foundation Trust in 2011, The QEH has approximately 500 inpatient beds across 22 wards. In 2024/25, we cared for more than 94,000 people in our Emergency Department, performed 25,400 day case procedures, and delivered more than 1,700 babies. We also treated more than 31,900 elective and non-elective inpatients.

We are a research active organisation and play a key role in clinical innovation. Last year we recruited more than 1,800 participants to National Institute for Health and Care Research (NIHR) portfolio studies.

Collaboration is a central element of our improvement journey. Over the past year, we have worked closely with NNUH and JPUH to develop a group model for service delivery. In March 2025, the full case for establishing the Norfolk and Waveney University Hospital Group was published. This new structure signals a transformative phase for The QEH, grounded in shared ambition, innovation and excellence.

Over the past three years, the Trust has undergone significant improvement. We are now rated ‘Good’ by the CQC in three domains – Caring, Well-Led and Effective – while our overall rating remains ‘Requires Improvement’. This progress provides a strong foundation as we strive toward becoming an ‘Outstanding’ Trust.

Our Maternity Services have also been rated ‘Good’ by the CQC. Inspectors recognised the considerable changes made, highlighting improvements in staff culture, communication, and leadership.

In May 2023, The QEH was named as part of the government’s NHP. This recognition marked a historic milestone, validating the urgent need for modern facilities in King’s Lynn. In January 2025, the government confirmed the replacement of RAAC-constructed hospitals as a national priority. As we move forward, we remain committed to realising the New QEH – an investment that will deliver world-class healthcare for our communities long into the future.

Progress and momentum in delivering a New QEH

The past year has marked a period of significant advancement in the New QEH Programme, as we continue our transition from vision to reality in developing a state-of-the-art healthcare facility for the communities of West Norfolk and beyond.

Following the landmark decision in May 2023 – when the Secretary of State for Health formally recognised the urgent need for a new hospital in King's Lynn – we have taken crucial steps to advance the programme. Our inclusion in the national NHP has both validated the strength of our case and provided the foundational funding required to initiate the early stages of development. This commitment was further reinforced in January 2025, with a ministerial announcement confirming the replacement of RAAC hospitals as a government priority, supported by a dedicated funding stream.

A year of progress and collaboration

Under the leadership of Paul Brooks MBE, Director of Estates and Facilities and Senior Responsible Officer for the New QEH Programme, and supported by our expanding programme team, we have worked at pace to refine our proposals in line with the national Hospital 2.0 design principles. Throughout the year, we have engaged extensively with stakeholders across the Norfolk and Waveney ICB, our Trust Board, regional partners, and national bodies to ensure the development of a facility that not only meets clinical requirements but is also fit for the future.

A core focus has been the development of the Strategic Outline Case (SOC). In recognition of our full compliance with Hospital 2.0 specifications, and to incorporate the latest national design and financial guidance, the SOC timeline has been revised. A resubmission is now scheduled for August 2025, following internal Trust Board approval and regional endorsement from the Norfolk and Waveney ICB. We have continued to work in close collaboration with the NHP team to ensure our plans remain fully aligned with national expectations.

Key developments

Among the most tangible milestones this year has been progress on our multi-storey car park (MSCP), an essential enabling scheme for the New QEH. The Outline Business Case was approved by the NHP Investment Committee in February 2025, and work has now commenced on the Full Business Case, with construction anticipated to begin in early 2026. In addition to supporting the new hospital, the MSCP will provide immediate operational benefits by improving access and easing pressure on the existing estate.

We have also focused on ensuring the New QEH is appropriately scaled to meet the needs of a growing and ageing population. Working in partnership with the NHP Transformation team and national GIRFT (Getting It Right First Time) clinical leads

we have reviewed and refined our Schedule of Accommodation (SoA) based on detailed activity modelling. This has enabled us to incorporate best practice while balancing physical and virtual capacity to deliver a modern, patient-centred model of care.

In parallel, we have undertaken a comprehensive review of our current estate and operational performance, benchmarking against national standards to ensure that our transformation plans deliver care that is accessible, efficient and sustainable.

Addressing challenges and planning ahead

As with any complex infrastructure programme, we have encountered a number of challenges. We are working closely with national design experts to ensure our proposals meet clinical and spatial requirements while maintaining flexibility to accommodate future innovation in service delivery. Engagement with regional and national stakeholders has played a key role in validating our approach and aligning the programme with broader system transformation priorities.

In addition, we have strengthened our internal governance and assurance frameworks, embedding rigorous programme management, financial oversight, and stakeholder engagement processes. Continued dialogue with regulators, commissioners and clinical leaders has ensured that the programme remains responsive to both strategic imperatives and operational realities.

As we move into the next phase, our attention will turn to detailed design, workforce planning and early enabling works. These activities will be shaped by ongoing engagement with staff, patients and members of our local communities to ensure the hospital reflects the needs and aspirations of those that will use its services.

A shared commitment to transformation

The New QEH is more than a capital development – it represents a once-in-a-generation opportunity to reimagine and transform healthcare delivery in West Norfolk. The dedication of our staff, the support of our stakeholders and the backing of our local communities continue to propel this programme forward.

With each milestone, we are bringing the vision of the New QEH closer to reality. While challenges remain, our clear strategic direction, collaborative ethos, and collective ambition will ensure that we continue to build momentum. This project is not only about replacing an ageing facility – it is about shaping the future of healthcare through innovation, integration, and excellence.

The New QEH is no longer an aspiration – it is becoming a reality. Together, we are building a hospital for the future.

Our Integrated Quality Improved Plan and the Care Quality Commission (CQC)

CQC registration and inspection overview

The QEH is registered with the Care Quality Commission (CQC) and, as of the latest inspection, holds an overall rating of 'Requires Improvement'. This rating reflects the outcome of our most recent comprehensive CQC inspection, which took place cross December 2021 and January 2022, with the subsequent report published in February 2022.

Domain	Rating
Overall	**Requires Improvement**
Safe	Requires Improvement
Effective	Good
Caring	Good
Responsive	Requires Improvement
Well-Led	Good

The inspection recognised the significant progress made by the Trust since being placed in special measures in 2018. In particular, it noted improvements in leadership and governance structures, alongside enhanced service delivery across a number of areas.

In October 2023, the CQC undertook a focused inspection of our Maternity Services, specifically reviewing the 'Safe' and 'Well-Led' domains. While the rating for 'Safe' remained as 'Requires Improvement', the rating for 'Well-Led' improved to 'Good', resulting in an overall uplift in the Maternity Service's rating to 'Good'. This positive trajectory highlights the progress made in strengthening leadership, culture, and safety across the service.

Regulatory notices and ongoing monitoring

The Trust continues to operate under four Section 31 conditions of the Health and Social Care Act 2008, which remain active on our registration. These notices relate to the following service areas:

- **Urgent and Emergency Care**: concerning compliance with the 15-minute triage standard

- **Diagnostic and Screening Services:** two notices, one addressing governance processes, and the other relating to escalation procedures for unexpected clinical findings
- **Maternity and Midwifery Services:** relating to the escalation of deteriorating patients in accordance with national guidelines and recognised best practice

A substantial programme of work has been undertaken to address each of these regulatory conditions. Oversight is maintained through the Trust's internal Evidence Assurance Group, which continues to monitor progress against defined action plans. The Trust intends to apply for the removal of these conditions during the 2025/26 reporting year, subject to appropriate evidence and regulatory agreement.

Adoption of the Single Assessment Framework

In line with the CQC's updated methodology, the Trust has begun its transition to the Single Assessment Framework – a unified inspection approach that replaces previous sector-specific frameworks. This model is structured around a set of quality statements aligned to the CQC's five key questions: Is the service safe, effective, caring, responsive, and well-led?

The new framework enables more dynamic assessments through the triangulation of a broader range of evidence sources, including patient experience, staff and partner feedback, and performance data. This approach provides a more holistic view of care quality and informs continuous improvement across the Trust.

Well-led review

In autumn 2024, the Trust commissioned an external consultancy to support an independent review of its 'Well-Led' arrangements. This review formed part of our wider quality governance development and provided an opportunity to benchmark leadership structures and cultural maturity against national best practice. A feedback and reflection session was held with the Trust's Senior Leadership team in November 2024 to review findings and inform future actions.

2024 CQC Inspection ratings for The QEH

	Safe	Effective	Caring	Responsive	Well-led	Overall
Urgent and Emergency Care	Good	Good	Not Rated	Requires Improvement	Good	Good
Medical Care (including Older People's Care)	Requires Improvement	Good	Good	Good	Good	Good
Surgery	Good	Good	Good	Requires Improvement	Requires Improvement	Requires Improvement
Critical Care	Good	Good	Good	Good	Outstanding	Good
Maternity	Requires Improvement ➔➔ Feb 2024	Good	Good	Good	Good ↑ Feb 2024	Good ↑ Feb 2024
Gynaecology	Requires Improvement	Good	Good	Requires Improvement	Requires Improvement	Requires Improvement
Services for Children and Young People	Good	Good	Good	Good	Requires Improvement	Good
End of Life Care	Good	Requires Improvement	Good	Requires Improvement	Requires Improvement	Requires Improvement
Outpatients	Good	Not Rated	Good	Requires Improvement	Requires Improvement	Requires Improvement
Diagnostic Imaging	Requires Improvement	Not Rated	Good	Requires Improvement	Requires Improvement	Requires Improvement
Overall Trust 2022	Requires Improvement	Good	Good	Requires Improvement	Good	Requires Improvement

Our corporate objectives

Key Performance Indicators for Delivery in 2024/25

Our strategy is underpinned by nine core objectives, each supported by a set of defined Key Performance Indicators (KPIs) designed to monitor progress and direct our efforts. These KPIs, developed under the leadership of the Senior Leadership team, align with our overarching priorities.

Throughout the year, performance has been consistently monitored, celebrating achievements and identifying areas for improvement. Quarterly updates have been provided to relevant committees and the Board of Directors, ensuring effective oversight and continued progress.

Significant progress has been made in achieving several objectives, thanks to the dedication and collaboration of our teams. Where challenges have emerged, we have adopted a proactive approach, focusing on solutions and reinforcing efforts to drive improvements. This structured methodology enables us to build on our successes while remaining responsive to evolving needs.

Looking ahead to 2025/26, we will continue to refine our KPIs and maintain transparency in our reporting, ensuring we remain on track to deliver the best possible outcomes.

Quality

Strategic objective one: Holistic and Person-Centred Care and Experience

Providing high-quality, person-centred care is central to our mission. We recognise the unique needs of each individual, ensuring that patients receive compassionate, respectful, and dignified care that promotes physical health, overall wellbeing, and quality of life.

Our approach:

Our focus is on:

- Listening to patients to shape care and services
- Providing timely, reliable information to empower patients in making informed decisions
- Enhancing access to services by removing barriers to care
- Strengthening our commitment to compassionate care by embedding dignity, empathy, and respect in all interactions

Achievements in year one

- We reviewed patient feedback, including Friends and Family Test (FFT) results, Medical Examiner reports, and formal complaints. These insights guided improvements in care, ensuring patient voices drive change

- A Standard Operational Policy for patient information leaflets was introduced, updating 80 leaflets to ensure accessibility and alignment with best practices
- A new weekly review process for complaints has expedited resolutions and facilitated the integration of learning into service improvements
- A thematic review of patient safety incidents highlighted trends in communication, documentation, and access to information, leading to preventive measures to improve patient safety
- We expanded our Patient Panel and collaborated with community groups to ensure services meet diverse patient needs, including the introduction of an on-demand British Sign Language service

Looking ahead

We will continue to refine our approach to person-centred care, ensuring every patient receives the best possible care, tailored to their individual needs, with their voice at the heart of decision-making.

Strategic objective two: Clinical Excellence

Delivering the highest standards of clinical care is essential to our commitment to excellence. Through continuous quality improvement, research, and innovation, we strive to provide safe, effective, and compassionate care.

Our approach

Our focus is on:

- Embedding continuous quality improvement and innovation to meet the highest clinical standards, with digital maturity at the forefront
- Working towards becoming a recognised teaching hospital by developing structured education, training, and research partnerships
- Investing in our workforce to support personal and professional growth through education, development, and succession planning

Achievements in year one

- We launched an Excellence Questionnaire to gather insights from clinical teams on best practice and areas for improvement
- We strengthened our approach to Point-of-Care Ultrasound (POCUS), with plans to develop the Trust as a centre of excellence for POCUS by 2030
- Progress towards teaching hospital status includes formalising partnerships, aligning our medical education programmes with national standards, and strengthening our reputation through branding and partnership opportunities
- Our ‘Grow Your Own’ programme supported recruitment and development across clinical services, and we expanded apprenticeship programmes, with 175 learners undertaking qualifications across Levels 2–7

Looking ahead

We will continue to build on our progress, refining our approach and collaborating with partners to strengthen education and clinical excellence.

Strategic objective three: Delivery of Operational Efficiency and Effectiveness

Efficient and effective service delivery is fundamental to providing high-quality care. By optimising resources, streamlining processes, and continuously improving access to services, we aim to deliver the best possible outcomes for our patients.

Our approach

We are committed to:

- Managing performance through quality, national, and local access metrics to ensure timely care across all patient pathways
- Reducing inefficiencies and maximising resources through best practice approaches, including Getting It Right First Time (GIRFT) and Model Health recommendations
- Enhancing patient flow and experience by improving discharge processes, expanding virtual ward capacity, and developing alternatives to hospital admission

Achievements in year one

- We improved theatre productivity and day surgery performance, with theatre utilisation reaching 76.8% by March 2025 and British Association of Day Surgery compliance improving to 83.4%.
- Via the CDC, we introduced additional capacity in MRI, CT, and non-obstetric ultrasound (NOUS) to manage diagnostic demand, although challenges remain in meeting the 95% DM01 standard within six weeks
- Key initiatives in cancer pathways, including ‘Straight to Test’ pathways and One-Stop Clinics, are being embedded to improve cancer waiting times
- We introduced the Frailty Same Day Emergency Care (SDEC) unit to provide alternative pathways for ambulance admissions, reducing unnecessary Emergency Department attendances

Looking ahead

We will continue to refine our approach to operational efficiency, focusing on productivity, effectiveness, and patient experience in line with national planning guidance.

Engagement

Strategic objective four: Our People

Our workforce is at the core of everything we do. We are dedicated to creating an engaged, motivated, and values-driven team that meets the needs of our local community now and in the future.

Our approach

Our people strategy is based on the four pillars of the NHS Long-Term People Plan:

- Looking after our people: prioritising staff well-being, mental health support, and a culture of care
- Belonging in the NHS: fostering an inclusive and supportive workplace where every colleague feels valued
- Growing for the future: investing in training, apprenticeships, and leadership development to build a strong workforce
- New ways of working and delivering care: embracing innovation to improve efficiency and staff experience

Achievements in year one

- We have continued to embed a Restorative Just Culture, ensuring fairness, learning, and continuous improvement in managing workplace issues
- A new Employee Relations system was introduced to streamline case tracking, with over 100 managers actively using the system
- The Manager Fundamentals Training Programme has been well received, with over 100 managers completing the training
- We have introduced a sickness absence action plan, expanded the use of our Employee Assistance Programme (EAP), and focused on mental health support for staff

Looking ahead

We will continue to invest in our people, ensuring that the Trust remains a great place to work and is equipped to meet the evolving needs of the communities we serve.

Strategic objective five: Governance and Leadership

Strong governance and leadership provide the foundation for patient safety, high-quality care, and continuous improvement across our organisation.

Our approach

We aim to:

- Streamline governance processes, ensuring clear accountability across all levels

- Strengthen leadership and succession planning to ensure a sustainable leadership pipeline
- Enhance governance frameworks and decision-making transparency
- Embed a culture of safety and quality aligned with regulatory standards

Achievements in year one

- Governance arrangements have been streamlined using a Reasonable / Accountable Consulted / Informed (RACI) framework, ensuring clarity in decision-making and accountability
- A gap analysis led to improvements and an extended RACI framework for Divisional Leadership teams and governance committees
- Policy compliance has been improved through a quarterly review process, aligning policies with acute partners where appropriate
- The Governance Improvement Plan has been fully integrated, supporting the Trust to work towards CQC well-led standards
- The Risk Management Policy has been updated, improving staff understanding of risk management and establishing a Corporate Risk Register

Looking ahead

We will continue strengthening governance and leadership at all levels as we move into a Group Model, ensuring transparency, accountability, and continuous improvement for safety and quality

Healthy Lives

Strategic objective six: Becoming a Digitally Enabled and Data-Driven Organisation

We are committed to digital transformation and data insights to drive improvements in patient care and operational efficiency.

Our approach

We are committed to:

- Implementing an Electronic Patient Record (EPR) system for better care coordination and reduced administrative burden
- Embedding digital solutions into care pathways to support effective, efficient care
- Using data-driven decision-making for improved patient outcomes
- Enhancing digital literacy among staff to maximise technology use

Achievements in year one

- A new Group Digital Strategy is in development, aligned with the NHS ‘What Good Looks Like’ framework

- Real-time performance insights are now embedded in decision-making through the Integrated Performance Report
- Significant progress on the EPR programme, with a roadmap established and key milestones achieved for implementation in 2026
- The Digital Maturity Assessment (DMA) was completed, benchmarking our progress
- The Shared Care Record is live, enhancing care coordination

Looking ahead

We will continue investing in technology, data, and digital skills to enhance healthcare delivery, creating a connected, efficient system with improved patient outcomes.

Strategic objective seven: Financial Sustainability

We are committed to the efficient management of our financial resources, ensuring that we provide the best possible care while maintaining financial stability.

Our approach

We aim to:

- Achieve recurrent financial balance to allow greater control over the Trust's development
- Embed a continuous cost and effectiveness improvement programme
- Maximise resources and identify income opportunities for better value from funding

Achievements in year one

- A £9m deficit was addressed with a £29.5m efficiency programme, with external support introduced to drive financial recovery
- The Procure-to-Pay (EP2P) system was successfully implemented, improving procurement efficiency
- Financial training for budget managers was rolled out as part of EP2P, strengthening financial literacy and accountability

Looking ahead

We will continue robust financial planning and improvement efforts, with the aim to achieve a breakeven position by 2025/26 and secure long-term financial sustainability.

Strategic objective eight: Sustainability and Environmental Responsibility

We are committed to 'Going Green', ensuring that our hospital delivers excellent patient care while reducing our environmental impact.

Our approach

We will focus on:

- Embedding sustainability across operations, from energy-efficient buildings to reducing waste
- Working with staff, suppliers, and the community to drive environmental change while maintaining high-quality care

Achievements in year one

- Solar panels and air source heat pumps have been installed, contributing to energy efficiency
- Green travel initiatives, including car-sharing and Electric Vehicle (EV) chargers, are being expanded
- Recycling rates increased by 47.15%, and environmentally friendly cleaning products have been trialled
- The Trust has recruited Green Champions and launched sustainability training for staff

Looking ahead

We will continue integrating sustainability into daily practices to reduce the Trust's environmental impact, creating a healthier future for patients, staff, and the wider community.

Strategic objective nine: Community and Stakeholder Partnerships

We are committed to delivering excellent community and stakeholder partnerships to improve the health and wellbeing of our local population.

Our approach

We are committed to:

- Building strong relationships with communities, primary care, and partner organisations for integrated healthcare delivery

Achievements in year one

- The King's Lynn Health Hub is under development, with service delivery expected in 2025/26
- The CDC is fully operational, providing essential diagnostic services
- Collaborative models, such as Discharge to Assess, have been rolled out to improve discharge processes and reduce delays
- The Smoking in Pregnancy Service has been successfully implemented across the Group, with early signs of a positive impact on smoking rates

Looking ahead

We will strengthen partnerships with community services and local organisations to improve care, reduce health inequalities, and enhance integrated healthcare delivery.

Pictured above: Staff cut the ribbon to open the new Community Diagnostic Centre.

Pictured left: The Community Diagnostic Centre viewed from the outside.

Going concern

The concept of going concern is a basic assumption within accounting practice where it is assumed that an entity will be able to continue to operate for a period of time sufficient to enable it to fulfil its commitments, obligations and objectives. In other words, the entity will not be forced to cease its business in the foreseeable future.

There is no presumption of going concern status for NHS Foundation Trusts and Directors must decide each year whether it is appropriate to prepare the Trust's accounts on the 'going concern' basis.

In making this assessment, the Board has taken into account best estimates of future activity and cash flows and has been mindful of the Government Financial Reporting Manual. This states that "the anticipated continuation of the provision of service in the future, as evidenced by inclusion of financial provision for that service in published documents, is normal sufficient evidence as 'going concern'."

The financial reporting framework applicable to NHS bodies, derived from the HM Treasury Financial Reporting Manual, defines that the anticipated continued provision of the entity's services in the public sector is normally sufficient evidence of going concern. The directors have a reasonable expectation that this will continue to be the case.

Long term planning and realistic plans for future transformation savings delivery provide the necessary assurance that the Trust is a going concern. There is an anticipated continuation of the provision of a service in the future.

The Board considered its 'going concern' position at its meeting in June 2025 and consideration of risks and uncertainties agreed that the use of a 'going concern' basis is appropriate.

Performance analysis: our finances

Overview of 2024/25 financial performance

The financial plan for 2024/25 was submitted in accordance with the national planning timeframes during May 2024. The plan was initially set at a £9.5m deficit and included a £29.5m Cost Improvement Programme (CIP). ICB deficit support was allocated to the Trust in September 2024 of £8.7m reducing the planned deficit to £0.8m.

During the first six months of 2024/25 the Trust averaged a deficit of £3.3m per month and in October 2024 the Trust engaged a financial recovery team.

There have been three phases to the work undertaken:

- Ensuring strong grip and control including delivering through actions such as vacancy control, ensuring that agency and other forms of temporary workforce spend are used only when clinically necessary. Putting in place forward looks for key areas of spend, such as temporary pay spend, to ensure adequate control
- Development of tactical CIP savings with each divisional and corporate area identifying where they can make savings
- Development of themed, more strategic savings plans, including areas such as theatre and outpatient productivity, management of temporary workforce needs, ensuring appropriate patient flow on emergency pathways and ensuring strategic savings plans for procurement

A Quality Impact Assessment is undertaken on all savings that are identified before implementation. The Trust has established a Financial Improvement and Productivity forum and is overseeing the development and progression of recovery plans.

To date the recovery process has seen a reduction in the forecast from the average monthly deficit of £3.3m for the first half of 2024/25 to £2.3m in the second half of the year with an underlying deficit of £1.9m in March.

The actual performance for the year was a £38.5m deficit, this was in line with the revised forecast financial position developed in November 2024.

The Trust spent £65.2m on capital expenditure across numerous projects. This was funded by our own internally generated resources and national funded schemes through Public Dividend Capital (DPC). This capital expenditure was in line with the plan.

Performance against our financial plan

The Trust delivered a deficit of £38.5m (excluding impairments) for the year compared to an adjusted £0.8m financial deficit plan for 2024/25.

The Trust's position includes some notional accounting adjustments of £14.4m relating to pension contributions and Apprenticeship Levy, these are represented within both income and expenditure giving no change to our reported position.

The Trust received additional income from the ICB for deficit support of £8.7m.

	Plan (£'000)	Actuals (£'000)	Variance (£'000)
Income	(311,336)	(325,400)	14,405
Pay	217,320	249,373	(32,053)
Non-Pay	79,013	96,820	(17,807)
Earnings before interest, tax, depreciation and amortisation (EBITDA)	**(15,003)**	**20,453**	**(35,456)**
Below EBITDA	15,785	18,040	(2,255)
Total (Surplus) / Deficit	**782**	**38,493**	**(37,711)**

Note: The table above excludes £4m of capitalised staff cost and impairments.

Analysis of Trust's income and expenditure

Income: We received £325.4m income for 2024/45 (2023/24 £321.8m), an increase of £3.6m (1%), with £1.1m additional income from patient care activities and £2.5m from other operating income sources. Further detail is given in notes 3.1 and 3.4 in the financial statements at the end of the report.

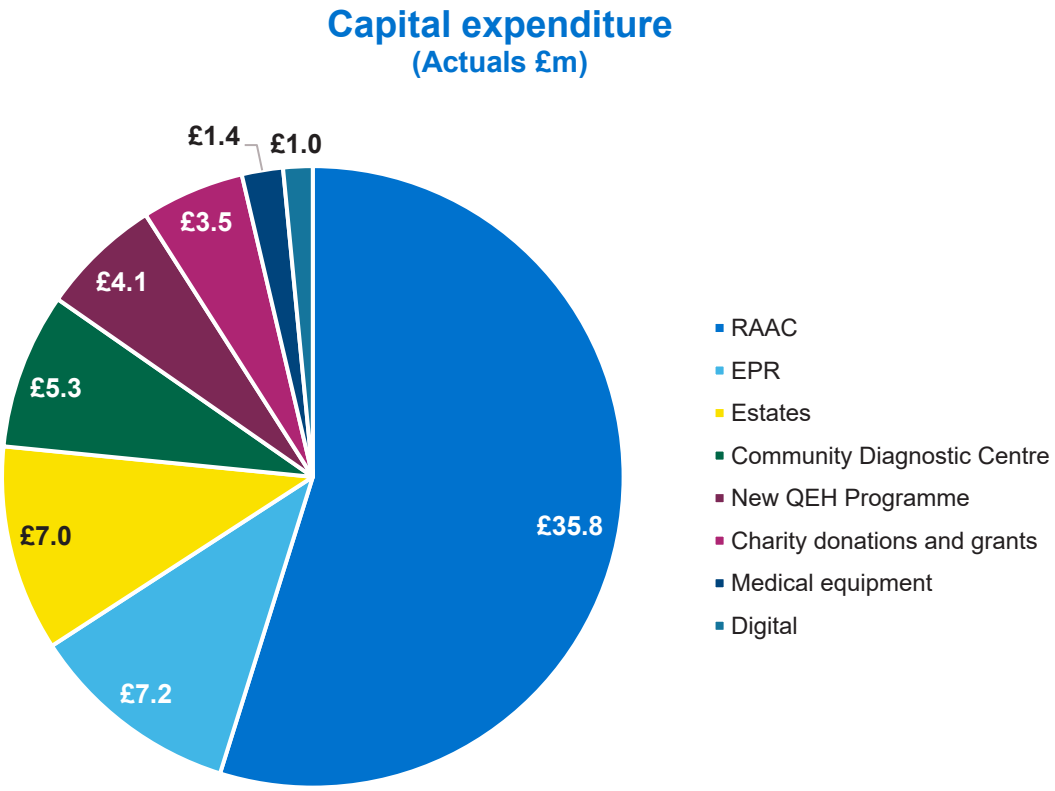
Pay expenditure: The Trust spent £252.2m on staff costs which includes capitalised staffing costs of £4m, which is £19.2m more than was incurred in 2023/24. Included in the increase are pay awards and national agenda for change decisions and continued operational pressures alongside additional costs to manage periods of industrial action throughout the year. Temporary staffing was also used to cover vacancies and sickness absences across all staff groups.

Non-pay expenditure: The Trust incurred £96.8m of non-pay expenditure, which was an increase of £21.9m when compared to the previous year. A full breakdown of our operating expenses is given in note 10 to the financial statements at the end of this report.

Capital expenditure

Our capital expenditure for 2024/25 was £65.26m, a £9.6m increase on the 2023/24 total of £53.1m, with increases in the RAAC programme and Electronic Patient Record (EPR) project.

A breakdown of that spend is shown in the chart below.



Our efficiency programme

The Trust set a challenging and ambitious efficiency target in 2024/25 of £29.5m (9%). During the year, work with community partners to reduce the numbers of no criteria to reside patients meant the Trust was able to safely close two wards. Following the commencement of a financial recovery team in November 2024, significant reductions were made to pay spend, including agency and bank spend, as better control was introduced. Financial recovery remains underway at the Trust as we enter into 2025/26.

Sustainability: Delivery and taskforce on climate-related financial disclosures

NHS England's NHS Foundation Trust Annual Reporting Manual has adopted a phased approach to incorporating the Delivery and Taskforce on Climate-related Financial Disclosures (TCFD) recommended disclosures as part of sustainability annual reporting requirements for NHS Bodies, stemming from HM Treasury's TCFD

aligned disclosure guidance for public sector annal reports. TCFD recommended disclosures as interpreted and adapted for the public sector by the HM Treasury TFCD aligned with disclosure application guidance, will be implemented in sustainability reporting requirements on a phased basis up to the 2025/26 financial year.

Local NHS bodies are not required to disclose scope 1,2 and 3 greenhouse gas emissions under TCFD requirements as these are computed nationally by NHS England.

The phased approach incorporates the disclosure requirements of the governance, risk management and metrics and target pillars for 2024/25. These disclosures are provided below.

Our Green Plan outlines our proposed aims, plans and outcomes to embedding sustainability into our core operational activity. We recognise our impact on the environment and the strong link between sustainability and public health, particularly for disadvantaged groups who are most vulnerable to the impacts of climate change, including worsening health and increased socioeconomic inequality.

At The QEH, we are committed to minimising our environmental impact and embedding sustainability into everything we do. Our Green Plan shows how we will contribute to the national ambition for a net zero health service by reducing our carbon footprint and ensuring sustainability is at the heart of our core operational activity. It includes actions which will contribute to our overarching aim of becoming net zero.

We recognise the strong link between sustainability and public health, particularly for disadvantaged groups who are most vulnerable to the impacts of climate change, including worsening health and increased socio-economic inequality. As a healthcare provider, we have been grappling with the effects of an unprecedented health crisis that has challenged the resilience of our sector and necessitated changes to the ways we serve our community.

During 2024/25, various schemes have taken place to reduce our carbon impact. They include:

Estates and Facilities

- Assess and identify further opportunities in the use of the buildings and facilities to reduce our carbon footprint. Increase the number of solar panels on new buildings and to put provide greener renewable energy heating like heat source pumps
- Continue to monitor and manage the Trust’s energy usage
- The Estates Team to continue to support the changes in reduced water usage taps, sensor lighting

- Continue to eliminate unnecessary single-use plastic and packaging supplied in our catering department
- To review and report on the Trust energy and water usage / performance to look at way of reducing our carbon footprint
- To continue to work with the Trust to reduce the amount of waste the Trust produces
- Our Estate: the Trust made a successful bid to the NHS National Energy Efficiency Fund and have been awarded funding of £586k to upgrade our lighting to the latest energy efficient LEDs to support our Green Plan and goal to significantly reduce our carbon footprint
- Switch off campaign: turning off lights in unoccupied areas and in offices at the end of the day can cut lighting costs by 20%

Travel and transport

- To use our recent survey to support the continued work in terms of reducing traffic to and from the hospital, looking at alternative means of transport, etc.
- Improve pedestrian infrastructure
    - Provide better signage around and outside the hospital for pedestrians
    - Introduce staff walking club - encourage staff to be more active and advertise via intranet, email and other channels
    - Raise awareness of health benefits of walking - promote journey planning on foot service ‘www.walkit.com’ on notice boards and intranet, provide tailored walking maps for people to take the safest pedestrian routes when walking to and from the site
- Improve cycling infrastructure
    - Cycle to work scheme - continue to promote cycle to work scheme for employees
    - Review cycle shelters - review cycle parking facilities on site in terms of safety, security and accessibility
    - Promote of cycle information - promotion of events such as ‘National Bike Week’. To work with Cycling UK to support people to cycle to work
- Public transport
    - QR codes - provide up to date bus and rail information via a QR code on notice boards around the hospital
    - Liaise with bus operators - discuss discounted travel for staff on public transport with bus operators, as well as providing additional services to rural areas and potential for shuttle bus from King’s Lynn

    - Advertise promotions on public transport - advertise any promotions / discounts offered by public transport operators on notice boards around the hospital and intranet

- Car sharing
    - Working with MobilityWays to support car sharing across the Trust – looking at reduced parking and dedicated spaces for anyone who car shares outside of own family who may be living at the same address. Currently we have 350 members on the car sharing app
- Other initiatives
    - Promote the use of EV chargers – the Trust is looking to install new EV chargers, approximately 10 chargers which will be 20 bays
    - Host sustainable travel awareness days - host sustainable travel awareness days on awareness days such as 'World Environment Day' or 'World Sustainability Day'
    - Working with 'Dash' in terms of cycle to work where staff can purchase or hire a bike to enable alternative ways to travel
- Development of the Trust's new car park strategy including the increased numbers of EV chargers that can be made available to staff and patients

Supply chain and procurement

- Procurement to continue to work with our suppliers to reduce the overall carbon footprint
- Continue to review local frameworks supplier arrangements as standard

Workforce and System Leadership

- Continue to work with the wider system in supporting sustainability across the NHS as a whole
- Continue to work with our sister Trusts (NNHU and JPUH), bi-monthly meetings to support each other with the sustainability / green agenda
- Bi-monthly "The QEH Goes Green" Forum, to discuss what is happening across the Trust and what support needs to be put in place to ensure new schemes are taken forward

General

- Green Champions – continue to recruit to Trust wide Green Champion, currently the Trust has 15 champion who play a vital role in support The QEH

to go greener, they also contribute to the bi-monthly The QEH Goes Green Forum

- The Trust intrant has a yearly calendar of events that happen each year which is linked to sustainability
- Nature / walking trail around the site to encourage staff to take 10 to 20 minutes out of there day to go for a walk in the fresh air. We are looking to add to this several walks within our woodlands again to support staff's health and wellbeing

Waste services

- The Trust has invested in recycling bins which to date 123 bins have been given out showing that 69% of department are now recycling, which is fantastic which in turn reduces the amount of waste having to go to landfill sites

Catering services

- The Trust has currently purchased two state of the art food digesters which will support approximately 80% reduction of food waste across the Trust. Food waste both from patients and the production of meals will be turned into compost that can be used for biofuels, this product will be collected monthly from the Trust which supports the reduction of mission from lorries that collect our current food waste daily
- Purchase of green wheely bins for the main kitchen, so that effective recycling can happen on a daily basis again showing a positive impact on our recycling figures

Over the coming year, our aim is continuing to work on the following:

- Install solar panels on three new buildings, reducing carbon emissions by 20%. Reduced carbon emissions and energy costs. Contributes to the UK's renewable energy goals and demonstrates the Trust's commitment to sustainability
- The most important benefit of using heat pumps in NHS hospitals is energy efficiency. They are much more energy efficient than traditional heating systems, and this can help to reduce energy costs within The QEH. As a Trust heat source air pumps will be installed on 6 new buildings, reducing carbon emissions by 16%
- Better control of heating / ventilation out of hours as part of the reduction of the Trust Carbon Footprint in line with the NHS's 'Delivering a 'Net Zero' - National Health Service' document as part of the Health and Care Act 2022

- In line with the East of England Collaborative Procurement Hub (Simpler Recycling' Reforms) The UK Government has introduced new legislation to ensure consistent recycling practices across England. As part of this new legislation the Trust will increase recycling by 40% which is also part of the Trust's Green Plan commitment
- Increase Green Travel – increase provision of EV infrastructure across the site for patients, victors and staff in line with other Trusts within the system
- Continue with our travel incentives to encourage staff to choose greener ways to reach work, such as car share schemes, walk or cycle to work

Governance

The Board receives quarterly updates via its Finance and Performance Committee. Reports monitor progress against goals and targets for addressing climate related issue. Both groups consider how climate related issues impact broader organisational plans and performance monitoring.

A member of the Executive team is assigned as Senior Responsible Officer and has formed a sustainability group whose purpose is defined in its terms of reference to create and oversee the programme of work to deliver The QEH Green Plan.

Other areas of escalation are taken via the Trust Management Group as appropriate / required.

Risk management

The Sustainability group is responsible for identifying and assessing climate related risks. The main identified risk is associated with financial penalties for using fossil fuels, meaning the Trust is open to volatile utility pricing. If the Trust continues to use fossil fuels and grid electricity in the short to medium term, there is a risk that the Trust will incur fines with respect to carbon emissions and volatile utility prices.

The Trust is mitigating this risk by exploring the decarbonisation of heat and its supporting infrastructure.

Risks are escalated by the Sustainability group to the Trust Management Group, Finance and Performance Committee and the Board as part of reporting alongside other Trust risks as appropriate.

Metrics and targets

The table below shows the KPIs The QEH uses to monitor overall progress as instructed by NHS England:

Focus area	Metric	Outcome
Workforce	Names board-level lead for green plan	Paul Brooks, Director of Estates and Facilities
Medicines	N_2O volume and emissions	250 bottles per year
	Entonox volume and emissions	444 bottles per year
Travel and transport	% of owned / leased fleet that is ULEV or ZEV	None in corporate fleet
	Total fleet emissions	Not monitored
	Only ZEVs in its salary sacrifice scheme	No
	Does the organisation operate sustainable travel-related schemes for staff	Yes, working in partnership with MobilityWays
Estates and Facilities	Emissions from fossil-fuel-led heating sources	6,672,839.33kg CO_2e
	Number of oil-led heating systems	None
	% of gross internal area covered by LED lighting	98%
	% of sites with heating decarbonisation plan	9%
Supply chain and procurement	Inclusion of CRPs and Net Zero Commitment	All relevant procurements are performed in compliance with the

	requirement in all relevant procurements	Government guidelines detailed in PPN 06/20 and PPN 002
	Inclusion of requirement for minimum 10% social value in procurements, including KPIs	All relevant procurements are performed in compliance with the Government guidelines detailed in PPN 06/20 and PPN 002
Food and nutrition	Weight of food waste, spoilage, production, unreserved and plate waste	758.05 tonnes (2024/25) which is 63.17 tonnes per month
Adaptation	Number of overheating occurrences triggered a risk assessment (in line with heatwave plan)	2
	Number of flood occurrences triggered a risk assessment	0

Financial planning for 2025/26

The Trust submitted a financial plan on 30 April 2025 for 2025/26 which is in line with the timeline requirements of the national planning guidance.

The Trust has worked alongside ICS partner organisations and has submitted a break-even plan, which includes £22.5m of non-recurrent deficit support funding. The assumptions included regarding inflation are consistent across the ICS and / or in line with national guidance.

The plan contains a £18.3m efficiency target, this equates to 5.3% of relevant expenditure. There remains a degree of delivery risk that is acknowledged within the overall programme; however, ambitious plans are in place to deliver this target, including large scale procurement programmes, further work on non-elective length of stay, reductions to sickness rates and improved procurement and management of drugs.

Our charity

The net assets of The QEHKL Charity at 31 March 2025 were £2.2m (2023/24: £5.0m), a decrease of 56%, this reflects the charity's continued support for our staff and patients across the hospital. In 2024/25 initiatives included a surgical robot (£1m) and the opening of the Peddars Ways - a five-bed palliative care unit (£1.6m). The Trust has received both legacies and donations in year that have facilitated these significant investments, for which it is extremely grateful.

Pictured above: *Staff from The QEH at the end of a 26-mile sponsored walk to raise funds for the Peddars Way palliative care unit.*

Performance analysis: our care

This section outlines the Trust's performances against several key performance indicators (KPIs), which are regularly reported to NHS England and the Department of Health and Social Care.

At a glance

Operation performance	2023/24	2024/25	Increase / decrease	Percentage change
Emergency attendances	88,970	94,033	5,063	5.7%
Emergency admissions	42,828	44,928	2,100	4.9%
Patients waiting longer than four hours from arrival in ED to admission, transfer or discharge	32,669	31,867	-802	-2.5%

Operational performance summary

The pressures on urgent and emergency care across the Trust and the wider NHS have remained significant throughout the year, with a sustained increase in demand. In response, several key operational changes were implemented to improve performance:

- The former Emergency Department (ED) resuscitation area has been repurposed to accommodate ambulance handovers and rapid assessments. This initiative has contributed to strong performance in ambulance handovers throughout the year
- The ongoing RAAC decant programme has continued to impact elective theatre capacity. The Delivery Suite has been temporarily relocated to Wolferton Ward, and the emergency maternity theatre, part of the Delivery Suite footprint, has led to the reallocation of one of the elective inpatient theatres
- A new Admissions Unit for elective inpatients was opened in the former Endoscopy Unit, now known as Holme Ward. This dedicated space supports patients on the day of surgery and is strategically co-located with theatres, enhancing the efficiency of patient pathways

The impact of urgent and emergency care pressures on the Trust and wider NHS has again been significant and there has been a significant increase in demand which has been sustained throughout the year.

The former ED resuscitation area has been repurposed as a space for ambulance handovers and rapid assessments. This has supported the strong performance throughout the year in ambulance handovers.

The RAAC decant programme has continued to have a significant impact on elective theatre capacity with the decant of the Delivery Suite to Wolferton Ward.

The emergency maternity theatre is part of the Delivery Suite footprint, so this temporary move required the reallocation of one of the elective inpatient theatres as an emergency maternity theatre.

The Delivery Suite moved back to its original location at the beginning of June 2025.

A new Admissions Unit for elective inpatients has been opened in the previous Endoscopy Unit, now known as Holme Ward. This provides dedicated space for patients on the day of surgery and is co-located with theatres so supports a more efficient patient pathway on the day of surgery.

Four-hour emergency access standard

Our focus this year has been on maintaining safety within the ED while improving patient flow and the overall experience. Significant changes to patient flow into and through the hospital include:

- The redesign of the acute floor in March 2024 to establish an Acute Assessment Unit, improving the streaming of appropriate emergency patients
- The implementation of processes to support the timely handover of ambulance patients, reducing delays and ensuring ambulances are available to respond to further calls
- The completion of work in ED in August 2024 to create a modern, fit-for-purpose resuscitation area that meets current clinical building standards
- The opening of a Frailty SDEC Unit in September 2024, providing care for patients on the frailty pathway who do not require admission
- The expansion of our Discharge Lounge in August 2024, which supports early discharge and the Home for Lunch campaign

Throughout the year, we admitted, discharged, or transferred 66.1% of patients from our ED within four hours of arrival. This performance, compared to the national standard of 95% and the 24/25 national operational planning guidance objective of 78%, represents an improvement over the 63.3% achieved in 2023/24.

Year	Attendances	Breaches	Performance	Variance	Growth
2020/21	61,726	11,220	81.8%	-8,655	-12.3%
2021/22	80,057	26,388	67.0%	18,331	29.7%
2022/23	84,876	34,630	59.2%	4,819	6.0%
2023/24	88,970	32,669	63.3%	4,094	4.8%
2024/25	94,033	31,867	66.1%	5,063	5.7%

Emergency Department attendances

ED performance has been affected by several factors, including the volume of attendances, which increased by 5.7% from the previous year. The design of our ED has not been able to accommodate the increased patient volume, and high numbers of patients have had to wait in the department for a hospital bed.

Performance improved in the first five months of the year but deteriorated in the latter half, particularly during the winter months, which presented significant challenges. We continue to work with our Norfolk and Waveney ICS partners to manage demand and avoid unnecessary admissions, with a particular focus on reducing the number of patients who spend more than 12 hours in ED. This cohort has remained high at over 10% and addressing this will be a priority for 2025/26.

Winter planning

The NHS anticipates a sustained increase in demand for urgent and emergency care during the winter months, with a surge in acute presentations such as respiratory, gastrointestinal, and cardiovascular conditions. Cold weather can exacerbate health problems, resulting in increased inpatient bed pressure and ED overcrowding. To mitigate the impact of these seasonal pressures, the Trust implemented the following initiatives for the winter of 2024/25:

- The opening of 19 temporary additional beds on Leverington Ward to support capacity
- The engagement of a private transport provider to assist with discharges, ensuring that transport delays do not affect patient flow
- The opening of a Frailty SDEC unit to support patients who may not require admission but need urgent care
- A new, expanded discharge lounge to accommodate both seated patients and those requiring a bed or trolley while awaiting discharge

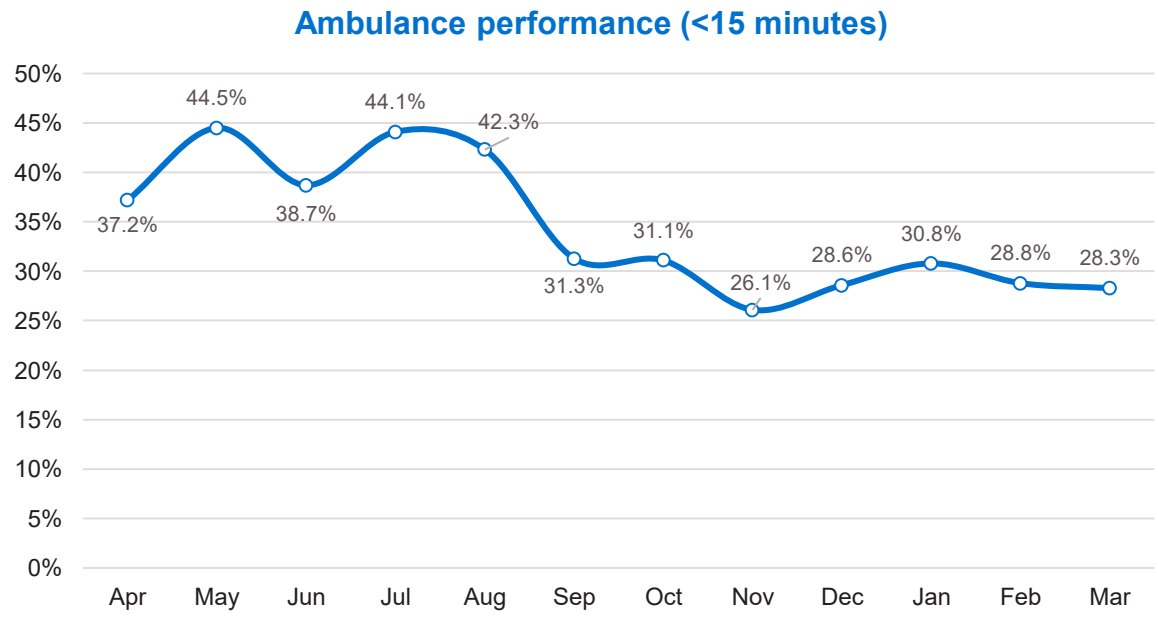
- Bed modelling informed by the National Emergency Care Improvement Support Team (ECIST), which contributed to a realignment of the Trust's emergency bed base in October 2024
- The assumption of responsibility for commissioning Intermediate Care Beds from the Norfolk and Waveney ICB, consolidating capacity into two care homes in King's Lynn

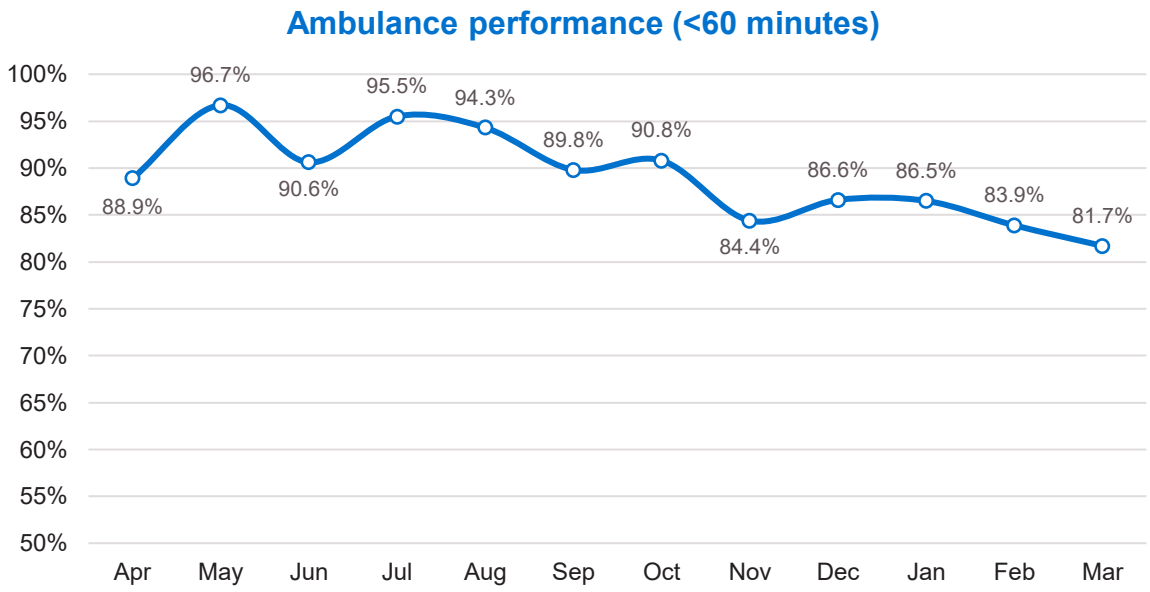
Ambulance handovers

Timely ambulance handovers are integral to meeting the four-hour emergency access standard. The handover waiting time measures the duration that ambulance crews wait with patients before ED can accept them. The national target is for handovers to occur within 15 minutes, with the expectation that 95% of handovers should occur within 30 minutes.

In 2024/25, over 72% of handovers took place within 30 minutes, and over 89% within 60 minutes. Despite a nearly 10% increase in ambulance conveyances from the East of England Ambulance Service NHS Trust (EEAST) compared to the previous year, the Trust has made significant improvements in ambulance handover times.

We continue to collaborate with EEAST and other ICS partners to reduce ambulance handover delays and further enhance patient experience.




Ambulance performance (<60 minutes)
100%
95%
90%
85%
80%
75%
70%
65%
60%
55%
50%
88.9%
96.7%
90.6%
95.5%
94.3%
89.8%
90.8%
84.4%
86.6%
86.5%
83.9%
81.7%
Apr
May
Jun
Jul
Aug
Sep
Oct
Nov
Dec
Jan
Feb
Mar

Monthly ambulance conveyances by EEAST

	0-15 minutes	15-30 minutes	30-60 minutes	60-120 minutes	120+ minutes	Total
Apr	684	643	306	125	79	1,837
May	870	793	228	41	24	1,956
Jun	747	696	304	117	65	1,929
Jul	874	776	243	81	9	1,983
Aug	845	795	246	91	22	1,999
Sep	608	809	352	111	89	1,969
Oct	592	746	342	105	65	1,850
Nov	499	719	419	185	115	1,937
Dec	616	787	441	172	107	2,123
Jan	592	746	329	137	118	1,922
Feb	437	603	362	184	104	1,690
Mar	539	651	379	200	172	1,941

Cancer access standards

In 2024/25, cancer referrals to the Trust increased significantly, particularly in urology and dermatology, which saw increases of 15% and 19% respectively. The Trust has focused on transforming pathways to meet the Faster Diagnosis Standard (FDS), transitioning towards straight-to-test models and one-stop clinics.

Throughout 2024/25, the Trust consistently met the 28-day FDS target, achieving an aggregate performance of 71.77%, up from 69.22% in 2023/24. However, challenges in reducing the backlog of patients waiting more than 62 and 104 days for treatment have persisted, largely due to increased demand and diagnostic delays.

Despite these challenges, the Trust has made progress, reducing the number of patients waiting more than 62 days for treatment from 179 in Q1 to 139 at the end of

Q4. Additionally, the Trust has consistently met the 31-day Decision to Treat (DTT) standard, achieving over 90% for the majority of the year.

Cancer performance

	28-day general FDS	31-day general treatment standard	62-day general standard
Apr	71.54%	93.71%	61.26%
May	74.06%	96.57%	59.17%
Jun	72.12%	98.56%	64.64%
Jul	74.10%	95.71%	56.00%
Aug	71.00%	92.53%	61.46%
Sep	74.39%	92.68%	60.52%
Oct	75.02%	98.25%	60.43%
Nov	70.61%	91.81%	60.59%
Dec	71.36%	92.41%	60.51%
Jan	62.22%	91.15%	51.14%
Feb	72.51%	97.86%	58.06%
Mar	72.09%	91.57%	63.94%

18-Week Referral to Treatment (RTT) standard

The Trust's performance against the national 92% standard for incomplete RTT pathways has shown an improvement over the past year, with a total performance of:

March 2025 – 57.9%

March 2024 – 58.6%

March 2023 – 64.7%

March 2022 – 62.8%

March 2021 – 58.2%

March 2020 – 79.2%

	Total incomplete waiting list number	Patients waiting under 18 weeks	Patients waiting over 18 weeks and over	Performance
Apr	26,372	15,674	10,698	59.4%
May	26,454	15,708	10,746	59.4%
Jun	26,762	15,688	11,074	58.6%
Jul	26,475	15,253	11,222	57.6%
Aug	26,898	15,404	11,494	57.3%
Sep	26,486	15,004	11,482	56.6%
Oct	26,139	14,865	11,274	56.9%
Nov	25,496	14,532	10,964	57.0%
Dec	25,572	14,482	11,090	56.6%
Jan	24,579	13,923	10,656	56.6%
Feb	25,319	14,736	10,583	58.2%
Mar	25,512	14,476	10,749	57.9%

In line with 2024/25 national planning guidance, the Trust has made significant progress in reducing the number of patients waiting more than 65 weeks. At the beginning of April 2024, the Trust had zero patients waiting over 65 weeks and 24 who had expressed choice to wait and 492 patients waiting over 52 weeks. At the end of March 2025, the number over 65 weeks has reduced to 3 (including those who had expressed choice) and there were 548 patients waiting over 52 weeks.

Research, innovation and development

In 2024/25, The QEH's Research and Innovation Service responded to the structural changes within the National Institute for Health and Care Research (NIHR) and its evolving objectives. The Clinical Research Network (CRN), which had been in operation for a decade, was replaced by the Research Delivery Network (RDN), reducing the geographical coverage from 15 to 12 regions. The QEH now operates under the East of England Regional Research Delivery Network (RRDN), led by NNUH. Additionally, the government's continued emphasis on commercial research and the response to Lord O'Shaughnessy's 2023 independent report, Commercial Clinical Trials in the UK, has underscored the expectation that the Trust not only increases participation in commercial research but also meets setup and delivery targets. Given that research and innovation at The QEH is primarily funded by the NIHR, it is essential that these key performance targets are achieved.

Research activity

During 2024/25, the Trust made significant strides in research recruitment, with 1,832 participants enrolled in studies on the NIHR portfolio. This achievement far exceeded the target of 750 patients and marked the highest number of participants recruited in the Trust's history during a non-COVID-19 pandemic year.

	Total participants enrolled in research studies
2017/18	867
2018/19	985
2019/20	759
2020/21	2,193
2021/22	1,472
2022/23	1,203
2023/24	1,269
2024/25	1,832

The QEH has also successfully met new expectations for commercial research, with studies launched in previously unrepresented specialties, including cardiology, dermatology, nephrology, and rheumatology. These efforts align with key NIHR RDN targets, particularly in relation to funding streams. The Trust has met both internal and external NIHR targets for 2024/25, securing continued funding for the 2025/26 period. There has been strong departmental support for research studies across the Trust, with various services playing a leading role in recruiting patients who have already passed through their usual care pathways.

The Trust has made an impressive start in 2025, excelling in both commercial and non-commercial research. In particular, the Trust has achieved remarkable success in the large, NIHR-funded POP-I study, coordinated by the University of Nottingham. Led by Dr. Pradip Sarda, the research team has recruited the highest number of patients nationally in 2025. The study, which focuses on the treatment of patients aged 60 and above suffering from anaemia after major emergency surgery, has garnered recognition from the Chief Investigator, Professor Ian Moppett, for its exceptional recruitment levels. This success has been made possible through outstanding cross-disciplinary collaboration between the clinical team, research staff, and the pharmacy department.

In the field of cardiology, Dr Rudolf Duehmke is leading research on heart failure patients through the BalanceD-HF study, in collaboration with AstraZeneca. As one of 15 UK sites involved in this study, Dr Duehmke and his team have surpassed recruitment expectations, positioning The QEH as the UK's leading site for patient enrolment. This achievement has been acknowledged by the global study team and has further enhanced the Trust's reputation for delivering complex clinical research.

These successes in both commercial and non-commercial research underpin the inclusion of Research and Innovation in the case for group model working. The performance of The QEH provides a strong foundation for expanding and developing further research projects, ultimately benefiting the local patient population and fostering an engaged and innovative workforce.

Developing our approach to health inequalities

Health inequalities refer to avoidable, unfair, and systematic differences in health outcomes between various groups of people. These inequalities can manifest in different ways, including disparities in health status, access to care, the quality of care received, and the opportunities individuals have to lead healthy lives. In this context, health inequalities extend beyond the status of people's health to encompass differences in healthcare access, care experiences, and the broader social determinants of health.

Health inequalities can include:

- **Health status:** variations in life expectancy and general health outcomes
- **Access to care:** the availability and accessibility of healthcare services

- **Quality and experience of care:** disparities in patient satisfaction and the quality of care provided
- **Behavioural health risks:** differences in health-related behaviours, such as smoking rates
- **Wider determinants of health:** factors such as housing quality, employment, and education

In England, health inequalities are often analysed across four broad categories:

1. **Socio-economic factors:** including income and employment
2. **Geography:** differences between urban and rural areas
3. **Specific characteristics:** such as sex, ethnicity, or disability, including those protected under law
4. **Socially excluded groups:** including individuals experiencing homelessness

Given the multifaceted nature of health inequalities, these cannot be tackled in isolation. Addressing them requires a collaborative, multi-agency approach, involving a range of stakeholders at local and system levels. The past year has provided further clarity on the steps needed to address these issues effectively.

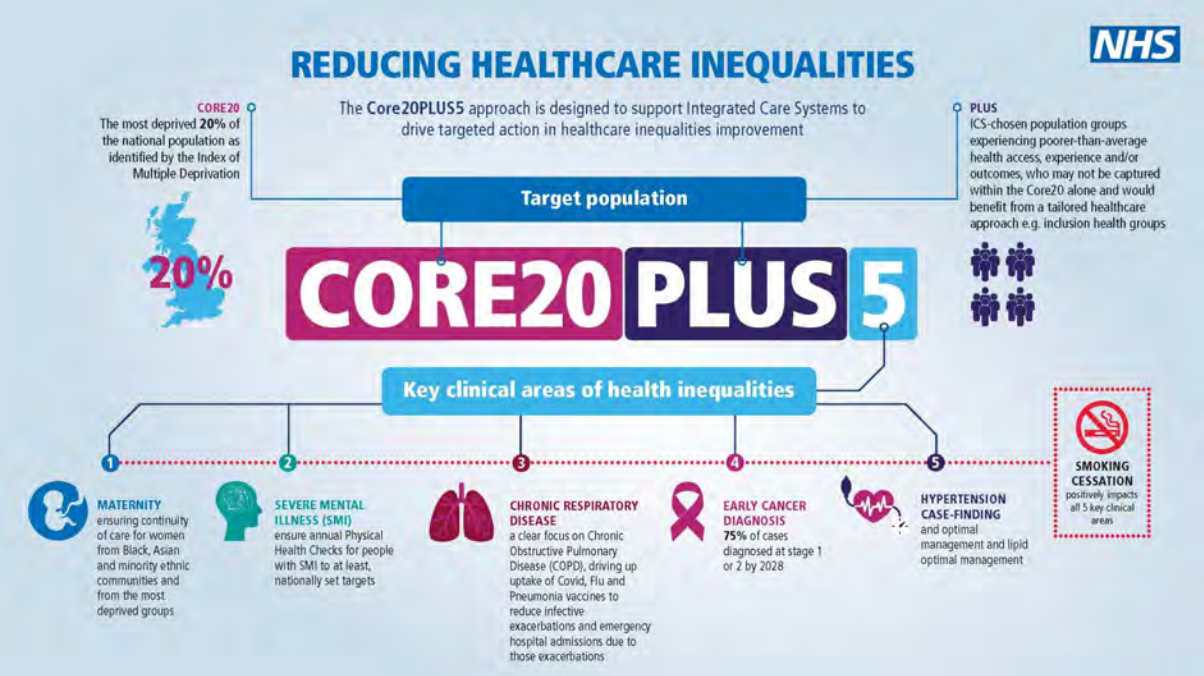
The Core20PLUS5 approach

Core20PLUS5 is a national initiative designed to reduce health inequalities by targeting specific populations and clinical areas requiring accelerated improvement. The approach identifies two key components:

- **Core20:** the most deprived 20% of the population, as defined by the national Index of Multiple Deprivation (IMD), which includes seven domains covering a wide range of social determinants of health
- **PLUS:** population groups identified by the Integrated Care System (ICS) that experience poorer-than-average health access, outcomes, or experiences, but are not included in the Core20
- **5:** five priority clinical areas that need focused attention, with national governance and support to ensure system-wide improvement. These priorities include:
    - **Maternity:** ensuring continuity of care for women from Black, Asian, and minority ethnic communities, as well as those from the most deprived backgrounds
    - **Severe Mental Illness (SMI):** ensuring that 60% of individuals living with SMI receive annual health checks
    - **Chronic Respiratory Disease:** focusing on Chronic Obstructive Pulmonary Disease (COPD) and improving vaccination uptake for COVID-19, flu, and pneumonia to reduce hospital admissions
    - **Early Cancer Diagnosis:** ensuring 75% of cases are diagnosed at stages one or two by 2028

- **Hypertension Case-finding:** identifying and managing high blood pressure to reduce the risk of heart attacks and strokes

NICE (National Institute for Health and Care Excellence) has also identified smoking cessation as a critical intervention that positively impacts all five priority areas. As a result, smoking cessation has been integrated as a central focus of the Core20PLUS5 framework.



The success of Core20PLUS5 in engaging health and social care organisations has led to its expansion to include children and young people, under a framework known as ‘Core20PLUS5 – an approach to reducing health inequalities for children and young people.’ This extension focuses on five key clinical priorities for children, including asthma management, diabetes care, epilepsy support, oral health, and mental health services.

Norfolk and Waveney Strategic Framework for Action

The Trust has actively contributed to the development of the Norfolk and Waveney Health Inequalities Strategic Framework for Action 2024 – 2034. Published by the ICS in May 2024, this system-wide framework outlines a unified approach to addressing health inequalities across the region. It identifies key priority groups, including ethnic minority communities, people experiencing homelessness, and individuals in vulnerable social circumstances.

The strategic vision of the framework is clear:

“We will come together to tackle unfair and avoidable differences in health outcomes. We will do this by listening to communities, prioritising prevention, and taking action together, making health inequalities everybody’s business.”

This framework also sets out guiding principles for partner organisations, emphasising collaboration, community engagement, and the creation of equitable services. Place-based partnerships, such as Health and Wellbeing Partnerships and Place Boards, will coordinate local action to address socio-economic health inequalities and healthcare disparities.

Strengthening leadership and accountability through partnership

Throughout the year, the Trust has played an active role in addressing local health inequalities by contributing to the West Norfolk Place Board and the West Norfolk Health and Wellbeing Partnership. These collaborations involve local councils, health service providers, and voluntary sector organisations, with a shared commitment to

improving the health and wellbeing of West Norfolk's communities through effective partnership working.

A notable achievement has been the involvement of the internationally renowned academic, Professor Sir Michael Marmot, and his Institute for Health Equity, who have supported a two-year programme aimed at reducing health inequalities across West Norfolk. This initiative adopts the eight evidence-based 'Marmot Principles' to reduce health inequalities, which focus on areas such as early childhood development, fair employment, sustainable communities, and tackling discrimination.

Trust Health Inequalities Action Plan 2024/25

The Trust's Health Inequalities Action Plan 2024/25, approved in September 2024, marks a significant step in aligning with the Norfolk and Waveney Health Inequalities Strategic Framework. As the first of its kind, the action plan focuses on creating the foundational conditions needed for long-term success in reducing health inequalities.

The plan outlines 10 key actions, including the establishment of clear communications and pledges, governance structures, and self-assessment processes. It also emphasises the importance of community engagement, the integration of voluntary and community organisations, and the development of robust data analysis systems to inform decision-making.

Noteworthy activities for 2024/25 include:

- Identification of a Non-Executive Director, Executive Director, and Clinical Lead for Health Inequalities
- Hosting a board development session focused on health inequalities
- Completing a self-assessment of the Trust's strategic direction and capacity to address health inequalities
- Developing a Patient and Carer Voices Collaborative platform to enhance patient coproduction
- Strengthening relationships with local partners, such as Norfolk Citizens Advice, to support patients with access to advice services

The Trust is committed to ongoing staff education and training to embed a culture of health inequalities improvement across the organisation, ensuring that addressing these issues becomes a central part of our clinical delivery.

Smoking cessation

A key focus of the Trust's health inequalities work is smoking cessation, particularly within the Core20PLUS groups, where smoking prevalence is higher. The Trust has made significant progress in establishing tobacco dependence services, including a new smoking in pregnancy pathway and an inpatient tobacco dependency treatment programme. These services are supported by new funding from NHS England and

are part of a broader collaboration with the Norfolk and Waveney ICS Prevention Programme and Norfolk Public Health.

The Trust's maternity service has seen considerable growth, with additional resources provided to support pregnant individuals in their efforts to quit smoking. For inpatient services, a new Tobacco Dependency team will provide behavioural support to help individuals achieve long-term smoking cessation.

In ED, the Trust is exploring new interventions, including the use of vapes to support smoking cessation through brief interventions, based on the successful Cessation of Smoking Trial in Emergency Departments (CoSTED).

Through these efforts, the Trust is committed to reducing the impact of tobacco dependence, which remains a major driver of health inequalities across the region.

"We have continued our close working relationship with Team QEH over the past 12 months. One of our major partnerships has been creating the hospital's new Youth Council.

"It saw us starting from scratch doing lots of work digitally as well as the very important work of chatting to 16 to 25 year-olds face-to-face about its aims.

"So far, we have been part of 14 events and engaged directly with around 25 key employers in West Norfolk, and that work continues.

"More importantly, these young people are having a direct line into planning for the new hospital as well as looking into a number of things including domestic violence support for patients, enhancing the information pipeline for recruitment of young people, and exploring how the digital world can impact and improve healthcare through the likes of the NHS App and Electronic Patient Record.

"Exciting times for them and, indeed for us, as we aim to continue growing the Youth Council."

Alex Stewart
Chief Executive, Healthwatch Norfolk

Directors' Report

How our hospital is governed

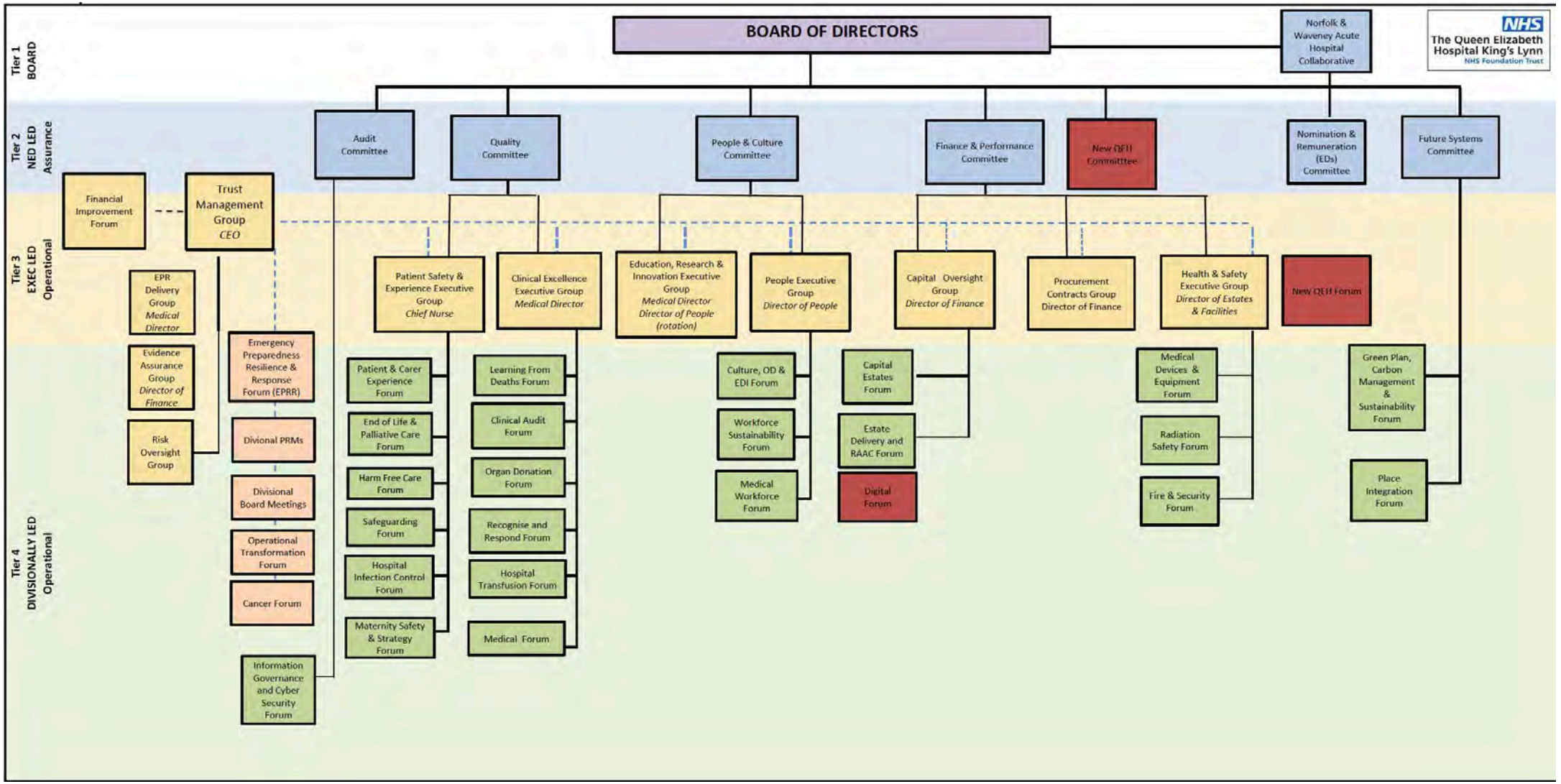
What is a Foundation Trust?

A Foundation Trust is a public benefit corporation. This means:

- The Trust is accountable to the communities we serve through the Council of Governors and Foundation Trust Members
- Members of the Foundation Trust elect public and staff representatives from the membership to serve on the Council of Governors
- The Trust is independent and accountable direct to Parliament
- The Trust remains part of the NHS
- Our key regulators are NHS England (referred to here as 'the regulator') and the Care Quality Commission
- A Foundation Trust has both a Board of Directors and a body to represent the interests of its membership and the community it serves. At The QEH, this body is called the Council of Governors. The Council of Governors has a range of statutory, strategic and locally determined functions
- The Trust operates within a framework of corporate governance, which can be defined as 'the means by which Boards lead and direct their organisations so that decision-making is effective, and the right outcomes are delivered. In the NHS, this means delivering safe, effective services in a caring and compassionate environment in a way that is responsive to the changing needs of patients and service users[**]

[**] NHS Foundation Trust Code of Governance 2023

Governance structure



Our Board of Directors

Non-Executive Directors

Dr Andy Wood OBE,
Interim Chair (from December 2024)

Dr Andy Wood OBE was appointed Interim Chair of the Board of Directors at The QEH in November 2024.

He is currently Chair of East Coast Community Healthcare CIC, a social enterprise delivering community-based NHS services across Norfolk and Suffolk.

Dr Wood served as Chief Executive Officer of Adnams, the Suffolk-based brewery, for 14 years until July 2024. In addition, he chairs the Norse Group and Visit East of England.

He was awarded the Order of the British Empire in 2013 for his environmental responsibilities.

Graham Ward,
Deputy Chair and Non-Executive Director

Graham Ward is a Chartered Accountant with a diverse career in accountancy, industry, and management consultancy, including 16 years as a senior director at PricewaterhouseCoopers (PwC) and Deloitte. He subsequently served as Commercial Director at the University of Nottingham until 2013.

Mr Ward has held numerous NHS non-executive roles since 2004, including positions at Nottingham City Hospital, Nottingham City Primary Care Trust/Clinical Commissioning Group, and Sherwood Forest Hospitals NHS Foundation Trust, where he served as Chair.

He is Chair of the Trust's Finance and Performance Committee and currently operates his own consultancy practice. He also serves in advisory and governance roles at Acis Group and Mission Room Ltd.

Claire Fernandez,
Non-Executive Director

Claire Fernandez is a Research Manager with extensive experience in project delivery and strategic leadership across academia, industry, and the NHS.

She holds a scientific research background, having conducted ten years of fundamental research at Cambridge and Oxford institutions.

Ms Fernandez is the Trust's Senior Independent Non-Executive Director, Maternity and Neonatal Safety Champion, and a member of the Quality Committee, Future Systems Committee, and Committees in Common.

Sue Hayter,
Non-Executive Director

Sue Hayter is a retired Chief Nurse with a career spanning roles across the UK and Cyprus. She retired from full-time NHS service in 2010.

Following retirement, she continued to support the NHS and local government through quality and patient safety roles.

Ms Hayter chairs the Trust's Quality Committee and is the designated Wellbeing Guardian.

Simon Roberts,
Non-Executive Director

Simon Roberts is an experienced healthcare leader with a career spanning executive and advisory roles in both the NHS and private sector.

He has contributed to NHS England's transformation initiatives and held board-level roles supporting emerging Integrated Care Systems.

Mr Roberts is Chair of the People and Culture Committee, a member of the Audit Committee, and the Trust's Freedom to Speak Up Non-Executive Lead.

Dr William Van't Hoff,
Non-Executive Director

Dr William Van't Hoff is a paediatric nephrologist and former Chief Executive of the National Institute for Health and Care Research (NIHR) Clinical Research Network. He led the national research response during the COVID-19 pandemic.

His previous positions include roles at Great Ormond Street Hospital, the Royal College of Paediatrics and Child Health, and the NIHR

Dr Van't Hoff brings a wealth of clinical, academic, and strategic leadership to the Board.

Saqhib Ali,
Non-Executive Director (from July 2024)

Saqhib Ali is a qualified accountant and founder of a social enterprise that provides financial education and support to vulnerable communities.

He has over three decades of financial leadership experience across sectors including banking, automotive, and aviation.

Mr Ali currently chairs Audit Committees at Buckinghamshire, Oxfordshire and Berkshire West ICB and Cambridgeshire and Peterborough ICB. He concluded his term with Northamptonshire Healthcare NHS Foundation Trust in December 2024.

Daniel Childerhouse,
Associate Non-Executive Director

Chief Executive of Future Projects, a charity providing education and support services, Daniel Childerhouse holds numerous board and advisory positions across Norfolk's third sector.

He is co-founder of the Living Wage Norwich charity and the Great Yarmouth and Waveney VCSE (Voluntary, Community and Social Enterprise) group.

Gabriel Evbota BEM,
Associate Non-Executive Director

Gabriel Evbota is Customer Engagement Manager at HM Treasury, with a career spanning over two decades in government service.

He is active in local football governance and community engagement, having served as Chair of the Norfolk FA Inclusion Strategy Advisory Group.

Mr Evbota was awarded the British Empire Medal in 2019 for his public and voluntary service.

Jason Selvarajah,
Associate Non-Executive Director

Jason Selvarajah has held various leadership roles within policing since relocating to Norfolk in 2000.

He is a member of the National Black Police Association and a vocal advocate for equality, diversity, and inclusion.

Andrea Finegan,
Associate Non-Executive Director (from December 2024)

Andrea Finegan brings extensive leadership experience in finance and infrastructure. She is a Fellow of the Institute of Directors and a visiting fellow at the University of East Anglia.

Ms Finegan's recent roles include Non-Executive Director at Pantheon Infrastructure PLC and Chief Operational Officer for the Schroders Greencoat Valuation Committee.

Chris Lawrence,
Chair (to November 2024)

Chris Lawrence served as substantive Chair from November 2022 to November 2024, bringing over 40 years of experience across NHS, charitable, and private sectors.

He previously held leadership roles at Hertfordshire Partnership University NHS Foundation Trust and senior positions in the banking and cultural sectors.

Alan Brown,
Non-Executive Director

Alan Brown shared more than 40 years of experience in digital solutions, including 13 years in healthcare with the Board during his time as a Non-Executive Director at the Trust between May 2018 and March 2025.

Mr Brown also held non-executive roles at Hinchingbrooke Healthcare NHS Trust and Northwest Anglia NHS Foundation Trust.

David Dickinson,
Non-Executive Director (to June 2024)

David Dickinson is a retired Director of Resources with a background in public finance. He held senior roles in local government and was a member of the Chartered Institute of Public Finance and Accountancy.

Executive Directors

Alice Webster,
Chief Executive

Alice Webster was appointed Chief Executive in March 2023, having previously served as Interim Chief Executive since October 2022 and the Trust's Chief Nurse since May 2021.

She brings significant senior NHS leadership experience, including roles at NHS Improvement and Isle of Wight NHS Trust.

Ms Webster is an Associate Professor at the University of East Anglia and is recognised for her compassionate leadership and delivery of sustainable change.

Lorraine Hooper,
Interim Director of Finance (from October 2024)

Lorraine Hooper joined the Trust in October 2024. She brings extensive board-level financial experience, including roles as Chief Finance Officer (CFO) at University Hospitals of Leicester and Director of Finance at Nottinghamshire Healthcare NHS Foundation Trust.

Simon Illingworth,
Chief Operating Officer

Simon Illingworth joined in August 2023 and has a strong background in operational leadership across NHS organisations in the Midlands.

He leads on service transformation and performance delivery to support safe, high-quality care.

Dr Rebecca Martin,
Medical Director

Dr Rebecca Martin was appointed in September 2023. A consultant anaesthetist, she has held senior clinical leadership roles at East Kent Hospitals and Mid Essex Hospital Trust.

She provides medical leadership across the Trust, including workforce development and digital transformation

Pippa Street,
Chief Nurse

Pippa Street joined in August 2023. She is an experienced nurse leader with a broad career across acute, community, mental health, and commissioning settings.

She champions person-centred care and leads the Trust's nursing and quality governance functions.

John Syson,
Director of People

John Syson has over 20 years of NHS experience and joined the Trust from Bedfordshire, Luton and Milton Keynes ICS.

A Chartered Institute of Personnel and Development (CIPD) member, he focuses on culture, workforce development, and organisational change.

Carly West-Burnham,
Director of Strategy and Integration (non-voting)

Carly West-Burnham leads on strategic planning, partnership working, and integration with the wider health and care system.

She has worked within the West Norfolk health system since 2007.

Paul Brooks MBE,
Director of Estates and Facilities (non-voting)

Paul Brooks joined the Trust in October 2022 and has over four decades of NHS experience.

He leads the New Hospital Programme and was awarded the British Empire Medal MBE in 2020 for services to healthcare leadership.

Chris Benham,
Director of Finance (to November 2024)

Chris Benham served as Director of Finance until November 2024. He held senior financial positions across NHS and private sectors and is a Fellow of the Association of Chartered Certified Accountants.

Jill Hall,
Interim Director of Corporate Affairs (non-voting)
(to December 2024)

Jill Hall served as Interim Director of Corporate Affairs until December 2024 bringing over 26 years of NHS and local government experience.

She oversaw corporate governance, risk management, and Board assurance processes.

Board statement

The Board confirms that it possesses the necessary balance of skills, experience, and independence to effectively meet the governance requirements of the Trust.

Statutory statements

As part of the Directors' Report, the Trust is required to make the following statutory statements:

- So far as the Directors are aware, there is no relevant audit information of which the NHS Foundation Trust's auditor is unaware
- The Directors have taken all the steps that they ought to have taken as Directors in order to make themselves aware of any relevant audit information and to establish that the NHS Foundation Trust's auditor is aware of that information
- The Trust can confirm that it has complied with the cost allocation and charging requirements set out in HM Treasury and Office of Public Sector Information Guidance
- The Trust has made no political donations to any individual, body or organisation in 2024/25
- The Trust works to the Better Payment Practice Code. We aim to pay at least 95% of invoices within the agreed terms unless there is a dispute or for other reasons. For most of our partners, this would be within 30-days of the date of invoice or receipt of goods and services
- Our Trust is committed to working with all our supplier partners fairly, consistently, and professionally, and all suppliers are paid to these terms (unless they are a very small local business). All suppliers receive a payment each week if there is one due under the extended payment days, subject to those in query or dispute

The Trust's performance for 2024/25 is shown in the following tables:

Non-NHS	Number	£'000
Total bills paid in the year	55,318	198,599
Total bills paid within target	41,440	166,095
Percentage of bills paid within target	74.9%	83.6%

NHS	Number	£'000
Total bills paid in the year	1,139	15,586
Total bills paid within target	531	3,182
Percentage of bills paid within target	46.6%	20.4%

Total	Number	£'000
Total bills paid in the year	56,457	214,185
Total bills paid within target	41,971	169,277
Percentage of bills paid within target	74.3%	79.0%

"Through a time of change for the NHS, The QEH has continued to focus on delivering improved patient care and efforts to tackle waiting lists, Accident and Emergency waiting times, cancer referrals, as well as deliver more checks and scans through the new Community Diagnostic Centre. With an increased focus on research, robotics, and delivering innovative same day hip replacement, The QEH continues to focus on outcomes for patients.

"The welcome confirmation of the funding available for the new QEH is a major step forward reflecting the hard work of the team. I look forward to making progress on this new hospital scheme for patients, staff, and our community."

James Wild MP
Member of Parliament for North West Norfolk

Remuneration report

Trust Remuneration Report

The Remuneration Report has been audited.

Annual statement on remuneration

The Remuneration Report summarises our remuneration policy and its application in connection with the Executive Directors.

The Nomination and Remuneration Committee (Executive Appointments) considers and acts with delegated authority from the Board of Directors on all matters concerning the remuneration, allowances and other terms of service of the Executive Directors. The committee comprises the Trust Chair, all Non-Executive Directors and the CEO (unless the committee is considering the remuneration of the CEO).

The committee is attended by others at the request of the Chair in an advisory capacity where appropriate.

Non-Executive Directors' remuneration and terms and conditions of office are developed and reviewed by the Nomination and Remuneration Committee of the Council of Governors, making recommendations for approval by the Council of Governors.

All Directors of the Trust are subject to individual performance review. This involves the setting and agreeing of objectives for a 12-month period running from 1 April to 31 March.

The full remuneration report of salary, allowances and benefits of senior managers are set out in the Foundation Trust Directors' Remuneration Report - Salaries and Allowances section of the Annual Report on Remuneration.

Remuneration for Non-Executive Directors is also set out within that section.

Mark Friend
Interim Group Chair

26 June 2025

Senior managers' remuneration policy

Item	Salary / fees	Taxable benefits	Annual performance related bonus	Long term related bonus	Pension related bonus
How this supports the short- and long-term objectives of the Foundation Trust	Ensure the recruitment and retention of sufficient calibre to deliver the Trust's objectives	None disclosed	None paid	None paid	Ensure the recruitment and retention of sufficient calibre to deliver the Trust's objectives
How the component operates	Determined by the Nomination and Remuneration Committee using a range of data and criteria as set out in the Remuneration Committee section. Paid in even twelfths	None disclosed	None paid	None paid	Contributions paid by both employee and employer except for any employee who has opted out of the scheme in line with national regulations
Maximum payment	As set out in the accounts	None disclosed	None paid	None paid	Contributions are made in accordance with the NHS Pension Scheme

Framework used to assess performance	The Trust's values-based appraisals and objective setting process is used for all staff, including Executive Directors	None disclosed	None paid	None paid	Not applicable
Performance period	Tailored to individual posts	None disclosed	None paid	None paid	Not applicable
Amount paid for minimum level of performance	Salaries are agreed on appointment and set out in the contract of employment	None disclosed	None paid	None paid	Not applicable
Explanation of whether there are any provisions for recovery of sums paid to Directors or provisions for withholding payments	Any sums paid in error may be recovered	None disclosed	None paid	None paid	Any sums paid in error may be recovered

Very Senior Managers (VSM)

The Trust's definition of very senior managers (VSMs) relates to Executive Directors operating at Board level.

Service contract obligations

All Executive Directors are required to provide six months' notice. However, in appropriate circumstances this could be varied by mutual agreement. Terms of each of the Non-Executive Directors are given in the details of the Board members in the Board of Directors section.

Director and Governor expenses

Expenses are reimbursed to both Directors and Governors in accordance with the Trust's policies. Aggregate Non-Executive Director expenses for 2024/25 were £21,046 and included a relocation payment of £3,292 for one director.

Remuneration committees

In accordance with the Code of Governance, the Trust has two Nomination and Remuneration Committees:

The Nomination and Remuneration Committee (Executive Appointments)

A committee of the Board with delegated authority to approve the remuneration of the CEO, Executive Directors and other Directors reporting directly to the CEO. The committee is chaired by the Trust Chair. Membership is all Non-Executive Directors and the CEO (unless the committee is considering the remuneration of the CEO).

Executive remuneration is benchmarked using the NHS England Guidance on Executive Remuneration. The committee has been informed by this guidance in setting remuneration of substantive Executive Director appointments to the Board during the course of the year.

Further information on other aspects of the work of the committee and meeting attendance can be found in 'The Board of Directors' section.

The Nomination and Remuneration Committee of the Council of Governors

The committee makes recommendations to the Council of Governors in respect of Non-Executive Director appointments, remuneration and terms and conditions of office. Membership includes seven Governors and the Trust Chair (unless the committee is considering the remuneration of the Trust Chair).

The remuneration of Non-Executive Directors is determined by the Council of Governors. Remuneration is in line with national guidance on the 'Structure to align Remuneration for Chairs and Non-Executive Directors of NHS Trusts and NHS Foundation Trusts' published in November 2019. In line with the guidance, an additional payment is made to those holding the roles of Deputy Chair and Senior Independent Director. Remuneration for each of the Non-Executive Directors is given in the details of the Board members in 'The Board of Directors' section.

Further information on other aspects of the work of the committee and meeting attendance is set out in the table under 'The Council of Governors composition 2024/25.

Both Nomination and Remuneration Committees were supported by the Trust's Director of People, Director of Corporate Affairs and the Trust Secretary.

Details of remuneration and audited information

Details of Directors' remuneration for the period ended 31 March 2025 are set out in the remuneration tables.

Reporting bodies are required to disclose the relationship between the total remuneration of the highest paid director in the organisation against the 25th percentile, median and 75th percentile of the organisation's workforce. Total remuneration of the employee at the 25th, median and 75th percentile has not been broken down to disclose the salary component as total remuneration and salary are the same.

The calculation uses the basic salary of each employee. Part-time staff have had their salary grossed up to their full-time equivalent salary.

The banded remuneration of the highest paid director, calculated for comparison purposes on a pro-rate full-time basis at The Queen Elizabeth Hospital King's Lynn NHS Foundation Trust in the financial year 2024/25 was £210,000 to £215,000 (2023/24 £185,000 to £190,000). The relationship to the remuneration of the organisation's workforce is disclosed in the table below.

In 2024/25, 44 members of the workforce received remuneration in excess of the highest paid director. Remuneration ranged from £12 to £439,000.

Percentage change in remuneration of highest paid director

	Percentage change for highest paid director	Percentage change for employees as a whole
Salary and allowances	13.3%	5.5%
Performance pay and bonuses	Not applicable	Not applicable

The information is presented in this way to:

- Ensure transparency in Executive remuneration
- Provide the Trust with an opportunity to monitor its own remuneration and note any adverse or anomalous trends

Fair pay multiple	2024/25		
	25th percentile	Median	75th percentile
Mid-point of banded remuneration of highest paid director	£212,500	£212,500	£212,500
Total remuneration	23,615	29,970	42,008
Ratio	9.00	7.09	5.06

Fair pay multiple	2023/24		
	25th percentile	Median	75th percentile
Mid-point of banded remuneration of highest paid director	£187,500	£187,500	£187,500
Total remuneration	22,383	28,407	37,350
Ratio	8.39	6.61	5.03

Total remuneration includes salary, non-consolidated performance related bonuses, benefits in kind as well as severance payments. It does not include employer pension contributions, the cash equivalent transfer value of pensions, overtime or shift allowances.

The median and lowest salary cost for the Trust is low compared to some other trusts. This is as a results of the Trust not having outsourced non-clinical services, for example domestic and catering staff remain employees of the Trust.

Median pay has increased by 5.5% against 2024 as a result of the annual pay award.

Salaries and allowances

Foundation Trust Directors Remuneration Report		1 April 2024 to 31 March 2025					
Salaries and allowances		**(a) Salary**	**(b) Expense payments (taxable)**	**(c) Performance pay and bonuses**	**(d) Long-term performance pay and bonuses**	**(e) All pension-related benefits**	**(f) TOTAL (a to e)**
Non-Executives		**Bands of £5,000**	**To nearest £100**	**Bands of £5,000**	**Bands of £5,000**	**Bands of £2,500**	**Bands of £5,000**
Chris Lawrence	Chair *(resigned November 2024)*	30-35	1,400	-	-	-	30-35
Andy Wood	Interim Chair *(appointed December 2024)*	15-20	-	-	-	-	15-20
Alan Brown	Non-executive	10-15	-	-	-	-	10-15
David Dickinson	Non-executive *(resigned June 2024)*	0-5	-	-	-	-	0-5
Simon Roberts	Non-executive	10-15	1,900	-	-	-	10-15
Graham Ward	Non-executive	10-15	-	-	-	-	10-15
Dr Claire Fernandez	Non-executive	10-15	1,300	-	-	-	15-20
Sue Hayter	Non-executive	10-15	-	-	-	-	10-15
Saqhib Ali	Non-executive	5-10	1,400	-	-	-	10-15
William Van't Hoff	Non-executive	10-15	-	-	-	-	10-15
Associate Non-Executive Directors							
Daniel Childerhouse	Associate non-executive	5-10	500	-	-	-	10-15
Gabriel Evbota	Associate non-executive	5-10	1,700	-	-	-	10-15
Andrea Finegan	Associate non-executive	0-5	200	-	-	-	5-10
Jason Selvarajah	Associate non-executive	5-10	300	-	-	-	10-15
Executive Directors							
Chris Benham††	Finance Director *(resigned November 2024)*	105-110	-	-	-	-	105-110
Alice Webster	Chief Executive	195-200	100	-	-	20.0-22.5	215-220
Simon Illingworth	Chief Operating Officer	135-140	-	-	-	92.5-95.0	230-235
Rebecca Martin	Medical Director	210-215	-	-	-	-	210-215
Pippa Street	Chief Nurse	130-135	-	-	-	125-127.5	255-260
Lorraine Hooper	Interim Director of Finance *(appointed October 2024)*	80-85	-	-	-	-	80-85
John Syson	Director of People	130-135	-	-	-	10-12.5	140-145

†† Chris Benham received a payment in lieu of notice of £76,000.

Foundation Trust Directors Remuneration Report		1 April 2023 to 31 March 2024					
Salaries and allowances		**(a) Salary**	**(b) Expense payments (taxable)**	**(c) Performance pay and bonuses**	**(d) Long-term performance pay and bonuses**	**(e) All pension-related benefits**	**(f) TOTAL (a to e)**
Non-Executives		**Bands of £5,000**	**To nearest £100**	**Bands of £5,000**	**Bands of £5,000**	**Bands of £2,500**	**Bands of £5,000**
Chris Lawrence	Chair	45-50	500	-	-	-	50-55
Alan Brown	Non-executive	10-15	100	-	-	-	10-15
David Dickinson	Non-executive	0-5	-	-	-	-	0-5
Simon Roberts	Non-executive	10-15	300	-	-	-	10-15
Dr Ian Mack	Non-executive	5-10	-	-	-	-	5-10
Graham Ward	Non-executive	10-15	200	-	-	-	10-15
Dr Claire Fernandez	Non-executive	10-15	1,300	-	-	-	15-20
Sue Hayter	Non-executive	10-15	-	-	-	-	10-15
Executive Directors							
Govinda Raghuraman	Acting Medical Director	95-100	100	-	-	-	95-100
Chris Benham	Finance Director	150-155	-	-	-	10-12.5	165-170
Denise Smith	Chief Operating Officer *(to 31 December 2022)*	0	-	-	-	-	0
Alice Webster	Chief Executive	185-190	100	-	-	170-172.5	360-365
George Briggs	Interim Chief Operating Officer *(to 31 May 2023)*	30-35	-	-	-	-	30-35
Simon Illingworth	Chief Operating Officer *(from 1 September 2023)*	65-70	-	-	-	2.5-5.0	70-75
Rebecca Martin	Medical Director *(from 1 September 2023)*	110-115	-	-	-	-	110-115
Pippa Street	Chief Nurse *(from 1 September 2023)*	75-80	-	-	-	102.5-105	180-185
John Syson	Director of People *(voting director from 21 June 2023)*	75-80	-	-	-	12.0-12.5	90-95

The highest paid director of the Trust in 2024/25 was the Medical Director and for 2023/24 it was the Chief Executive.

The full salaries of the Medical Director and Chief Nurse are disclosed in the previous tables and include elements of pay that relate to their clinical role.

Taxable benefits cover the monetary value of benefits in kind, such as car mileage allowances where subject to income tax.

Pension benefits

Pension benefits									
		(a) Real increase in pension at pension age	(b) Real increase in pension lump sum at pension age	(c) Total accrued pension at pension age as at 31 March 2025	(d) Lump sum at pension age related to accrued pension at 31 March 2025	(e) Cash equivalent transfer value at 1 April 2024	(f) Real increase in Cash Equivalent Transfer Value	(g) Cash Equivalent Transfer Value at 31 March 2025	(h) Employer's contribution to stakeholder pension
		Bands of £2,500	Bands of £2,500	Bands of £5,000	Bands of £5,000	£'000	£'000	£'000	£'000
Alice Webster	Chief Executive	2.5-5.0	-	90-95	240-245	1,986	35	2,179	-
Chris Benham	Director of Finance	-	-	40-45	-	622	-	667	-
Pippa Street	Chief Nurse	5.0-7.5	10.0-12.5	65-70	175-180	N/A	N/A	N/A	-
Simon Illingworth	Chief Operating Officer	2.5-5.0	7.5-10.0	35-40	95-100	642	82	782	-
Rebecca Martin	Medical Director	-	-	65-70	170-175	1,634	-	1,579	-
John Syson	Director of People	0-2.5	-	30-35	75-80	542	2	598	-

Patient safety

Patient Safety Incident Response Framework (PSIRF)

The NHS Patient Safety Strategy (2019) introduced the Patient Safety Incident Response Framework (PSIRF), replacing the former Serious Incident Framework (2015). PSIRF provides a strategic approach to developing and sustaining effective systems for responding to patient safety incidents. It promotes a culture of continuous improvement and learning across healthcare settings.

The four central aims of PSIRF are:

- Compassionate engagement and involvement of those affected by patient safety incidents
- A systems-based approach to learning
- Considered and proportionate responses
- Strengthened oversight that supports effective response systems and continuous improvement

By adopting a systems-based approach, PSIRF encourages understanding of the complex factors contributing to incidents, enabling prevention and the measurable reduction of repeat risks through improvement science. Emphasis is placed on the quality of Patient Safety Incident Investigations (PSIIs), enhancing trust and confidence among patients, families, carers, and staff in the Trust's commitment to safety.

Since the transition to PSIRF in September 2023, approximately 50 staff members at The QEH have undertaken training delivered by NHS England-approved providers. This training supports learning response leads, oversight roles, and engagement leads in applying system-thinking and engaging compassionately with those affected by safety events.

The Trust published its first Patient Safety Incident Response Plan (PSIRP) in September 2023. The plan outlined how The QEH would respond to incidents and set out the Trust's local patient safety priorities, based on risk profile analysis. These included:

- Early identification and escalation of the deteriorating patient
- Nutrition and hydration
- Hospital-acquired thrombosis

A full analysis of patient safety data is underway to inform the PSIRP for 2025/26. Updated safety priorities will be agreed through the Patient Safety and Experience Executive Group and Quality Committee in April–May 2025, identifying themes for in-depth PSIIs.

Incident reporting

In 2024/25, the Trust recorded a total of 9,498 patient safety incidents (8,511 excluding pressure ulcers and pre-existing skin damage on admission). Of these, 30 incidents were categorised as causing severe harm or death.

	Total reported patient safety incidents, excluding pressure ulcers on admission	Safety incidents categorised as major or catastrophic	Total incidents commissioned as PSII or NE
2024/25	8,511	30	17
2023/24	7,494	35	31
2022/23	6,508	47	49
2021/22	7,549	29	54
2020/21	7,631	29	56
2019/20	7,007	27	55
2018/19	7,710	32	50

Key achievements during 2024/25 included:

- Embedding of divisional incident huddles, providing regular oversight of emerging safety risks and enhancing engagement with incident management at ward and service level
- Introduction of a variety of learning response tools, which improved staff participation and satisfaction with the investigation process
- Use of enhanced investigation techniques, including observational work, process mapping, and supportive conversations, enabling earlier identification of improvement opportunities and more immediate remedial action
- Broad adoption of the Systems Engineering Initiative for Patient Safety (SEIPS) and human factors frameworks to better understand contributory factors within complex healthcare systems
- Establishment of operational PSIRF meetings between the Patient Safety team and risk, governance and quality leads to review and strengthen implementation of PSIRF processes

- Enhanced dissemination of learning from investigations via staff reports, newsletters, intranet updates, and the patient safety intranet page
- Development of a new training programme in partnership with the Education team, focusing on compassionate engagement with patients and families and building confidence in delivering patient safety conversations
- Qualification of the Trust's associate director of patient safety and improvement as a patient safety specialist, having completed Levels 3 and 4 of the NHS Patient Safety Syllabus via Loughborough University. The Trust is now fully compliant with NHS contract requirements for this role
- Integration of the Learning from Patient Safety Events (LFPSE) platform into the Datix system
- Production and launch of a Datix training video on the importance of incident reporting and a just culture
- Inclusion of patient safety training in core programmes such as 'New to The QEH' and THRIVE (Transforming Healthcare, Reflection, Innovation, Values, Excellence), with a focus on learning from incidents and quality improvement

Patient safety learning events

Two Trust-wide patient safety learning events were held during 2024/25. Topics covered included:

- Quality improvement in mouthcare for stroke patients
- Supporting patients with dysphagia in acute settings
- Effective use of fluid balance charts
- The impact of sensory impairment on patient safety and experience
- WHO World Patient Safety Day: Improving Diagnosis for Patients – Get it Right, Make it Safe

All event materials were made available to staff via the Trust intranet.

Patient Safety Incident Investigations (PSII)

	Emergency Care and Medicine	Clinical Support and Cancer Services	Surgery	Women's and Children's	COO	Total
Diagnostic incident including delay	2	1	0	1	0	4

	Emergency Care and Medicine	Clinical Support and Cancer Services	Surgery	Women's and Children's	COO	Total
Maternity/obstetric incident – baby only	0	0	0	4	0	4
Treatment delay	1	0	0	0	1	2
Sub-optimal care of the deteriorating patient	2	0	0	0	0	2
Medication incident	0	0	1	1	0	2
Substance misuse whilst inpatient	1	0	0	0	0	1
Venous thromboembolism	1	0	0	0	0	1
Surgical/invasive procedure incident	0	0	1	0	0	1
Total	7	1	2	6	1	17

Never Events

During 2024/25, the Trust reported two Never Events:

1. A wrong-site nerve block
2. A self-administration of medication via an incorrect route

In both cases, no harm was caused to the patients involved. These incidents were fully investigated, and learning was shared through appropriate governance processes.

Duty of Candour

The Trust continues to uphold the statutory Duty of Candour as defined in the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Regulation 20. This applies to all incidents resulting in, or with potential to result in, moderate, severe or prolonged harm, or death.

The Duty of Candour includes three key phases:

1. Initial conversation (within 10 working days) with the patient or their representative
2. Written notification
3. Offer of final report following completion and governance approval of the investigation

In 2024/25, compliance rates were:

1. Phase one: 97%
2. Phase two: 95%
3. Phase three: 100%

Slight dips in phases one and two compliance during the first two quarters were addressed through process improvements. Compliance is monitored at both Divisional Board level and corporately through the Patient Safety and Experience Executive Group.

Phase one compliance

	Phase one required	Phase one completed	Phase one count (completed within 10 working days)	Phase one % (completed within 10 working days)
Quarter one	41	41	39	95%
Quarter two	55	55	51	93%
Quarter three	80	80	80	100%
Quarter four	58	58	58	100%
Overall compliance	**234**	**234**	**228**	**97%**

Phase two compliance

	Phase two required	Phase two completed	Phase two count (completed within 10 working days)	Phase two % (completed within 10 working days)
Quarter one	35	35	31	89%
Quarter two	47	47	42	89%
Quarter three	49	49	49	100%
Quarter four	50	50	50	100%
Overall compliance	**181**	**181**	**172**	**95%**

Phase three compliance

	Phase three required	Phase three completed	Phase three count (completed within 10 working days)	Phase three % (completed within 10 working days)
Quarter one	2	2	2	100%
Quarter two	4	4	4	100%
Quarter three	4	4	4	100%
Quarter four	9	9	9	100%
Overall compliance	**19**	**19**	**19**	**100%**

Learning from Patient Safety Events (LFPSE)

The Learn from Patient Safety Events (LFPSE) system is a national NHS initiative developed to replace the National Reporting and Learning System (NRLS). It provides a central platform for recording, reviewing and analysing patient safety events to support learning and improvement at both local and national levels.

In April 2024, The QEH successfully integrated LFPSE into its local incident reporting system, Datix. This enhancement supports improved analysis, trend identification and learning from patient safety events across the organisation.

Patient Reported Outcome Measures (PROMs)

Patient Reported Outcome Measures (PROMs) assess health outcomes from the patient's perspective, focusing on improvements in health following specific surgical procedures. PROMs are collected for patients undergoing hip and knee replacements in England, using standardised questionnaires completed before and after surgery. These measures provide valuable insights into the quality and effectiveness of care delivered to NHS patients.

As of 1 October 2017, following a national consultation by NHS England, routine PROMs data collection for varicose vein and groin hernia procedures was discontinued.

The COVID-19 pandemic significantly impacted elective surgical activity across the NHS. In response to national guidance, all non-urgent elective surgery was suspended during parts of the 2020/21 reporting period, and service delivery remained reduced during 2021/22. This had a direct effect on the volume of hip and knee replacement procedures reported in PROMs, as well as on patient engagement with the completion and return of pre- and post-operative questionnaires. As a result, comparisons with pre-pandemic data should be interpreted with caution.

For the 2024/25 reporting period, the only PROMs data available for publication at the time of reporting relates to the period October to December 2023:

Participation rate: Hernia	Participation rate: Hip	Participation rate: Knee	Participation rate: Vein
0%	65%	70%	0%

Below is the numerator used for this reported period (scanned questionnaires by procedure):

Total scanned: Hernia	0
Total scanned: Hip	43
Total scanned: Knee	58
Total scanned: Vein	0

Patient and carer experience

At The QEH, we are committed to engaging patients, carers, and the public meaningfully to drive continuous service improvement. Patient experience is central to the care journey, with every staff member playing a vital role in providing compassionate, person-centred care.

In 2024, the Patient Experience team underwent a structural review to align with the Trust's quality priorities, including Clinical Effectiveness, Patient Safety, and Experience. This review resulted in key appointments, including a dedicated FFT administrator, a new patient experience and engagement lead, and an associate director of patient experience and engagement.

Patient experience is a core component of 'Our Strategy,' which outlines how we will embed person-centred care over the next seven years. The strategy highlights staff responsibility in ensuring care is delivered with empathy and tailored to individual needs. Significant progress was made toward strategic objective one: Holistic and Person-Centred Care. This included demographic analysis based on the 2021 Census to identify care needs within our communities.

A comprehensive review of FFT feedback (April 2023 – March 2024) identified gaps in engagement with non-English-speaking patients. In response, FFT materials were translated into six key languages, and multilingual feedback options were introduced. Common feedback themes, such as concerns around waiting times and communication, have been prioritised for improvement.

Feedback from bereaved relatives, collected via the Medical Examiner's Office, showed positive responses, reflecting improvements in end-of-life care. Community engagement efforts, including collaboration with the Hanseatic Union, focused on addressing cultural and language barriers, improving access to services, and ensuring equitable care for all communities.

Internal governance and reporting – forums and sub-groups

In 2024/25, the Trust continued its commitment to enhancing patient experience by actively participating in forums supporting carers, individuals with disabilities, sensory impairments, and veterans. The Trust retained the Carers Friendly Tick with the highest distinction and re-accredited as a Veterans Friendly Trust, reinforcing its efforts to reduce health inequalities and support the Armed Forces Covenant.

Ongoing engagement with specialist groups – including those focused on learning disabilities, autism, mental health, dementia, end-of-life care, and spiritual wellness – ensured that patient experience remained at the forefront. The Patient Panel continued to play an essential role in shaping services, with regular assurance reports provided to the Patient Experience and Carer Forum.

Chaplaincy services

The Chaplaincy team provided spiritual and pastoral care to patients, carers, families, and staff. With four chaplains, working varied hours, and 12 trained volunteers, the team supported over 3,000 patients in 2024, offering emotional support across wards. Collaborative work with the Integrated Care System and Palliative Care teams, particularly in the newly opened Peddars Way end-of-life unit, continued. The Chaplaincy also launched mindfulness sessions for staff and facilitated bereavement support groups for the public.

Voluntary services

Volunteers remained integral to Trust operations, supporting a wide range of clinical and non-clinical services. A key highlight was the successful expansion of the patient buggy service pilot, with two vehicles now operational five days a week. Volunteer engagement grew significantly, with tailored role profiles, structured induction, and training enhancing integration into teams. The new reward and recognition scheme further supported volunteer retention and engagement.

Patient Experience Programme

Now in its second year, the Patient Experience Programme comprises eight workstreams focused on continuous quality improvement. These workstreams are informed by patient feedback, incidents, and strategic priorities.

- **Listening to our patients:** patient stories were presented to the Board, providing valuable insights into care quality and identifying opportunities for improvement. The Patient and Readers Panels continued to engage with Trust-wide initiatives, ensuring the patient voice shaped service delivery
- **Let's Get Moving:** this workstream promoted mobility to prevent deconditioning through initiatives like the 'Exemplar Ward', outdoor mobility spaces, and the 'Ward Steps Challenge'. A new dashboard tracked progress, receiving national recognition from NHS England Getting It Right First Time (GIRFT)
- **Optimising nutrition and hydration:** the Trust launched a new Nutrition and Hydration Strategy with patient involvement. Key improvements included reintroducing protected mealtimes, expanding mealtime support, and enhancing allergen awareness
- **Quality and timely discharge:** the Trust focused on improving discharge processes, implementing criterion-led discharge, a new discharge lounge, and digital tools like Patient Observation Management Systems (POMS) and Optimised Patient Tracking and Intelligent Choices Application (OPTICA). These efforts led to improved flow and reduced discharge-related complaints
- **Education and training:** national award nominations and Royal College of Nursing accreditation highlighted the success of education programmes,

including the THRIVE graduate scheme and frailty awareness training. New training supported the integration of technologies such as POMS

- **Learning disability and autism:** the Trust made significant progress in supporting patients with learning disabilities and/or autism, introducing new feedback tools, care planning processes, and environmental adjustments on Stanhoe Ward
- **Environment and accessibility:** feedback-driven facility improvements included a new patient menu, better signage, and enhanced digital entertainment options. AccessAble contract was renewed for three years, benefiting over 17,000 users
- **Volunteers Matter:** the Trust significantly expanded its volunteer services in 2024/25, increasing the active volunteer cohort from 40 to 167 and developing 54 distinct roles, enhancing patient and staff support across multiple services; initiatives included strengthened governance, enhanced volunteer engagement, targeted support for outpatient attendance, and partnership work with Vision Norfolk and AccessAble to improve patient experience and accessibility

Governance and oversight

Workstream updates are regularly reported to the Patient and Carer Experience Forum and escalated to the Patient Safety and Experience Executive Group and the Quality Committee, ensuring patient experience remains central to Trust priorities.

Carers and Armed Forces

In January 2025, the Trust received the Carer Friendly Tick Award, achieving the highest level of recognition and securing a place in the Hall of Fame. The Trust continued to mark Carers Week and Young Carers Action Day annually to raise awareness and support. In September 2024, the Trust retained its Veteran Aware accreditation, reaffirming its commitment to supporting veterans and their families through the Armed Forces Forum and partnerships with veterans' organisations.

Introducing The QEH Youth Council

The QEH has introduced its very own Youth Council. This is the first of its kind in Norfolk and has been set up to ensure the voices of young people are heard. It aims to make sure decision makers know what those aged 16 to 25 think about the services and care they receive and also act as a link between the hospital and the local community to create stronger bonds with local people.

Public engagement

Four engagement events were held across Norfolk, Cambridgeshire, and Lincolnshire to support strategic objective one, providing opportunities for community feedback and public involvement in shaping services.

Patient stories at Board

Patient stories were presented at Public Board meetings, directly influencing service improvements. Key stories focused on emergency care, learning disabilities, dementia, and gastrointestinal care, leading to initiatives such as improved outpatient environments and tailored dementia support.

Friends and Family Test (FFT)

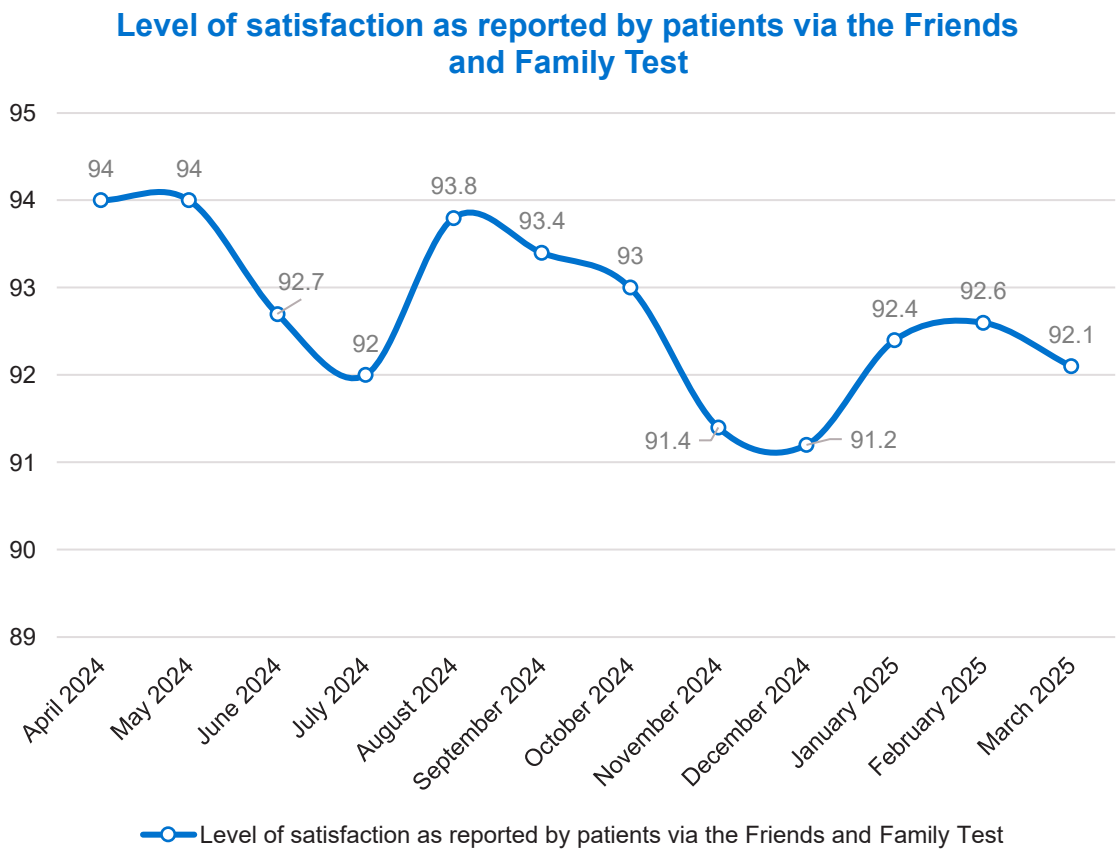
FFT feedback, collected via Envoy, is set to expand from April 2025 with a new provider offering digital and card-based feedback options. FFT insights have already informed improvements in communication during delays. A new Patient Experience role with IT expertise will further enhance FFT system management, data analysis, and reporting efficiency.

"The Queen Elizabeth Hospital has been committed to improving the health and lives of its residents in Norfolk for more than 40 years. It has been in the national news for some time regarding its urgent need for a rebuild and, as a council, we are delighted that government funding has finally been secured to transform this much-needed facility into a state-of-the-art hospital.

"As a close partner and stakeholder with strong working relations, the council will continue to work with the hospital to safeguard its future and support its commitment to providing outstanding care for the community.

"Together with everyone in West Norfolk, we look forward to seeing this vision come to life and the new possibilities it will bring to our future."

Kate Blackmore
Chief Executive, Borough Council of King's Lynn and West Norfolk



National patient surveys

The Trust participated in five national surveys:

- Adult Inpatient Survey
- Maternity Survey
- Children and Young Persons Survey
- Urgent and Emergency Care Survey
- Cancer Patient Experience Survey

	Month sampled	Month published	Response rate	Average national response rate
Adult Inpatient Survey	January 2024	May 2024	43%	42%
Maternity Survey	February 2024	November 2024	43%	41%
Children and Young Persons Survey	June 2024	Awaiting publication		
Urgent and Emergency Care Survey	April 2024	November 2024	45%	29%
Cancer Patient Experience Survey	November 2023 – February 2024	July 2024	58%	52%

Additionally, the Trust piloted a new Stroke Patient Reported Experience Measures Survey (PREMS), which has since been adopted into the national programme. Survey results are reviewed by divisional teams and integrated into quality improvement actions through the Trust's governance structures.

- **Adult Inpatient Survey (2024):** with a 43% response rate, areas for improvement included pain management, communication, and discharge processes. Actions include enhanced discharge planning, pain management training, and improvements in mealtime support and communication
- **Maternity Survey:** significant year-on-year improvements were seen, particularly in antenatal and postnatal experiences. Areas requiring further attention include discharge, pain relief, and communication
- **Urgent and Emergency Care Survey:** with a response rate increase from 22% to 45%, feedback highlighted the hospital environment and facilities, guiding further service improvements
- **Cancer Patient Experience Survey:** the Trust received a 58% response rate, exceeding the national average. No scores were below the expected range, and six scores exceeded expectations, reflecting high-quality, patient-centred care

Quality Assurance Visit (QAV) Programme

Launched in 2022, the Quality Assurance Visit (QAV) Programme continues to provide valuable feedback on patient care and the effectiveness of improvements. Monthly, unannounced reviews are conducted across clinical areas, with structured Reviewer packs supporting consistent, actionable feedback. The 'You Said, We Did' approach ensures continuous improvement, with progress tracked and achievements celebrated.

Themes for improvement	Positive themes
Estates – repairs / maintenance	Great teamwork / multi-disciplinary teamworking
Information governance	Area clean and tidy
Infection prevention and control issues – poor hand hygiene, inconsistencies around PPE wearing and bare below the elbow	Welcoming, kind and friendly staff
Inconsistent documentation standards	Good levels of security in the ward
Uniform inconsistencies – not wearing 'Nurse in charge / name badge'	Positive patient experience and patient care
Patient communication	Staff approachable, helpful and friendly

Patient information governance

A robust governance process was introduced for patient-facing information to ensure quality, accuracy, and accessibility. This initiative, led by the Patient Information Lead and the Readers Panel, included the development of a new Patient and Public Information Policy and the review of 69 leaflets.

Conclusion for 2024/25

This year saw significant progress in the Patient Experience Programme, with enhanced collaboration across the Trust and the ICS. Thematic action planning, informed by patient and carer feedback, continues to shape service delivery and improvements.

Key priorities for 2025/26

- Continue the development of eight core workstreams
- Support digital strategy and the implementation of patient portals
- Use FFT and national surveys to inform quality improvements
- Strengthen collaboration across the ICS and group model

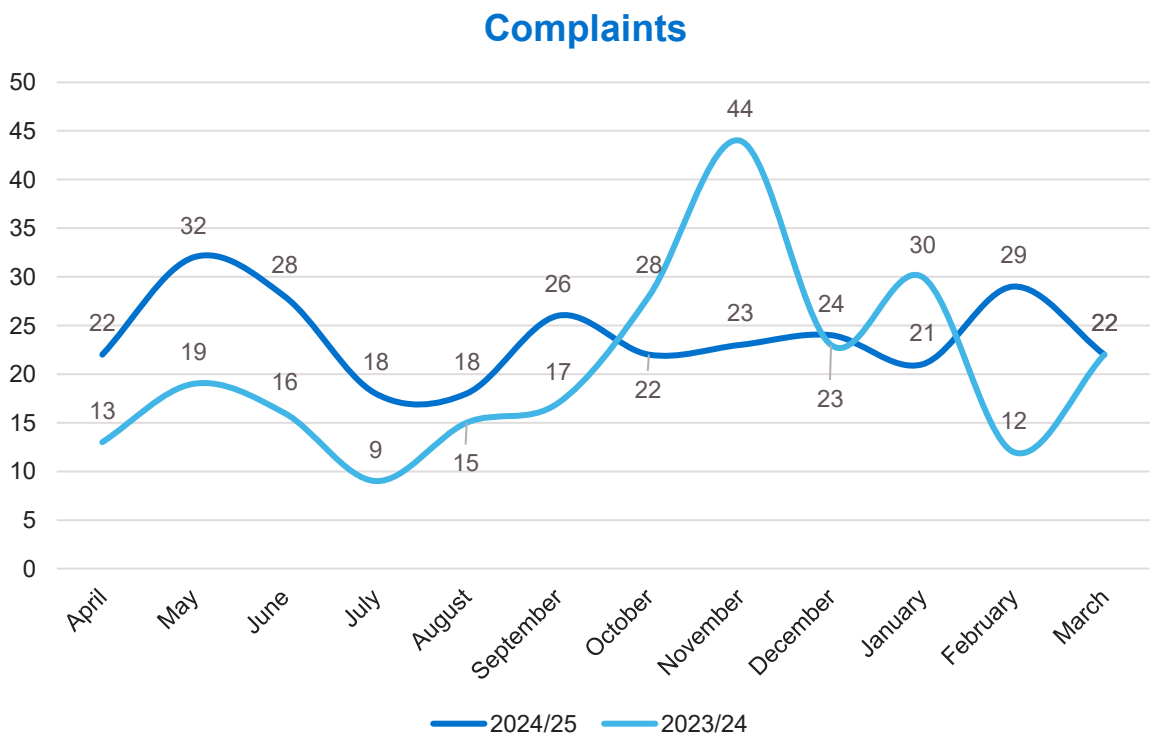
Complaints, Patient Advice and Liaison Service (PALS) and Compliments

Commitment to learning and improvement

The Trust is dedicated to learning from patient feedback, including complaints, concerns, and compliments, to drive continuous improvement in the quality of care provided. All feedback is managed in accordance with the Trust's Complaints Policy and the NHS Complaints Regulations, ensuring a structured and transparent approach to addressing issues and enhancing patient experience.

Complaints management

The Complaints team is responsible for ensuring that formal complaints are thoroughly investigated and responded to within the statutory 30-working-day timeframe. In 2024/25, the Trust received 285 formal complaints, marking a 12% increase from the 249 received in 2023/24. The distribution of complaints by month and by division is detailed in the accompanying charts.



	Q1 – 2024/25	Q2 – 2024/25	Q3 – 2024/25	Q4 – 2024/25	Total 2024/25
Clinical Support and Cancer Services	4	2	2	2	10
Emergency Care and Medicine	46	33	40	40	159
Surgery	18	16	18	17	69
Women's and Children's	13	9	7	10	39
Other	1	2	2	3	8
Total	**82**	**62**	**69**	**72**	**285**

Response time performance

The Trust aims to respond to all complaints within 30 working days. Quarterly performance data indicates that while the majority of complaints were addressed within this timeframe, there were instances where extensions were applied, and cases were reopened, which may affect the reported figures. Starting from April

2025, the Trust will report on the actual number of complaints responded to within 30 working days, providing a more accurate reflection of performance.

Response time – working days	Q1 – 2024/25	Q2 – 2024/25	Q3 – 2024/25	Q4 – 2024/25	Total 2024/25
Less than 30 days	75%	58%	72%	77%	70%
More than 30 days	25%	32%	28%	23%	30%

Key themes

The top ten themes identified from patient complaints during 2024/25 are as follows:

Complaints	Number
Clinical treatment	272
Communication	252
Values and behaviours (staff)	122
Patient care	162
End of life care	31
Patient dignity and wellbeing	26
Prescribing	16
Trust admin, policies and procedures	13
Access to treatment or drugs	10
Appointments	10

These themes are subject to further analysis to inform targeted improvement initiatives.

Process enhancements

In Q3 of 2024/25, the Trust collaborated with Divisional Leadership teams to review and refine the complaints management process. The revised process, implemented in January 2025, includes:

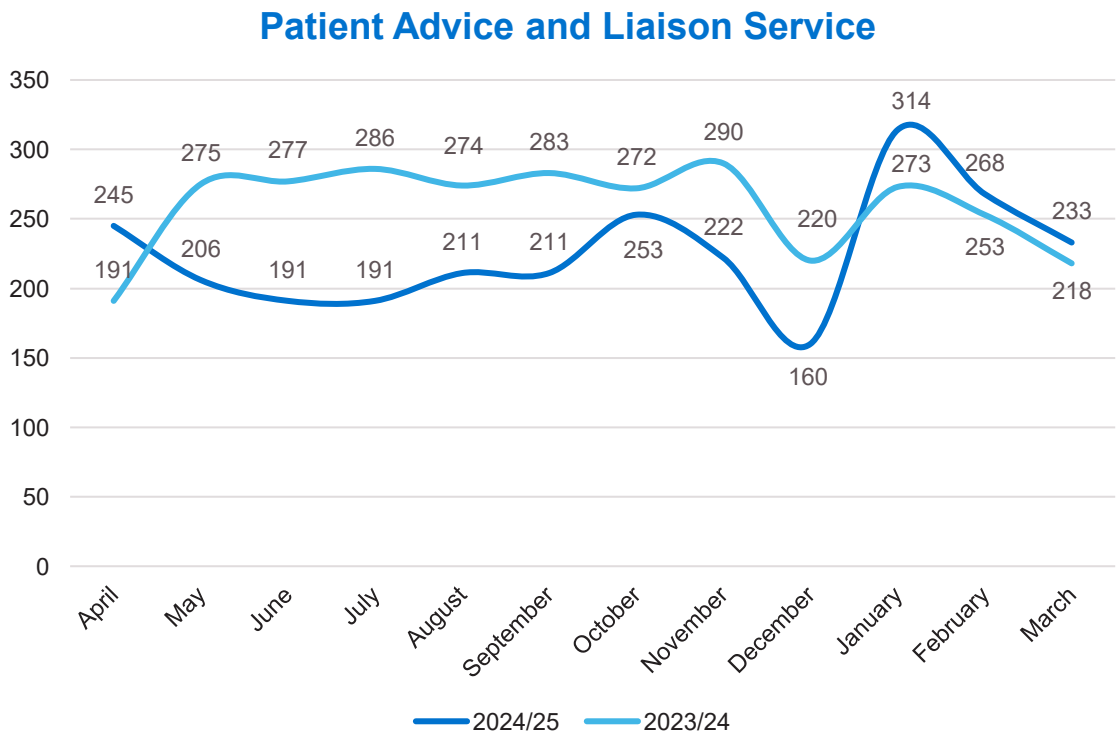
- Divisional operations directors appointing the most appropriate investigating manager for each complaint

- Investigating managers leading investigations, drafting response letters, and collaborating with the Complaints team to finalise responses
- Final response letters being reviewed by the Divisional Leadership team before undergoing chief nurse and chief executive sign off

This approach aims to streamline the process, enhance accountability and ensure timely and qualitative responses.

Patient Advice and Liaison Service (PALS)

PALS serves as a confidential service offering advice, support, and information to patients, families, and carers. In 2024/25, PALS logged 2,690 concerns, an increase from 2,616 in 2023/24. The service focuses on resolving concerns promptly to alleviate anxiety and prevent escalation into formal complaints. PALS also plays a crucial role in identifying areas for service improvement through the collection and analysis of feedback.



	Q1 – 2024/25	Q2 – 2024/25	Q3 – 2024/25	Q4 – 2024/25	Total 2024/25
Clinical Support and Cancer Services	51	47	26	30	154
Emergency Care and Medicine	225	202	223	246	896

Surgery	168	146	199	274	787
Women's and Children's	38	35	55	67	195
Other	160	183	132	183	658
Total	**642**	**613**	**635**	**800**	**2,690**

Compliments

The Trust values and acknowledges the positive feedback received from patients and their families. In 2024/25, 1,470 compliments were recorded, compared to 1,510 in the previous year. These compliments are shared with staff to recognise their dedication and to promote a culture of excellence in patient care.

	Q1 – 2024/25	Q2 – 2024/25	Q3 – 2024/25	Q4 – 2024/25	Total 2024/25
Clinical Support and Cancer Services	8	16	10	20	54
Emergency Care and Medicine	145	175	249	302	871
Surgery	130	116	36	50	332
Women's and Children's	56	41	21	43	161
Other	14	10	10	18	52
Total	**353**	**358**	**326**	**433**	**1,470**

Parliamentary and Health Service Ombudsman (PHSO)

In instances where complainants remain dissatisfied after the Trust's internal processes, they may escalate their concerns to the PHSO. During 2024/25, the PHSO contacted the Trust regarding 14 escalated complaints, a 100% increase from the seven referred in 2023/24. Of these:

- Eight cases are under review to determine if a formal investigation is warranted
- Two cases are currently under formal investigation
- Seven cases were closed during the year, four of which underwent formal investigation

Planned improvements for 2025/26

The Trust is committed to further enhancing its complaints management processes in the coming year by:

- Reviewing and refining the newly implemented complaints process in collaboration with Divisional Leadership teams to ensure timely and qualitative responses
- Aiming for a 100% compliance rate in responding to complaints within 30 working days
- Increasing the number of complaints resolved through Local Resolution Meetings (LRMs)
- Continuously improving internal processes and procedures to operate as a high-performing, cohesive team
- Updating documented procedures to reflect continuous improvement efforts
- Ensuring comprehensive staff training to mitigate risks associated with staff absences during peak periods
- Collaborating with divisions to audit learning from complaints against other Trust key performance indicators
- Working closely with the Patient Experience and Patient Safety team to effectively share learning from complaints

"Since becoming an MP, less than a year ago, I have been delighted to work with and support the Trust. On my visits I have seen how it continues to deliver excellent patient care despite the challenges presented by the outdated buildings.

"Recently, we have also received confirmation of the £1 billion to £1.5 billion funding from the new Government for the hospital rebuild. This is very welcome news for everyone involved and follows much campaigning and lobbying. I know for staff and patients alike this is much needed and fantastic news and will help ensure West Norfolk will have the modern hospital it deserves."

Terry Jermey MP
Member of Parliament for South West Norfolk

Staff report

We are committed to working with our staff, trade union representatives and other stakeholders to embed the Trust values of Kindness, Wellness and Fairness in everything we do. Alongside this, we also fully support the national NHS People Plan and People Promise, which are designed to improve working lives of all NHS staff while outlining what they can expect from their employers and colleagues.

The NHS People Plan is made up of four key themes, which are:

- Looking after our people - with quality health and wellbeing support for everyone
- Belonging in the NHS - with a particular focus on tackling the discrimination that some staff face
- Growing for the future - how we recruit and keep our people, and welcome back colleagues who want to return
- New ways of working and delivering care - making effective use of the full range of our people's skills and experience

The NHS People Promise

The QEH People Plan

The QEH People Plan was developed in response to both the national plan and 'Our Strategy' as well as building on the 2023/24 People Plan. During 2024/25, it focused on supporting the delivery of the Trust's strategic objectives. We have sought to do this by making The QEH a better place to work, by improving our people processes, policies and systems. We have embedded four Associate Non-Executive Directors to bring diverse and different lived experiences and skills to the Board and the governance and leadership of the Trust.

We have begun the journey of improving the way we manage employee relations cases, working with the Freedom to Speak Up (FTSU) team and trade unions to make these processes quicker, fairer and more compassionate.

We have maintained our extensive apprenticeship programme with over 170 apprenticeships active in March 2025. In addition, we have continued our work experience and school and college engagement work. We now fulfil an important role as an anchor institution in King's Lynn and West Norfolk with great working relationships with our higher and further education partners. We have begun the process to obtain teaching hospital status in 2025/26.

We have also seen improvements in the training experiences of our medical students and junior doctors in training, with better GMC survey results and more trainees than in 2023/24.

Staff numbers (whole-time equivalents)

The table below shows staff numbers as at 31 March 2025 and 31 March 2024.

Staff group	Permanent		Other (agency and bank)		Total	
31 March	**2025**	**2024**	**2025**	**2024**	**2025**	**2024**
Medical and dental	466	454	42	20	508	474
Ambulance staff	2	2	0	0	2	2
Administration and estates	1,070	729	87	31	1,157	760
Healthcare assistants and other support staff	919	942	87	195	1,006	1,137
Nursing, midwifery and health visiting staff	1,171	998	65	164	1,236	1,162
Nursing, midwifery and health visiting learners	5	4	0	4	5	8

Scientific, therapeutic and technical staff	270	368	19	27	289	395
Healthcare science staff	25	59	1	5	26	64
Social care staff	0	0	0	0	0	0
Total average numbers	**3,928**	**3,556**	**301**	**446**	**4,229**	**4,002**

There has been some re-classification of staff between identified staff groups in the above table.

We have increased the number of substantive staff in post by over 100 WTE and reduced our time to hire during 2024/25 by improving recruitment processes and expanding our use of digital processes and automation into the recruitment process.

We have introduced effective grip and control measures for substantive, Bank and agency usage. This has substantially reduced the Trust's use of bank workers and agency staff by over 50% while maintaining service levels.

Breakdown of staff by gender

Category	Female	Male	Total
Executives	5	4	9
Non-executives	3	9	12
Senior managers	10	9	19
Other	3,090	993	4,083
Total	**3,108**	**1,015**	**4,123**

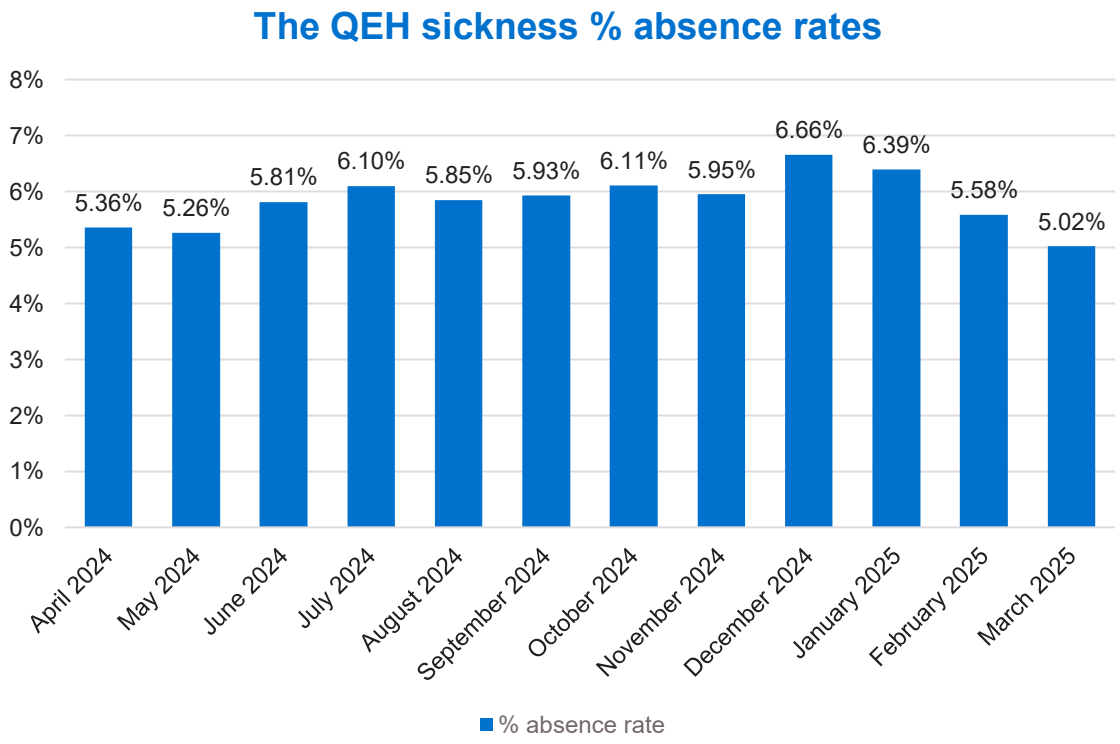
Staff sickness

Our sickness rate was 5% at the end of March 2025, against a target of 4.5%. This was from a starting position of over 6% in March 2024 and 6.24% at the end of March 2023.

During the year, we invested in support to help staff to stay well. We have also focused on:

- Promoting our Employee Assistance Programme (EAP)
- Recruiting a Wellbeing Officer to raise the awareness of employee support programmes at the Trust and provide support to our staff

- We have implemented a new attendance management policy and have improved our processes



We continue to support divisions to proactively manage staff who are on sick leave, and especially those on long-term sick leave, by putting plans in place to support them to come back to work safely.

We have successfully reduced the volume of sickness absence caused by stress, anxiety and depression by:

- Appointing a specialist in post-traumatic stress disorder, who focus on emotional wellness and other issues related to trauma and stress
- Offering staff support from a Clinical Psychologist
- Giving staff direct access to a Mental Health First Aider or Clinical Psychologist
- Strengthening our Occupational Health service by employing additional staff to provide support
- Increasing the number of Mental Health First Aiders across the Trust
- Recruiting and training mediators to support the informal resolution of employee relations cases, in turn reducing the workplace stress they cause

Steps we have taken to help safeguard our staff's physical health include:

- Offering COVID-19 vaccinations to patients and staff
- Offering the flu vaccinations to all staff

- Enhanced and extended our ‘No Excuse for Abuse’ campaign that re-enforces the behaviour expected towards our staff who provide essential care and supports staff to raise concerns should issues occur

Staff turnover

The retention of skilled and experienced staff is an important element of the Trust’s People Strategy. We have an ongoing focus on continuously improving staff experience and retaining and developing our talented people. The NHS Staff Survey also gives us the opportunity to act on feedback from our team.

We have been accepted onto NHS England’s People Promise Exemplar Programme, which commenced in Q3 of 2024/25. This programme seeks to implement changes and improvements to staff experience to help support retention of talent.

Staff annualised turnover for permanent staff declined slightly from 11.87% in March 2024 to 11.58% in March 2025.

Pictured above: *Staff and volunteers recognised at the annual Team QEH Awards event.*

Staff communications and engagement

Staff wellbeing and engagement remain central to our organisational priorities. Oversight is provided by the Culture, Organisational Development and Equality, Diversity and Inclusion (EDI) Forum, working in close collaboration with our staff networks. Our wellbeing initiatives are structured around three key pillars: financial health, physical health and emotional health.

Financial health

Financial wellbeing is a core component of our employee support offer. By embedding financial wellbeing into workplace culture, we aim to reduce stigma, promote internal and external resources, and respond to the specific challenges our staff face. Current support measures include:

- **Wagestream** – enabling staff to access a percentage of their earned wages in advance, reducing reliance on overdrafts and high-interest borrowing
- **Crisis loans** – up to £1,500 available for staff facing urgent financial need
- **NHS discounts** – regularly promoted on a dedicated intranet page

Physical health

Promoting the physical wellbeing of our workforce continues to be a strategic priority. Evidence consistently shows that healthy, supported staff deliver better patient care. Initiatives to support physical health include:

- **Enhanced changing facilities** – upgraded to improve accessibility and inclusivity
- **Extended catering provision** – the Midnight Café serves hot food until 2am, ensuring equitable access for night staff

Emotional health

We are committed to supporting the emotional and psychological wellbeing of our staff. Current initiatives include:

- Staff psychology service – a dedicated, in-house service tailored to The QEH staff
- Mental Health First Aiders (MHFAs) – available across the Trust to offer peer support and signposting
- Wellbeing Guardian – a senior role holding the organisation to account for delivering its wellbeing agenda
- Wellbeing passports – portable records that outline adjustments and support for individual staff, ensuring consistency across departments

Staff reward and recognition

We recognise and value the outstanding contribution of our people. Our reward and recognition programme includes a range of formal and informal mechanisms to celebrate individual and team achievements.

Annual Staff Awards

In October, the Trust hosted the annual Team QEH Awards, generously sponsored by PA Consulting, at the Corn Exchange in King's Lynn. The event welcomed 332 attendees and was live streamed to over 300 additional viewers. Entertainment was provided by Eddie 'The Eagle' Edwards, Lavender Hill Mob Theatre Company and the Marham Military Wives Choir.

Over 700 nominations were received, each reflecting the passion and commitment of our staff, volunteers and teams. Awards were presented in 14 categories by the Trust Chair and Chief Executive:

- Exceptional Quality of Care Award
- One to Watch Award
- Leader of the Year Award
- Award for Outstanding Achievement in Innovation
- Kindness Award
- Wellness Award
- Fairness Award
- Living our Values Award
- Clinical Team of the Year Award
- Non-Clinical Team of the Year Award
- Working Together Award
- The John Voaden Volunteer of the Year Award
- Unsung Hero Award
- The Chair's Award

Ongoing recognition

In addition to the Team QEH Awards, we deliver year-round recognition through:

- **Long Service Awards** – recognising continuous NHS service at 15, 20, 25, 30, 35 and 40 years. In 2024, we celebrated 5,775 years of combined service, with a cumulative total of 26,965 years recognised since 2020
- **Volunteer recognition** – presented at a dedicated event hosted by the Chief Executive
- **Living our Values Awards** – presented monthly based on over 300 nominations in 2024/25, with winners recognised in Board presentations and public forums. All nominees are acknowledged through formal letters, handwritten cards, and listings on the staff intranet and Trust website

- **Team of the Week** – featured across internal and external communication channels
- **Recognition for retirees** – acknowledging service at the point of retirement
- **Appreciation vouchers** – distributed during key holidays and special events, complemented by executive-led 'Thank You' events
- **Staff recognition boards** – displayed at hospital entrances
- **Peer thank-you cards** – available for staff to recognise colleagues informally

NHS Staff Survey 2024

The annual NHS Staff Survey measures experience across seven domains aligned to the NHS People Promise, as well as indicators on engagement and morale. All measures are scored out of 10.

In 2024/25, the response rate at The QEH was 47%, down from 51% the previous year. While scores across most domains remained static or declined, all indicators remain below the benchmark average for acute and community trusts.

Indicators	2024/25		2023/24		2022/23	
('People Promise' elements and themes)	Trust score	Benchmarking group score	Trust score	Benchmarking group score	Trust score	Benchmarking group score
People Promise:						
We are compassionate and inclusive	6.8	7.2	7.0	7.2	6.9	7.2
We are recognised and rewarded	5.6	5.9	5.6	6.0	5.5	5.7
We each have a voice that counts	6.2	6.7	6.4	6.7	6.3	6.6
We are safe and healthy	5.8	6.1	5.9	6.1	5.7	5.9
We are always learning	5.2	5.6	5.3	5.6	5.1	5.4
We work flexibly	5.7	6.2	6.1	6.2	5.9	6.0
We are a team	6.5	6.7	6.5	6.8	6.4	6.6
Staff engagement	6.4	6.8	6.7	6.9	6.5	6.8
Morale	5.6	5.9	5.8	5.9	5.5	5.7

Areas of focus in 2024/25

Key focus areas based on survey feedback included:

- Team working and mutual respect among colleagues
- Line management effectiveness – including communication, inclusion, and support
- Speaking up culture – including how concerns are raised, heard, and addressed

Future priorities

The 2024/25 survey identified key areas for improvement:

- Supporting leadership development to model Trust values and cultivate high-performing teams
- Strengthening mechanisms for learning from incidents and ensuring fair treatment of staff involved
- Enhancing staff wellbeing and engagement through targeted interventions
- Reinforcing organisational pride, ensuring The QEH is a place staff would recommend for care

Our planned response will include:

- A triangulated and co-produced programme of improvement across all divisions
- Continued rollout of Manager Fundamentals training and Trust Values refresh sessions
- Further development of our wellbeing engagement programme, launched in December 2024
- Improved communication across all levels of the organisation, making decision-making processes and outcomes more transparent
- Establishment of an inclusive staff forum for honest, constructive dialogue and collaborative improvement

Investing in staff development

The Trust remains committed to developing and supporting our workforce through a comprehensive range of learning and career development opportunities. These initiatives are designed to enhance staff capability, promote progression, and ensure we attract and retain a skilled, compassionate workforce.

We continue to provide early career development through school and college work experience placements and a growing apprenticeship offer. These programmes not only provide entry routes into the Trust but also enable existing staff to expand their skills and progress their careers.

In 2024/25, over 700 work experience placements were supported, and more than 55 new apprentices were enrolled. Our T-Level programme also continues to

expand, developed in close partnership with our multidisciplinary teams and local education providers. We currently host T-Level students across Health and Adult Nursing, Business Management and Administration, Engineering and Manufacturing, and onsite Construction. 14 T-Level students are presently placed with the Trust, including three students preparing to continue into second-year placements in Business Administration.

In April 2024, we held our most successful Careers Clinic to date at the King's Lynn Job Centre. The event welcomed over 400 members of the local community and provided career advice, information and guidance about roles in the NHS.

Leadership and management development

Informed by the 2024 NHS Staff Survey and aligned with the NHS England Line Management Framework, we launched the Management Fundamentals Programme in June 2024. To date, over 170 managers have enrolled across four cohorts. The programme equips managers with the skills to lead compassionate, high-performing teams. Plans for 2025/26 include the creation of a Management Fundamentals Network, enabling peer support, shared learning, and collaborative problem-solving across the Trust.

We are also pleased to report that, in partnership with Anglia Ruskin University (ARU), we are developing a satellite site for the delivery of pre-registration nursing programmes at The QEH. Approved by the Nursing and Midwifery Council in March 2025, this initiative marks a significant step towards strengthening our nursing workforce and increasing access to high-quality local nurse education.

Embedding our values

Feedback from the 2024 NHS Staff Survey highlighted that the Trust's core values, introduced in 2022, were not yet fully embedded. In response, we launched the Values Refresh Programme in June 2024. This initiative provides colleagues with an opportunity to reflect on how our values shape daily practice and contribute to the experiences of both patients and staff. Since its launch, over 1,800 staff members have participated. The programme is a key component of our strategy to build a supportive, inclusive culture where every colleague is empowered to deliver their best work.

Recognitions and achievements

We are proud to have received several awards and recognitions that reflect the impact of our education and development programmes:

- **NHSE Preceptorship Quality Mark (January 2024)** – awarded in recognition of our robust support for newly registered staff transitioning into professional roles

- **NHS Parliamentary Award regional winner and finalist (September 2024)** – Acknowledging the success of key education initiatives including:
    - **Caring with Kindness (launched 2022)** – over 900 participants, promoting patient-centred care
    - **Bereavement Training Programme (launched late 2022)** – over 430 staff trained to provide compassionate end-of-life care
    - **Frailty is Everyone's Business (launched January 2024)** – over 120 staff trained to better understand and respond to patient frailty
- **Nursing Times Workforce Awards finalist** – our Education Faculty was recognised for the fourth consecutive year, shortlisted for the 'Best Workplace for Learning and Development'

Enhancing clinical education: simulation-based training

In May 2024, the Trust opened a new Simulation Ward, made possible through a charitable donation. This modern, immersive environment strengthens clinical training through hands-on learning and reflective practice. Since opening, more than 170 staff and learners have engaged with simulation training.

Key features include:

- Advanced simulation technology including three Nursing SimAnnie mannequins and a SimMom simulator
- A flexible, hospital-grade ward environment equipped with a digital ward board, medication trolley, and resuscitation equipment
- Realistic clinical scenarios to enhance decision-making, supervision, and immediate feedback
- A strong focus on patient safety, reinforcing evidence-based practice and improving care outcomes

THRIVE: Graduate development programme

Launched in February 2024, the THRIVE Programme supports newly registered professionals beyond their preceptorship journey. Developed in collaboration with Dr Theresa Shaw, the Education Faculty, and the Norfolk Initiative for Coastal and Rural Health Equalities (NICHE), THRIVE provides participants with structured development, leadership exposure, and a psychologically safe space for growth.

Programme highlights include:

- Participation from staff across emergency care, medicine, and clinical support services
- Quality Improvement Projects (QIPs) focused on service improvement, patient experience and workplace culture
- Engagement with strategic Trust teams including Patient Safety, People and Culture, Research and Audit and the Executive team

- Culmination in a celebration event (February 2025) where delegates presented their QIPs to senior leaders and stakeholders

The programme has demonstrated a measurable increase in participants' confidence, leadership capabilities and capacity to implement positive change. THRIVE will be presented at the RCN Conference in March 2025, highlighting its innovative design and positive outcomes.

The Trust's strategic focus remains on equipping our workforce with the knowledge, skills, and behaviours required to deliver high-quality, compassionate care. Through continued investment in learning, leadership and innovation, we are building a sustainable, skilled workforce capable of meeting the evolving needs of our patients and communities.

Pictured above: *Inspirational nurse Leanne Howling who started working at The QEH as a housekeeper in 2012 and has since trained to become a registered paediatric nurse on the Neonatal Intensive Care Unit.*

Equality, Diversity and Inclusion

At The QEH, we remain firmly committed to promoting equality, diversity, and inclusion (EDI) across all aspects of our organisation. Our ambition is to foster a culture where every member of staff feels safe, valued, respected and empowered to bring their authentic selves to work. We recognise that embracing diversity strengthens our workforce and enhances the quality of care we provide to our patients.

Our approach aligns with the NHS People Plan, which highlights the need to cultivate a culture of belonging, trust, and fairness. This requires organisations to celebrate difference, actively challenge discrimination, and support staff wellbeing. These principles underpin our own Trust values of Kindness, Wellness and Fairness, which guide our decision-making and day-to-day interactions.

A key part of this work is promoting fairness and inclusivity for all, regardless of sex, race, religion or beliefs, gender identity, gender reassignment, disability, sexual orientation, marital status, or pregnancy and maternity. Strategic leadership for this agenda is provided by our Culture and Engagement Business Partner, with support from our active staff networks and dedicated Board-level sponsors.

Staff networks

Our EDI staff networks play a vital role in creating an inclusive workplace and shaping organisational culture. These groups provide peer support, raise awareness, and lead change through education and engagement activities. We maintain close collaboration with staff-side colleagues, involving them in key reviews and decisions through regular engagement, appraisals, and partnership forums.

REACH (Race, Ethnicity and Cultural Heritage) Network

The REACH Network continued to grow and thrive in 2024/25, supporting staff from over 81 nationalities across the Trust. The network provides a safe space for staff to share their experiences and promotes awareness of cultural heritage and equity.

Throughout the year, REACH led a number of key engagement and educational events:

- Onam celebration: marking the harvest festival of Kerala with traditional music, food, and cultural sharing
- Black History Month – ‘Reclaiming Narratives’: included educational sessions, performances, panel discussions, and a flag-raising ceremony to honour Black history and heritage
- South Asian Heritage Month: staff shared personal stories, fostering empathy and cultural understanding
- Race Equality Week: hosted an awareness and engagement event to highlight the importance of racial equity across the Trust

In addition to events, the REACH Network has actively contributed to recruitment equity by aiming for representation on all Band 7 (and above) and medical staff interview panels.

PRIDE Network

The PRIDE Network supports LGBTQIA+ colleagues and allies, providing a space for discussion, advocacy and visibility. In 2024/25, the network hosted several awareness-raising events and initiatives, including:

- Transgender Remembrance Service, held in partnership with the Spirituality and Belief Network, creating a reflective space to honour lives lost to anti-transgender violence
- Educational campaigns, including ‘What being an LGBTQ+ ally means’ and the importance of pronouns
- Active participation in King’s Lynn Pride, LGBTQ+ History Month, Trans Awareness Week, and Trans Day of Visibility

The network continues to collaborate with other NHS and local LGBTQ+ groups, strengthening inclusive practice both internally and externally.

Armed Forces Network

Our Armed Forces Network supports current and former military personnel and their families. In 2024/25, The QEH was awarded the prestigious Veterans Gold Award under the Defence Employer Recognition Scheme, reflecting our commitment to the Armed Forces Covenant.

Highlights include:

- Guaranteed interviews for armed forces applicants
- Bespoke placements through the NHS Step into Health Programme
- Continued collaboration with external organisations to enhance employment pathways and patient care for veterans and reservists

ENABLED (Enhancing Abilities and Leveraging Disabilities) Network

The ENABLED Network advocates for staff living with disabilities and promotes greater accessibility throughout the Trust. We continue to uphold our status as a Disability Confident Employer, guaranteeing interviews for disabled applicants who meet the minimum job criteria.

In 2024/25, the network:

- Delivered sensory impairment training to support inclusive patient care
- Worked closely with Estates and Facilities teams to inform accessibility planning
- Led awareness events for Neurodiversity Week, Men’s Health Month, and World Mental Health Day
- Partnered with AccessAble to further enhance the accessibility of The QEH facilities

Spirituality and Belief Network

Established initially as a patient-facing initiative, the Spirituality and Belief Network now supports staff across all belief systems, including those with no faith. The network promotes inclusive decision-making and empowers individuals to bring their whole selves to work.

In 2024/25, it hosted educational and celebratory events including Holi, Ramadan, Eid, Easter, Hanukkah, Passover, and Christmas, often featuring staff speakers sharing insights into their personal beliefs and traditions.

EDI calendar and wider achievements

We launched an EDI calendar to ensure important dates are recognised and celebrated Trust-wide. Monthly spotlight events have helped raise awareness, encourage discussion, and foster mutual understanding. Celebrated events included Black History Month, Neurodiversity Week, World Mental Health Day, Pride, Holi, and Armed Forces Day.

Additional EDI achievements in 2024/25 included:

- Reintroduction of the ‘No Excuse for Abuse’ campaign to protect staff from violence, harassment and aggression
- Launch of a new Trust EDI Action Plan, aligned with the Trust’s strategic objectives and the NHSE EDI Improvement Plan
- Ongoing monitoring and response to Workforce Race Equality Standard (WRES) and Workforce Disability Equality Standard (WDES) data to drive measurable change
- Receipt of the NHS Pastoral Care Quality Award, recognising our high standards in supporting internationally educated nurses and midwives
- Enhanced support for onboarding of international doctors, junior doctors and student nurses
- Contribution to the THRIVE Development Programme, delivering EDI and culture content in collaboration with the NICHE Team
- Delivery of bespoke EDI training across multiple departments to improve cultural competence

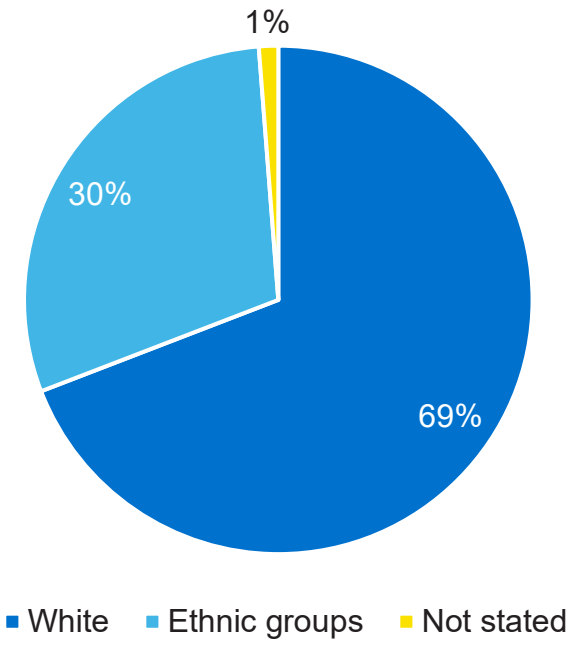
Looking ahead: priorities for 2025/26

Our EDI priorities for the coming year include:

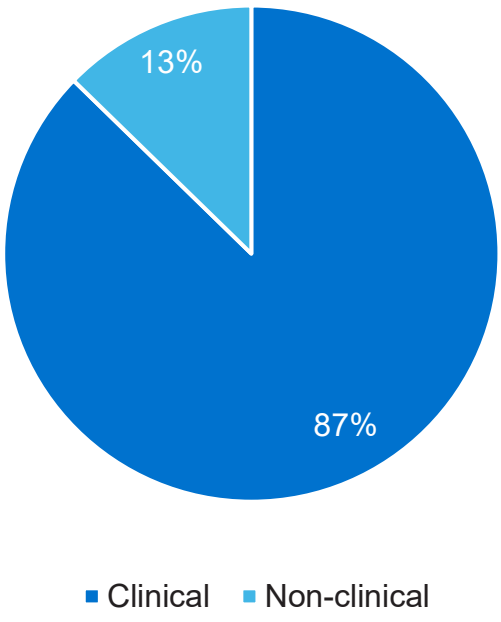
- Embedding a Just Culture across all people policies and practices
- Strengthening the staff network framework and increasing allyship across the organisation
- Advancing cross-system collaboration across Norfolk and Waveney to address inequality and improve staff experience
- Expanding The QEH Culture Toolkit to support, coach and engage staff more effectively

- Continuing the rollout of the Management Fundamentals and Trust Values training
- Refreshing and updating our internal campaigns to ensure they remain impactful and relevant

Total staff by ethnicity - February 2025



Breakdown of staff from an ethnic background - February 2025



Diversity data reporting

The diversity data the Trust collates is our WRES and WDES in line with NHS guidelines.

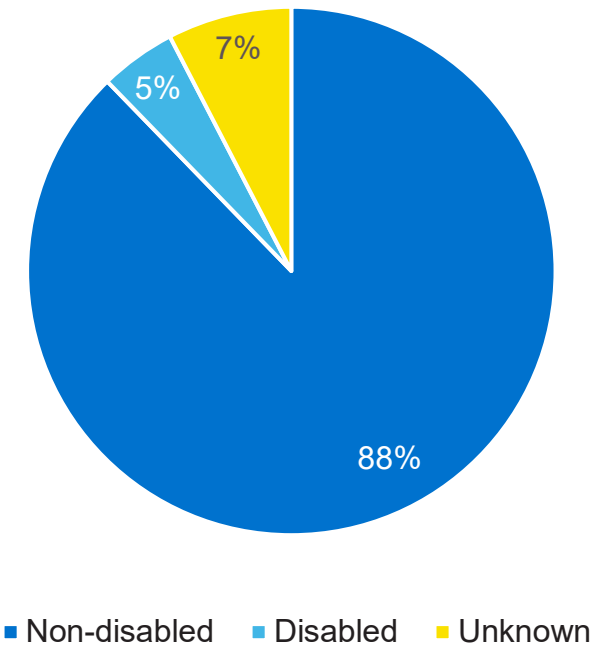
The data metrics monitor progress against a number of indicators of workforce equality, including a specific indicator to address the low numbers of BME Board members across the organisation.

Indicators one to four and nine are collated from our ESR (electronic staff records) and metrics five to eight are directly from our National Staff Survey.

NHS organisations use the metrics data to develop and publish an action plan. Year-on-year comparison enables NHS organisations to demonstrate progress against the indicators of disability equality.

Indicators one to three and 10 are collated from our ESR and metrics 4-9 are directly from our National Staff Survey.

Total staff by disability - February 2025



Raising concerns

At the Trust, we are committed to maintaining the highest standards of patient care. Our staff are often best placed to identify where care may fall short of the standards our patients deserve. We actively encourage all colleagues to raise concerns – whether related to safety, quality, or culture – either with their line manager or another member of the management team. All staff should feel confident that their feedback will be addressed constructively and in a timely manner.

Zero tolerance to sexual harassment and abuse

As part of a national NHS commitment to tackle unwanted, inappropriate, and harmful sexual behaviour, The QEH is preparing to launch a campaign in line with the NHS Sexual Safety Charter in 2025/26. This important initiative reinforces our zero-tolerance approach to sexual harassment and abuse, aligning with our ongoing 'No Excuse for Abuse' campaign.

In response to the recent amendment to the Equality Act regarding employers' Prevent Duty, and as part of the Trust signing the Sexual Safety Charter, we are launching a new programme initiative that further strengthens our stance. The Charter is focused on promoting a culture of respect, safety, and dignity across our hospital – for staff, patients, and visitors alike. We are committed to ensuring The QEH is a place where everyone feels safe, supported, and empowered to speak up.

The programme initiative will provide clear guidance, robust policies, and confidential reporting mechanisms to support those affected by inappropriate behaviour. We are making it clear: sexual harassment and abuse are unacceptable and will not be tolerated. Where necessary, we will take firm action, including prosecution.

This work not only strengthens our compliance with the Equality Act 2010 but also underlines that creating a respectful and inclusive environment is a shared responsibility. By supporting people to call out and report concerns, we are taking a critical step toward lasting cultural change within our organisation.

Freedom to Speak Up (FTSU)

We continue to promote a culture of openness and transparency through our Freedom to Speak Up (FTSU) service. We thank our staff for their continued engagement and feedback, which we treat with care and respect. Each concern raised through the service is acknowledged, with feedback and support provided throughout the process.

In 2024/25, a total of 338 staff members raised concerns through our three main reporting channels: our FTSU Guardians, FTSU Champions, and Executive Lead. This marks a 32% increase from the 257 concerns raised in 2023/24 and reflects a growing confidence among staff in speaking up safely.

Our FTSU service is delivered by:

- One full-time and one part-time Guardian
- Executive oversight from Alice Webster, Chief Executive Officer and FTSU Executive Lead
- Support from Simon Roberts, our designated Non-Executive Director
- A diverse team of FTSU Champions embedded across divisions

Key developments in 2024/25 included:

- Submission of quarterly data to the National Guardian's Office

- Regular reporting to the People and Culture Committee and Trust Board
- Completion of the National Guardian's Office Self-Assessment, which identified key areas for further development
- Implementation of a new national-standard database to enable improved analysis of trends, resulting in Trust-wide service improvements and culture reviews

We have increased visibility and awareness of FTSU through quarterly newsletters (digital and printed), induction sessions for new staff – including doctors and international nurses – and the use of Trust-wide communications such as posters and screensavers.

Whistleblowing

To further enhance accessibility, we have introduced a single dedicated phoneline for staff wishing to raise either whistleblowing or FTSU concerns. Staff can leave messages anonymously if preferred, ensuring all voices can be heard.

Local Counter Fraud Services (LCFS)

We work closely with our designated Local Counter Fraud Specialist as part of the national scheme led by NHS Counter Fraud Authority. This involves proactive and reactive work to ensure that precious NHS resources are not lost to fraud. It gives a clear route for concerns in relation to fraud to be reported and investigated, and for the development of an anti-fraud culture.

We take all necessary steps to counter fraud and bribery in accordance or advice issued by NHS Protect. This process is detailed in the Trust's Anti-Fraud and Bribery Policy.

Voluntary services

Our volunteers have once again played a vital role in supporting our patients, visitors and staff. They contribute across a wide range of services, from transporting patients via our buggy service and welcoming visitors at reception to supporting medicine delivery, ward activity and outpatient departments.

Developments in 2024/25 include:

- Introduction of a new lived experience volunteer role on the Stroke Ward, in partnership with the Stroke Association. This includes stroke survivors and a carer sharing their personal experiences with patients to support their recovery journey
- Collaboration with Vision Norfolk to support patients at the West Norfolk Eye Centre, offering signposting to further resources

- Reintroduction of Hospital Radio Lynn volunteers to the wards, providing a valued and uplifting presence for patients through live broadcasts and music requests

Expanding roles and partnerships

Our ward-based support continues to grow in both scope and diversity to meet emerging service needs. In partnership with NNUH and Helpforce, we launched a new initiative where volunteers call patients ahead of their radiology appointments to reduce non-attendance and answer any questions. A dedicated coordinator supports this initiative, ensuring patients are fully prepared for their visit.

Patient buggy service

Following a successful trial in 2023, the patient buggy service has been made permanent. Funding from the League of Friends enabled the purchase of two new electric buggies – named ‘Hopper’ and ‘Swifty’ through a staff and public competition – which are fully enclosed and equipped for both passenger safety and driver comfort.

Volunteer engagement and recognition

We held our first in-person volunteer celebration event since the pandemic in June 2024. This successful event included recognition from the Voluntary Services team and service areas, as well as long service awards presented by the Chief Executive. Due to positive feedback, a follow-up event is planned for 2025.

The annual volunteer survey saw a 78% response rate, up from 33% in 2023. Notably, 84% of respondents reported being 'very satisfied' with the support received from the Voluntary Services team, compared to 43% the previous year. This improvement reflects initiatives including:

- Buddying for new starters
- Enhanced onboarding processes
- Introduction of regular newsletters and volunteer meetings
- Responsive changes implemented following feedback from the 2023 survey

Volunteer records were updated to comply with new NHS England requirements for quarterly reporting, with the Trust meeting and exceeding the minimum national standards during the first year of submission.

We also worked with NHS England to help develop a new national volunteer recruitment website, which provides a centralised, accessible platform for individuals to explore volunteering opportunities across the NHS. The Trust actively uses this platform to promote local roles.

Looking ahead

Plans for 2025/26 include:

- Implementation of an electronic sign-in system, improving the efficiency of volunteer hour tracking and allowing real-time monitoring of volunteer attendance
- Further embedding of the annual celebration event and enhanced reward and recognition framework

Pictured left: *Volunteer Sarah Harvey who returned to The QEH where she received lifesaving care now volunteers as a hospital buggy driver and also on a busy ward.*

Pictured right: *Philip Seaman, one of five enthusiastic volunteers who call patients to remind them of their important hospital appointments.*

Estates, Facilities, Health and Safety, Fire and Net Zero

Estates

During 2024/25, the Estates team has delivered significant progress against a challenging and high-profile programme of works, underpinned by a £66 million Capital Programme. Key achievements include ongoing delivery of the RAAC (Reinforced Autoclaved Aerated Concrete) Programme, essential modernisation of the hospital estate – much of which is over 40 years old – and support to the NHP, a once-in-a-generation opportunity to build a new hospital.

Key achievements during 2024/25 include:

- Maintaining the safety and integrity of roof and wall structures, in accordance with surveyor recommendations
- Installation of steelwork to failsafe roof panels across the first floor, supporting the RAAC Programme. Decant wards, including Castleacre and Wolferton, have remained operational to facilitate these works
- Delivery of £1.5 million backlog maintenance works through a monitored plan
- Management of the RAAC external wall protection project across the site
- Continuation of LED lighting installation to improve energy efficiency Trust-wide
- Full refurbishment of the Resuscitation area within ED, creating a modern, compliant environment
- Installation of a new Gamma Camera within Radiology
- Development of a new servery and improved environment within The Hub
- Commencement of construction of a modular Sterile Services Department, future-proofed for integration into the New Hospital
- Enhancement of cycling facilities for staff and visitors
- Continuation of the Level 1 (L1) fire safety system installation across the site
- Ongoing improvements to fire safety across the estate

Significant progress on RAAC failsafe works can be seen on the accompanying site map, demonstrating extensive coverage of the first floor.

FIRST FLOOR PLAN

Looking ahead to 2025/26

The Estates team will:

- Continue delivery of Years 5 and 6 of the RAAC Programme, extending failsafe works across clinical and non-clinical areas on the first and ground floors
- Upgrade the ventilation system within the Central Delivery Suite to fully comply with COSHH regulations concerning Entonox exposure
- Complete the construction of the new modular Sterile Services Department
- Progress the RAAC external wall protection project
- Upgrade electrical infrastructure within the main kitchen alongside failsafe works
- Work collaboratively through the ICS Estates Group to support delivery of the Green Plan agenda
- Enhance facilities at the main entrance, commencing with refurbishment of the public toilets
- Continue to improve the ED environment, particularly within the Major Injuries area
- Deliver the 2025/26 backlog maintenance programme informed by the new Six-Facet Survey
- Continue implementation of the Trust-wide fire safety improvements

Facilities

The Facilities team is integral to maintaining a clean, safe and welcoming environment for patients, staff, and visitors. Covering Catering, Domestic Services, Portering and Security, Waste, Post and Linen Services, the team has demonstrated resilience and adaptability, particularly in the context of significant RAAC works across the site.

Key achievements during 2024/25 include:

- Completion of 164,132 portering tasks, including the movement of patients in 37,418 wheelchairs and 40,111 beds
- Processing and delivery of approximately 150,000 items of laundry per month
- Delivery of 537,107 patient meals, 72,996 staff and visitor meals in The Hub, and 183,360 ice cream portions to patients
- Provision of 1,600 staff Christmas meals and 340 patient meals on Christmas Day
- Installation of a new restaurant servery, supported by charitable funds, allowing continuity of catering operations during essential structural works
- Maintenance of the Trust's 5-star Environmental Health accreditation
- Participation by two chefs in the NHS Chef of the Year 2024 competition
- Expansion of the Trust's recycling infrastructure and installation of a food waste processor to generate biofuel
- Implementation of a lift-share scheme, with designated parking to support green travel initiatives
- Delivery of bespoke leadership development training for portering and domestic supervisors
- Completion of a tri-acute tendering process for clinical and non-clinical waste collection services

Looking ahead to 2025/26

The Facilities team will:

- Review the Trust's postal services to ensure value for money
- Continue management training across Facilities teams
- Increase CCTV storage capacity in preparation for future growth
- Implement e-rostering across all Facilities departments
- Develop a modernised catering facility for staff and visitors
- Oversee refurbishment of the Costa Coffee outlet
- Ensure Domestic Services achieve full compliance with the National Standards of Cleanliness

Health and Safety

The Health and Safety team provides essential support to maintain a safe environment for all Trust staff, patients, and visitors. The team's work includes risk assessment, incident investigation, compliance monitoring and advice.

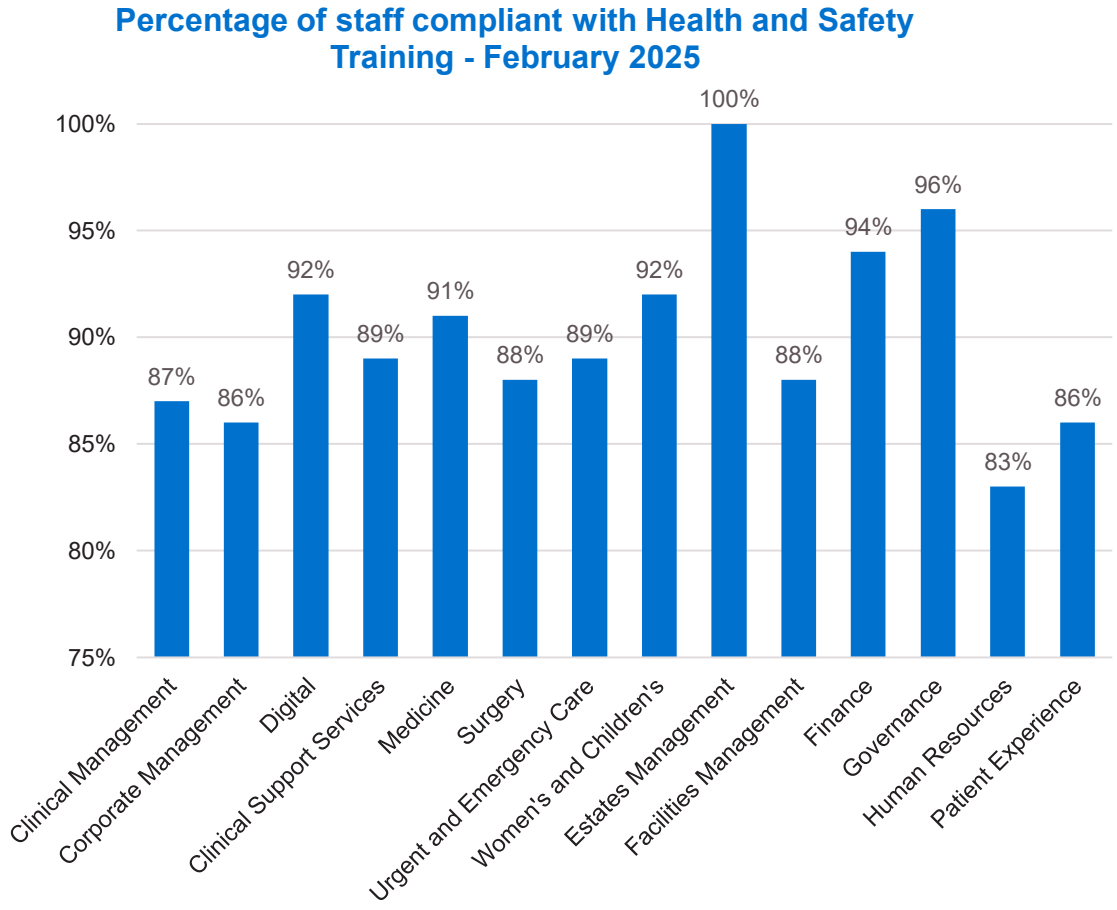
Key achievements during 2024/25 include:

- Delivery of a staff fit-testing service for appropriate FFP3 mask use
- Ongoing support to risk assessment and action planning across the Trust
- Regular completion of Health and Safety inspections and follow-up actions
- Continued development of the web-based Control of Substances Hazardous to Health (COSHH) management system
- Monitoring and investigation of reported incidents via the Datix system, ensuring compliance with Reporting of Injuries Diseases and Dangerous Occurrences (RIDDOR) requirements
- Timely submission of Premises Assurance Model (PAM), Patient Led Assessment of the Care Environment (PLACE), and Estates Returns Information Collection (ERIC) national returns
- Development of a confident and competent network of Health and Safety representatives
- Coordination of water safety testing with Estates and IPC teams
- Active participation in multiple forums and working groups
- Ongoing management of the Estates and Facilities Risk Register

Training and incidents

Mandatory Health and Safety training is delivered via the ESR platform, with current compliance at 90% Trust-wide.

During 2024/25, 394 staff safety incidents were reported, a marginal decrease from 395 incidents in 2023/24. Thirteen RIDDOR incidents were reported to the Health and Safety Executive (an increase from six in 2023/24). A re-launch of the Trust's Zero Tolerance campaign against violence at work is scheduled for April 2025.



Looking ahead to 2025/26

The Health and Safety team will:

- Continue to lead PAM, ERIC and PLACE returns
- Ensure effective space utilisation across the estate
- Support departmental risk management and action planning
- Coordinate water testing in augmented care areas
- Support the RAAC and New Hospital Programmes.
- Review the Risk Register monthly
- Support all capital and operational projects
- Conduct an annual review of contractor induction processes

Fire safety

The Trust remains committed to compliance with the (Regulatory Reform) Fire Safety Order 2005, ensuring a robust fire safety management system is maintained. The director of estates and facilities works closely with the local Fire Service to maintain high standards.

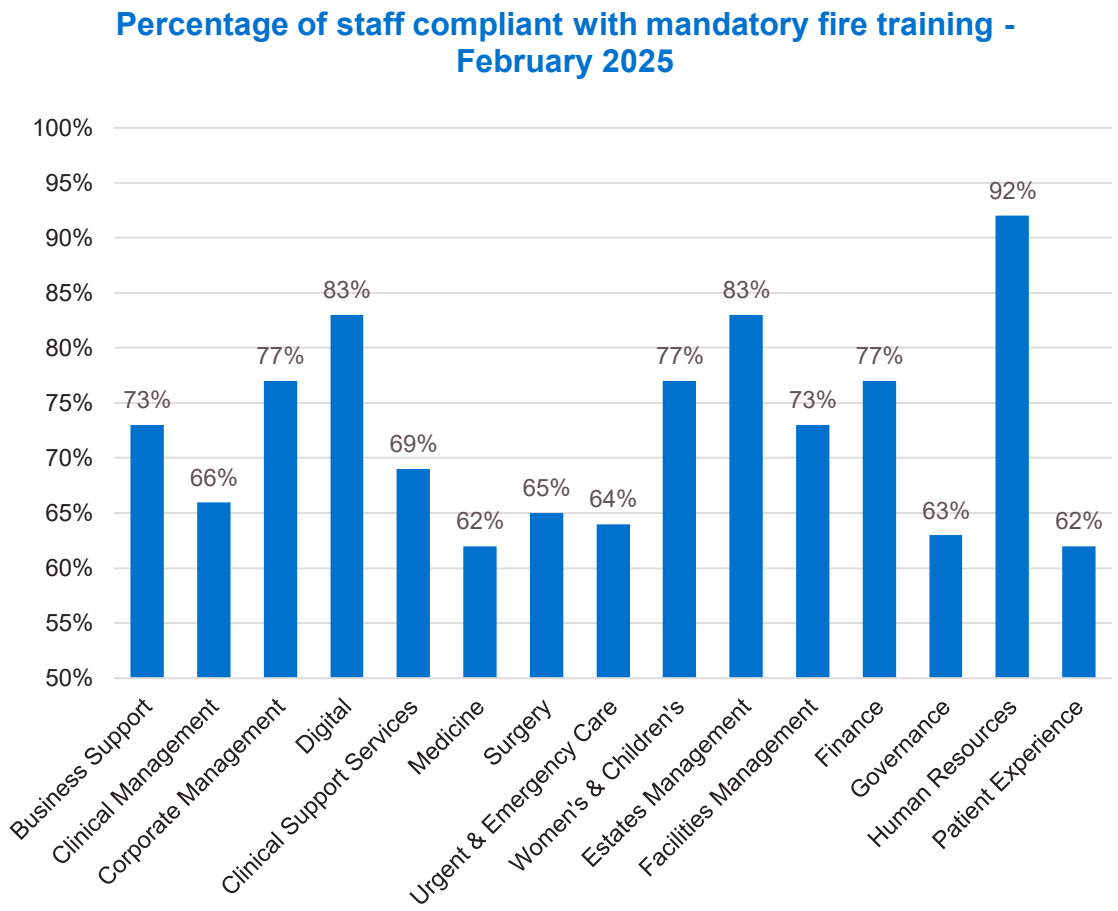
Key achievements during 2024/25 include:

- Continuation of the L1 Fire Alarm Upgrade Programme

- Implementation of fire safety measures for the Sandringham Unit
- Regular review and amendment of departmental fire risk assessments
- Ongoing informal inspections by the Fire Safety Officer Trust-wide
- Updated fire risk information and evacuation plans
- Provision of support to staff on fire safety matters
- Collaboration with the Project Management team and Fire Authorised Engineer
- Comprehensive redesign of fire safety training packages

Fire Safety training

Compliance with mandatory fire training stands at 68% against an 85% target. Improvements to training accessibility and content will be a focus for 2025/26.



Fire incidents

During 2024/25, 75 fire-related incidents were recorded, a reduction from 82 in 2023/24. There were two small fires caused by discarded cigarettes; both were managed without requiring attendance by the fire service. New fire beaters have been procured for outdoor fire prevention.

Accidental false alarms continue to represent the majority of incidents. Learning from these events is incorporated into training and awareness campaigns.

Areas of focus

- Continue to equip the Fire Safety Officer with skills and knowledge to support them in their role
- Re-establish the Fire Warden training for 2025/26
- Upgrade and certificate fire doors across the site - refresher training provided to Trust Maintenance team in relation to fire door maintenance provided by the Building Research Establishment, an approved training provider
- Ongoing progress that is seeing numbers of delegates attending the range of Fire Safety training is increasing
- Installation of the firefighting bridge head (dry riser) across the ground floor, first floor and roof space has commenced and set to continue
- Continuing to work closely with the fire service and support with fire team familiarisation visits to the trust during the year
- Update the fire risk assessments across the site and communicate these to the department leads, and the fire service if requested
- The project to install additional fire door sets to improve fire sub-compartmentation across the ground floor and first floor will be completed

Net Zero

The Trust is committed to supporting the NHS ambition to become the world's first net zero national health service by 2040. In line with the NHS Carbon Management Strategy, the Trust continues to embed sustainability across all operations.

Key achievements during 2024/25 include:

- Expansion of recycling facilities across the site
- Establishment of a network of Green Champions
- Delivery of sustainability awareness training in partnership with an external provider
- Introduction of green waste management solutions within Catering
- Development of a new staff nature trail to enhance biodiversity

Looking ahead to 2025/26

The Trust plans to:

- Achieve 90% LED lighting coverage across the estate
- Introduce further travel incentives and electric vehicle charging infrastructure
- Expand Green Travel initiatives
- Increase recycling capacity across the site
- Recruit additional Green Champions
- Implement a food and organic waste recycling system to reduce food waste by 90%
- Improve control over heating and ventilation systems to minimise the carbon footprint

Trade union time

The Trade Union (Facility Time Publication Requirements) Regulations 2017 requires the Trust to publish information regarding trade union facility time in accordance with schedule two of the regulations.

Relevant union officials

Number of employees who were relevant union officials during the period	Whole-time equivalent employee number
10	9.03

Percentage of time spent on facility time

Percentage of time	Number of employees
0%	1
1-50%	8
51-99%	1
100%	0

Percentage of pay bill spent on facility time

Total cost of facility time	£47,445.18
Total pay bill	£174,311,114.64
Percentage of the total pay bill spent on facility time, calculated as:	0.03%

(total cost of facility time divided by total pay bill) x 100

Paid trade union activities

Time spent on paid trade union activities as a percentage of total paid facility time calculated as:	1.82%

(total hours spent on paid trade union officials during the relevant period divided by total paid facility time hours) x 100

Gender pay gap

The gender pay gap is the difference between the average pay of men and women in an organisation. Any employer with 250 or more employees on a specific date each year must report their gender pay gap data.

Our report for 2024/25 can be found on the Gender Pay Gap Service website at https://gender-pay-gap.service.gov.uk/employers/15272/reporting-year-2024

Pictured above: *Jack, Kaci, Libby and Kelly at the inaugural Team QEH Youth Council meeting*

Pictured left: *Sithara Joseph, Patient Experience and Engagement Lead at The QEH and Antonia Hardcastle, Lead Governor at the launch event of the Youth Council.*

Expenditure on Consultancy

The Trust has spent £1.48m on consultancy in 2024/25, which has decreased slightly from £1.52m in 2023/24. The Trust continued to require a high level of support during the year, primarily within the Financial Improvement team and supporting our relationship with NHS Shared Business Services.

Off-payroll engagements

All existing off-payroll engagements outlined below have been subject to a risk-based assessment as to whether assurance is required that the individual is paying the right amount of tax. Where necessary, assurance has been sought.

Highly paid off-payroll engagements as of 31 March 2025, for more than £245 per day	Number of engagements
Number of existing arrangements as of 31 March 2025	3
Of which:	
Number that have existed for less than one year at the time of reporting	-
Number that have existed for between one and two years at the time of reporting	1
Number that have existed for between three and four years at the time of reporting	2
Number that have existed for four years or more at the time of reporting	-
All highly paid off-payroll workers engaged at any point during the year ended 31 March 2025 earning £245 per day or greater	
Number of off-payroll workers engaged during the year ended 31 March 2025	10
Of which:	
Not subject to off-payroll legislation	-
Subject to off-payroll legislation and determined as in scope for IR35	-
Subject to off-payroll legislation and determined as outside of scope for IR35	10

Number of engagements reassessed for compliance or assurance purposes during the year	-
Of which: number of engagements that saw a change to IR35 status following review	-
Off-payroll engagements of board members, and / or senior officials with significant financial responsibility, between 1 April 2024 and 31 March 2025	
Number of off-payroll engagements of board members, and / or senior officials with significant financial responsibility during the financial year	-
Number of individuals that have been deemed 'Board members and / or senior officials with significant responsibility' during the financial year. This figure must include both off-payroll and on-payroll engagements	-

Exit packages: other (non-compulsory) departure payment

	Expected sign	Number of payments agreed 2024/25	Total value of agreements in 2024/25	Number of payments agreed 2023/24	Total value of agreements in 2023/24	Sub-code
Voluntary redundancies including early retirement contractual costs	+	-	-	-	-	STA0720
Mutually agreed resignation (MARS) contractual costs	+	-	-	-	-	STA0730
Early retirement in the efficiency of the service contractual costs	+	-	-	-	-	STA0740
Contractual payments in lieu of notice	+	35	213	29	124	STA0750
Exit payments following employment tribunals or court orders	+	-	-	-	-	STA0760

Non-contractual payments requiring HMT approval (special severance payment)	+	-	-	-	-	STA0770
Total	**+**	**35**	**213**	**29**	**124**	
Of which non-contractual payments requiring HMT approval made to individuals where the payment value was more than 12-months of their salary	+	-	-	-	-	STA0790

Exit package cost band (including any special pay element)	Number of compulsory redundancies	Cost of redundancies (£'000)	Number of other departures agreed	Costs of other departures agreed (£'000)	Total number of exit packages	Total cost of exit packages (£'000)	Number of departures where special payments have been made	Cost of special payment element including in exit packages
Less than £10,000	-	-	33	107	-	-	-	-
£10,001 to £25,000	-	-	-	-	-	-	-	-
£25,001 to £50,000	-	-	1	30	-	-	-	-
£50,001 to £100,000	-	-	1	76	-	-	-	-
£100,001 to £150,000	-	-	-	-	-	-	-	-
£150,001 to £200,000	-	-	-	-	-	-	-	-
Greater than £200,000	-	-	-	-	-	-	-	-
Total	**-**	**-**	**35**	**213**	**-**	**-**	**-**	**-**

Disclosures set out in the NHS Foundation Trust Code of Governance

Compliance with the Code of Governance for NHS Provider Trusts

The Regulator has in place a Code of Governance which sets out a framework for the corporate governance arrangements of NHS provider trusts. NHS Foundation Trusts are required to provide some disclosures in their annual report to meet the requirements of the code. The table below replicates Schedule A to the code to list the required disclosures and provides an explanation or indication of where the information is contained within this annual report.

On 31 March 2025, the Board of Directors declares compliance with the provisions of Schedule A of the Code of Governance.

Provision	Provision summary	Supporting explanation
A2.1	The Board of Directors should assess the basis on which the Trust ensures its effectiveness, efficiency and economy, as well as the quality of its healthcare delivery over the long term, and contribution to the objectives of the ICP and ICB, and place-based partnerships. The Board of Directors should ensure the Trust actively addresses opportunities to work with other providers to tackle shared challenges through entering into partnership arrangements such as provider collaboratives.	The Trust is an active member of the Norfolk and Waveney Acute Hospital Collaborative which meets bi-monthly with clearly agreed priorities for delivery. Regular Chairs Assurance reports are shared with the Board of Directors. NED Chair of the Finance and Performance Committee (FPC) sits on the ICB Finance Committee and reports back via FPC and Board. In addition, updates on the Trust's work within the ICS and at Place are reported to the Future Systems Committee, supported by the underpinning governance of the Strategy and Transformation Executive Group and Place Integration Forum. Via the director of strategy and integration the Trust chairs the West Place Board and is instrumental in driving delivery of the agreed priorities and workplan at Place focusing on

		the wider determinants of health within West Norfolk. The Place Board has a clear delivery plan in place and is working in collaboration with the King's Lynn and West Norfolk Health and Wellbeing Partnership to ensure focused delivery. The Chair is the Trust's member of the Norfolk Health and Wellbeing Board and Norfolk and Waveney Integrated Care Partnership. Norfolk and Waveney Acute Provider Collaborative arrangements in place. The Trust is an active member of the Norfolk and Waveney Acute Provider Collaborative, Committee in Common. During 2024/25 the Trust has been actively involved in developing a Group Model arrangement. See 'Annual Governance Statement'.
A2.3	The Board of Directors should assess and monitor culture. Where it is not satisfied that policy, practices or behaviour throughout the business are aligned with the Trust's vision, values and strategy, it should seek assurance that management has taken corrective action. The Annual Report should explain the Board's activities and any action taken, and the trust's approach to investing in, rewarding and	The Board receives updates on: • Reports from People and Culture Committee detailing the work ongoing through the People Executive Group and at Divisional level • EDI Annual Report • WRES and WDES report • Staff Survey (national and quarterly Pulse) • Culture programme • Specific areas of culture work via the CEO report

	promoting the wellbeing of its workforce.	A workshop around culture and leadership was undertaken in 2024 addressing the Boards responsibility for equality, diversity and inclusion, culture, and health and wellbeing. Assurance role incorporated into the People and Culture Committee terms of reference.
A2.8	The Board of Directors should describe in the Annual Report how the interests of stakeholders, including system and place-based partners, have been considered in their discussions and decision-making, and set out the key partnerships for collaboration with other providers into which the Trust has entered. The Board of Directors should keep engagement mechanisms under review so that they remain effective. The Board should set out how the organisation's governance processes oversee its collaboration with other organisations and any associated risk management arrangements.	Executive Leads are identified as the relevant contact for specific stakeholders, e.g. CQC, Healthwatch and Norfolk and Waveney Acute Provider Collaborative. They report relevant matters to the Board.
B2.6	The Board of Directors should identify in the Annual Report each Non-Executive Director it considers to be independent. Circumstances which are likely to impair, or could appear to impair, a non-executive director's independence include, but are not limited to, whether a director: • Has been an employee of the trust within the last two years	There is a statement in the Annual Report that the Board has determined that the Chair and NEDs are independent. Statement of independence completed by Chair and NEDs annually, aligned to the Fit and Proper Persons process, which is report to the Audit Committee.

	• Has, or has had within the last two years, a material business relationship with the Trust either directly or as a partner, shareholder, Director or senior employee of a body that has such a relationship with the Trust • Has received or receives remuneration from the trust apart from a Director's fee, participates in the trust's performance- • Related pay scheme or is a member of the trust's pension scheme • Has close family ties with any of the Trust's advisers, Directors or senior employees • Holds cross-directorships or has significant links with other Directors through involvement with other companies or bodies • Has served on the Trust board for more than six years from the date of their first appointment • Is an appointed representative of the Trust's university medical or dental school. Where any of these or other relevant circumstances apply, and the Board of Directors nonetheless considers that the Non-Executive Director is independent, it needs to be clearly explained why.	
B2.13	The responsibilities of the Chair, Chief Executive, Senior Independent Director if applicable, board and	The Trusts Constitution and Standing Orders for the Practice and Procedure of the Board of Directors sets out the

	committees should be clear, set out in writing, agreed by the Board of Directors and publicly available. The Annual Report should give the number of times the board and its committees met, and individual director attendance.	expectations of the Chair, Deputy Chair, Senior Independent Director, and Board. The terms of reference for the Committees and Trust Management Board within the governance structure set out the responsibilities of all members, including the Chair and Board, which were ratified by the Board. The Annual Report outlines the number of times the Board and its Committees met through the reporting period, and individual attendance.
B2.17	The Board of Directors should meet sufficiently regularly to discharge its duties effectively. A schedule of matters should be reserved specifically for its decisions. For Foundation Trusts, this schedule should include a clear statement detailing the roles and responsibilities of the Council of Governors. This statement should also describe how any disagreements between the Council of Governors and the Board of Directors will be resolved. The Annual Report should include this schedule of matters, or a summary statement of how the Board of Directors and Council of Governors operate, including a summary of the types of decisions to be taken by the Board, the Council of Governors, Board Committees and the types of decisions that are delegated	The Board was scheduled to meet at least six times a year in the reporting period, with the cycle of business used to determine matters to be discussed. The Trusts Scheme of Delegation is in place and the Trust's Constitution outlines the roles and responsibilities of the Board of Directors and Council of Governors. Committee terms of reference are also in place for all meetings within the governance structure, outlining the purpose and responsibilities of each. The dispute resolution process is outlined in the Trust's Constitution. There were no instances of dispute in the reporting period.

	to the Executive Management of the Board of Directors.	
C2.5	Open advertising and advice from NHS England's Non-Executive Talent and Appointments team should generally be used for the appointment of the Chair and Non-Executive Directors. If an external consultancy is engaged, it should be identified in the annual report alongside a statement about any other connection it has with the Trust or individual Directors.	As part of the recruitment process for the Non-Executive Director (Audit Committee Chair) the Trust engaged an external consultancy firm. NHS England and the ICB were consulted with for the recruitment of the Interim Chair.
C2.8	The Annual Report should describe the process followed by the Council of Governors to appoint the chair and Non-Executive Directors. The main role and responsibilities of the Nominations Committee should be set out in publicly available written terms of reference.	See 'Committees of the Council of Governors'.
C4.2	The Board of Directors should include in the Annual Report a description of each Director's skills, expertise and experience.	See 'Board of Directors'.
C4.7	All Trusts are strongly encouraged to carry out externally facilitated developmental reviews of their leadership and governance using the Well-led framework every three to five years, according to their circumstances. The external reviewer should be identified in the Annual Report and a statement made about any	An external well-led review was commissioned by the Trust in 2023/24.

	connection it has with the trust or individual Directors.	
C4.13	The Annual Report should describe the work of the nominations committee(s), including: • The process used in relation to appointments, its approach to succession planning and how both support the development of a diverse pipeline • How the Board has been evaluated, the nature and extent of an external evaluator's contact with the Board of Directors and individual Directors, the outcomes and actions taken, and how these have or will influence board composition • The policy on diversity and inclusion including in relation to disability, its objectives and linkage to Trust vision, how it has been implemented and progress on achieving the objectives • The ethnic diversity of the Board and senior managers, with reference to indicator nine of the NHS WRES and how far the board reflects the ethnic diversity of the Trust's workforce and communities served • The gender balance of senior management and their direct reports	See 'Board of Directors', 'Equality, Diversity and Inclusion' and 'Staff Report'
C5.15	Foundation Trust Governors should canvass the opinion of	The Trust's Membership and Engagement Strategy sets out

	the Trust's Members and the public, and for appointed governors the body they represent, on the NHS Foundation Trust's forward plan, including its objectives, priorities and strategy, and their views should be communicated to the Board of Directors. The Annual Report should contain a statement as to how this requirement has been undertaken and satisfied.	how the Governors engage with the members and public. Performance against the Strategy is monitored by the Membership, Engagement and Culture Group of the Council of Governors. The Cycle of Business for the Council of Governors defines the items that will be presented to the Governors in relation to the forward plans of the Trust. Governors have the opportunity through Board meetings to raise questions in relation to key strategies and plans that the Board are considering. The draft Annual Operating Plan is shared with Governors each year as part of the development session so that their views can be taken into account prior to the Plan being approved by the Board of Directors. Statement in the Annual Report.
D2.4	The Annual Report should include: • The significant issues relating to the financial statements that the Audit Committee considered, and how these issues were addressed • An explanation of how the Audit Committee (and / or auditor panel for an NHS trust) has assessed the independence and effectiveness of the external audit process and its approach to the appointment or reappointment of the	See 'Annual Accounts' • Accounting policies and financial report requirements received by Audit Committee annually • Statement on independence included within the external auditor report on the accounts • See 'The Board of Directors' - 'The Audit Committee and audit' • The external auditor has not provided non-audit services in the year

	external auditor; length of tenure of the current audit firm, when a tender was last conducted and advance notice of any retendering plans • Where there is no internal audit function, an explanation for the absence, how internal assurance is achieved and how this affects the external audit • An explanation of how auditor independence and objectivity are safeguarded if the external auditor provides non-audit services	
D2.6	The Directors should explain in the Annual Report their responsibility for preparing the Annual Report and Accounts, and state that they consider the Annual Report and Accounts, taken as a whole, is fair, balanced and understandable, and provides the information necessary for stakeholders to assess the trust's performance, business model and strategy.	See 'Statement of Accounting Officer's Responsibilities'.
D2.7	The Board of Directors should carry out a robust assessment of the Trust's emerging and principal risks. The relevant reporting manuals will prescribe associated.	The Trust's Risk Management Framework was reviewed in Q3 2023/24 and ratified by the Audit and Risk Committee and Board of Directors in October 2024. Further details on the Trust's risk appetite and the level of risk that the Board is prepared to take in pursuing its strategy are reflected in the Board Assurance Framework.

		The Board of Directors received the Board Assurance Framework. The Accountable Officer, the Chief Executive, has responsibility for maintaining a sound system of internal control which his detailed within the Annual Governance Statement and included in the Annual Report.
D2.8	The Board of Directors should monitor the Trust's risk management and internal control systems and, at least annually, review their effectiveness and report on that review in the Annual Report. The monitoring and review should cover all material controls, including financial, operational and compliance controls. The Board should report on internal control through the Annual Governance Statement in the Annual Report.	See 'Annual Governance Statement'.
D2.9	In the Annual Accounts, the Board of Directors should state whether it considered it appropriate to adopt the going concern basis of accounting when preparing them and identify any material uncertainties regarding going concern. Trusts should refer to the DHSC group accounting manual and NHS Foundation Trust Annual Reporting manual which explain that this assessment should be based on whether a trust anticipates it will continue to provide its services in the public sector. As a result,	See 'Annual Governance Statement'.

	material uncertainties over going concern are expected to be rare.	
E2.3	Where a Trust releases an Executive Director, e.g. to serve as a Non-Executive Director elsewhere, the remuneration disclosures in the Annual Report should include a statement as to whether or not the director will retain such earnings.	Not applicable in 2024/25.
Appendix B, para 2.3 (not in Schedule A)	The Annual Report should identify the members of the Council of Governors, including a description of the constituency or organisation that they represent, whether they were elected or appointed, and the duration of their appointments. The Annual Report should also identify the nominated Lead Governor.	See 'Council of Governors composition 2024/25'.
Appendix B, para 2.14 (not in Schedule A)	The Board of Directors should ensure that the NHS Foundation Trust provides effective mechanisms for communication between Governors and Members from its constituencies. Contact procedures for Members who wish to communicate with Governors and / or Directors should be clear and made available to members on the NHS Foundation Trust's website and in the Annual Report.	See 'Contacting the Governors'.
Appendix B, para 2.15 (not in Schedule A)	The Board of Directors should state in the Annual Report the steps it has taken to ensure that the members of the Board, and in particular the Non-Executive Directors, develop an	See 'The Board of Directors' - 'The role of the Board of Directors'.

	understanding of the views of Governors and Members about the NHS Foundation Trust, for example through attendance at meetings of the Council of Governors, direct face-to-face contact, surveys of Members' opinions and consultations.	
Additional requirement of FT ARM resulting from legislation	If, during the financial year, the Governors have exercised their power* under paragraph 10C** of schedule 7 of the NHS Act 2006, then information on this must be included in the Annual Report. This is required by paragraph 26(2)(aa) of schedule 7 to the NHS Act 2006, as amended by section 151 (8) of the Health and Social Care Act 2012. * Power to require one or more of the Directors to attend a Governors' meeting for the purpose of obtaining information about the Foundation Trust's performance of its functions or the Directors' performance of their duties (and deciding whether to propose a vote on the Foundation Trust's or Directors' performance). ** As inserted by section 151 (6) of the Health and Social Care Act 2012).	Not applicable in reporting period.

The Board of Directors

As at 31 March 2025, the Board of Directors was made up of the Trust Chair, seven Non-Executive Directors and six voting Executive Directors. The six voting Executive Board positions at 31 March 2025 were:

- Chief Executive Officer
- Director of Finance
- Medical Director
- Chief Nurse
- Chief Operating Officer
- Director of People

The Trust was compliant with the Code of Governance for NHS Provider Trusts, with at least half the Board of Directors, excluding the Chair, to be Non-Executive Directors determined by the Board to be independent.

In accordance with the Trust's Constitution, the Non-Executive Directors are appointed by the Council of Governors, typically for a three-year term of office. With approval of the Council of Governors, Non-Executive Directors can serve up to nine years from the date of their first appointment, at intervals of no more than three years. Any decision to extend a term beyond six years is subject to rigorous review.

The Board of Directors met in public on seven occasions during 2024/25. The Board also met in private for twelve ordinary meetings and two extraordinary meetings, where its debate considered commercially sensitive and / or involved confidential issues. The Board also met in less formal workshop settings to undertake strategic planning and development activities.

Register of Directors' Interests

All Directors are required to complete and keep up to date their declarations of interest, which are recorded in the Register of Directors' Interests.

A copy of the register is presented in April at the Board's meeting in public. It is also available within public Board papers on the Trust's website and in the corporate governance section of the website.

The role of the Board of Directors

The Board of Directors has a dual role: leadership and control. As a unitary Board it has collective responsibility for setting the strategic direction of the organisation and for overseeing and ensuring the delivery of its strategy and the performance of the organisation.

Some of the responsibilities of the Board of Directors

- To ensure that the Trust meets its statutory duties and complies with the provisions of its provider licence and constitution
- To ensure that the organisation's policy framework is developed in accordance with the rights, pledges and responsibilities contained in the NHS Constitution
- To provide leadership for the organisation in respect of agreed organisational values and standards of conduct in accordance with accepted standards of behaviour in public life, which include the principles of selflessness, integrity, objectivity, openness, honesty and leadership (Nolan)
- To establish a robust performance management framework and support the Executive team in meeting the organisation's performance targets; monitoring the performance of the Trust and ensuring that the Executive Directors manage the Trust within the resources available, in such a way as to:
    - Ensure the quality and safety of healthcare services
    - Plan for continuous improvement
    - Protect the health and safety of Trust employees and all others to whom the Trust owes a duty of care
    - Use Trust resources efficiently and effectively
    - Promote the prevention and control of healthcare associated infection
    - Comply with all relevant regulatory, legal and code of conduct requirements
    - Maintain high standards of ethical behaviour, corporate governance and personal conduct in the business of the Trust
    - Maintain the high reputation of the Trust both with reference to local stakeholders and the wider community
- To engage, as appropriate, with the Council of Governors in accordance with the statutory and regulatory framework

The Board of Directors has agreed a reservation of powers and scheme of delegation which sets out a schedule of decisions reserved to the Board of Directors and those delegated to Board-level committees, executive management or individual Executive Directors. Terms of reference are in place for Board-level committees describing their roles and responsibilities and reporting requirements to the Board of Directors.

The duties of the Council of Governors are distinct from those of the Board of Directors. It has two clear duties:

- To hold the Non-Executive Directors individually and collectively to account for the performance of the Board of Directors
- To represent the interests of the Members of the Trust as a whole and the interests of the public

The responsibilities of the Council of Governors are to:

- Appoint and, if appropriate, remove of the Chair and Non-Executive Directors.
- Decide the remuneration and allowances and other terms and conditions of office of the Chair and other Non-Executive Directors
- Approve any new appointment of a Chief Executive
- Appoint and, if appropriate, remove of the External Auditor
- Approve amendments to the Trust's Constitution
- Approve an application by the Trust to enter into a merger, acquisition, separation or dissolution
- Approve significant transactions as outlined in the Trust's Constitution

The scheme of delegation references those decisions which require approval by the Council of Governors. The Trust's Constitution describes how disagreements between the Council of Governors and the Board of Directors would be resolved.

The Board of Directors, and in particular the Non-Executive Directors, have developed an understanding of the views of Governors and members about the NHS Foundation Trust, for example through:

- Attendance at meetings of the Council of Governors
- Governor attendance at Board of Director meetings
- Attendance at Governor committee meetings
- Governor observation of Board assurance committees
- Governor representation at some key meetings and working groups
- Non-Executive Director and Governor attendance at quality assurance visits
- Lead Governor meetings with the Trust Chair and CEO
- Question session at Annual Members Meeting (held in the Boardroom at The QEH in July 2024)
- Roadshows to engage with the community on the new hospital plans

Chair, Deputy Chair and Senior Independent Director

In a Foundation Trust, the Trust Chair chairs both the Board of Directors and the Council of Governors. In 2024/25, the Trust saw a change in Chair with Christopher Lawrence resigning and Dr Andy Wood being appointed Interim Trust Chair in November 2024, neither Trust Chair had any other significant commitments that had an adverse impact on their role as Chair of the Foundation Trust.

The Trust's constitution makes provision for the Board's appointment of a Senior Independent Director, who has particular duties regarding working with the Council of Governors and the Board of Directors to address any issues where it is inappropriate for the Chair to do so. The Trust's Senior Independent Director is Dr Claire Fernandez, who was appointed by the Board to the role of Senior Independent Director from January 2024, with this appointment supported by the Council of Governors.

The Trust's Deputy Chair is Graham Ward, Non-Executive Director, who was appointed in January 2024. The appointment was approved by the Council of Governors.

Delegation and committees of the Board of Directors

The Board delegates powers to formally constituted committees in accordance with its scheme of delegation.

Committees reporting and accountable to the Board of Directors during 2024/25 were:

- The Quality Committee
- The Finance and Activity Committee (formally Finance and Activity Committee until December 2024)
- The People and Culture Committee
- The Audit and Risk Committee (formally Audit Committee until December 2024)
- The Nomination and Remuneration Committee (Executive Director appointments)
- The QEH Committee in Common (the Norfolk and Waveney Acute Hospital Collaborative)
- The Future Systems Committee
- The Trust Management Group

The Trust's Charitable Fund Committee reports to 'The Board acting as Agent of the Corporate Trustee'.

The Audit Committee and audit

The Audit Committee met seven times during 2024/25. Its purpose is to provide independent assurance of the adequacy of the Board Assurance Framework and associated control environment, independent scrutiny of the Trust's financial, non-financial and quality performance to the extent that it affects the Trust's exposure to risk and weakens the control environment, and to oversee the financial reporting process. The work of the Audit Committee supports the completion of the Annual Governance Statement by the Accounting Officer.

The Audit Committee approves strategies and plans for countering fraud and receives reports from the Trust's Local Counter Fraud Specialist at each meeting. The committee approves the Internal Audit work programme and monitors the effectiveness of the Internal Audit function. The committee also receives and considers reports and opinion from both internal and external auditors. The Non-Executive Chair of the Audit Committee is a qualified accountant.

The Internal Auditors audit a range of both financial and quality controls at the Trust and provide levels of assurance accordingly.

The Trust's external auditor for the period covered by this Annual Report was KPMG.

The Audit Committee is satisfied concerning the ongoing independence of the External Audit function.

Nomination and Remuneration Committee (Executive appointments)

The Nomination and Remuneration Committee reviews and makes recommendations to the Board on the composition, balance, skill mix and succession planning of the Board. It oversees recruitment and appointment of the Chief Executive Officer (requiring the approval of the Council of Governors), recruitment and appointment of other Executive Directors and approves the remuneration of the Chief Executive Officer, Executive Directors and other Director's reporting to the Chief Executive.

2024/25 saw some change in the Executive team. The committee oversaw recruitment processes and approved the interim appointment to the position of director of finance. The committee approved the appointment of Lorraine Hooper as Interim Director of Finance, the appointment was within the context of ensuring balance, completeness and appropriate skills and experience within the Board.

The Committee oversaw recruitment processes of one new Associate Non-Executive Director. These developmental roles were successfully introduced in 2023/24 into enable individuals to gain experience and develop competencies to become successful future Non-Executive Directors within the NHS. Being non-voting, developmental position, recruitment was undertaken by the Board. The Board welcomed the support of Governors throughout the recruitment process.

The Nomination and Remuneration Committee (Executive appointments) receives advice from the Director of People.

Information on the nomination and remuneration of the Chair and Non-Executive Directors is available in the Council of Governors section of this Annual Report.

Evaluating the Board's performance

The Board of Directors used a number of methods to evaluate the performance of the Board and its committees. In 2024/25, performance evaluation methodologies included:

- Board self-assessment (after each Board meeting)
- Chief Executive and Executive Director appraisal
- Trust Chair and Non-Executive Director appraisal
- Board Development Programme
- Effectiveness review of the Audit Committee – using the model checklist of the NHS Audit Committee Handbook
- Review of committee terms of reference

- Committee self-assessment (after each committee meeting)
- Annual committee effectiveness reviews
- Committee Annual Reports

In 2024/25, the Board completed the self-certification requirements in relation to General Condition Six of the NHS Provider Licence. The Board also made its Corporate Governance Statement and declarations in relation to current and future compliance with the NHS Provider Licence Condition FT4.

The reviews made recommendations to further strengthen governance arrangements and work is ongoing to embed adjustments to governance systems and processes.

The Constitution

The Trust's Constitution sets out its governance arrangements. It is published on the Trust's website in the Corporate Governance section.

The Trust's and Governor's Constitution Working Group reviews the provisions of the constitution. Proposed changes were approved by the Board of Directors in December 2023 and the Council of Governors in March 2023. The review enabled the constitution to be updated to reflect legislative changes and requirements from the National Health Service Act 2006 and Health and Care Act 2022. Updates to the constitution did not affect the powers or duties of the Council of Governors.

Directors (voting Board members) 1 April 2024 – 31 March 2025	Date of end of NED terms of office	Audit Committee 7 meetings		Nomination and Remuneration Committee (ED Appointments) 5 meetings		Meetings attended out of 6 Board of Director (Ordinary) Meetings held in public	Meetings attended out of 7 Board of Director (Ordinary) Meetings held in private	Meetings attended out of 5 Governors' Council (ordinary) meetings in public	Meetings attended out of 3 Governors' Council (ordinary) meetings in private
Andy Wood – NED Trust Chair From: 2 December 2024	31 October 2025			Chair	1/1	3/7	4/12	1/5	2/3
Graham Ward – NED From: 26 August 2019 Appointed Acting Chair 1 April to 30 October 2022 Reappointed NED from 31 October 2022 Chair: Finance and Activity Committee Deputy Chair from January 2024	30 October 2025			✓	4/5	6/7	12/12	1/5	3/3
Simon Roberts – NED From: 20 May 2019 Reappointed: 20 May 2022 Chair: People Committee	19 May 2025	✓	7/7	✓	4/5	7/7	11/12	2/5	3/3
Dr Claire Fernandez – NED From: 1 July 2020 to 30 June 2023 Reappointed 1 July 2023 Chair: Future Systems Committee Senior Independent Director from 1 January 2024	30 June 2026			✓	3/5	7/7	11/12	2/5	3/3
Sue Hayter – NED From: 1 May 2021 Reappointed from 1 May 2024 for three-year period Chair: Quality Committee	30 April 2027			✓	3/5	7/7	11/12	2/5	3/3
William Van't Hoff – NED From: 1 February 2024	31 January 2027			✓	4/5	7/7	12/12	2/5	3/3
Saqhib Ali – NED From: 22 July 2024 Chair: Audit Committee	21 July 2027	✓	5/5	✓	3/5	3/7	6/12		3/3
Alice Webster Chief Nurse from May 2021 Acting CEO from October 2022 CEO from March 2023			3/7		2/5	7/7	12/12	5/5	3/3
Lorraine Hooper Interim Director of Finance From 7 October 2024		✓	4/4			4/7	6/12		
John Syson Director of People From 1 August 2023 (Interim from 20 March 2023)						7/7	12/12		
Pippa Street Chief Nurse From 21 August 2023						7/7	12/12		
Dr Rebecca Martin Medical Director From 1 September 2023						6/7	9/12		

Simon Illingworth Chief Operating Officer From 28 August 2023							5/7	11/12		
Chris Lawrence - NED Trust Chair From: 31 October 2022		30 November 2025			Chair	3/5	4/7	6/12	2/5	
Alan Brown – NED, Vice Chair, Senior Independent Director From 1 May 2018 Reappointed 1 May 2012 to 30 April 2024 1 May 2024 to 30 June 2024 1 July 2024, stepped down 31 March 2025 Vice Chair, Senior Independent Director to 31 December 2023 Chair: Charitable Funds Committee		30 April 2025	✓	7/7	✓	4/5	6/7	11/12	2/5	3/3
David Dickinson - NED From 2 July 2018 Reappointed 1 July 2021 to 30 June 2024 Chair: Audit Committee		30 June 2024	Chair	2/2	✓	0/5	0/7	0/12	0/5	0/3
Chris Benham Director of Finance From 1 January 2020 to 30 November 2024		30 November 2024		2/2			3/7	5/12	3/3	1/1
KEY:	✓ = Committee Member	No longer serving on the Board of Directors								
		Not a committee member, attendance by invitation								

The role of the Council of Governors

The Council of Governors:

- Appoints the Chari and Non-Executive Directors to the Board of Directors
- Sets the remuneration of the Chair and Non-Executive Directors
- Approves the appointment of the Chief Executive Officer
- Appoints the auditor
- Influences decisions about developing services

Statutory duties for Governors:

- To hold the Non-Executive Directors individually and collectively to account for the performance of the Board of Directors
- To communicate with their member constituencies and the public and transmit their views to the Board of Directors
- To contribute to the development of the Foundation Trust's forward plans

Governors:

- Can require Directors to attend a meeting to obtain information about Foundation Trust performance or Director performance
- Vote to approve:
    - Constitutional changes
    - A merger, acquisition, dissolution, or separation
    - An increase by more than 5% of the Foundation Trust's non-NHS income

Advice and training for Governors:

- Foundation Trust are required to ensure their Governors have the skills and knowledge needed to carry out their roles

The composition of the Council of Governors

Public Governors (16):

- Theresa Banks – West Norfolk
- Chris Brewis – South East Lincolnshire
- David Chittenden – Breckland, North Norfolk and Rest of England
- Esmé Corner – West Norfolk
- Mark Dyer – Cambridgeshire / Fenland
- Prudence Fox – West Norfolk
- Antonia Hardcastle – Breckland, North Norfolk and Rest of England
- Bob King – West Norfolk
- Betty Lewis – Cambridgeshire / Fenland
- Alan Maltby – South East Lincolnshire

- Mike Press – West Norfolk
- Andrew Riley – West Norfolk
- Sara Shaw – West Norfolk
- Barbara Turner – West Norfolk
- Vacancy – Cambridgeshire / Fenland
- Vacancy – West Norfolk

Staff Governors (6):

- Risa Birbal – Staff Clinical
- Sheena Johnson-Banks – Staff Non-Clinical
- Leanne Kendrick – Staff Non-Clinical
- Ruth Overton – Staff Clinical
- Karen Wilson – Staff Clinical
- Alasdair Willett – Staff Non-Clinical

Appointed Governors (7):

- Lesley Bambridge – Norfolk County Council
- Matthew Brown – Freebridge Community Housing
- Jane Evans – West Norfolk Carers
- Alexandra Kemp – Borough Council of King's Lynn and West Norfolk
- Sue Madden – University of East Anglia
- Peter Wilkinson – Breckland District Council

Lead Governor's Statement

This year has been one of significant transformation and resilience across our Trust. As Lead Governor, I have had the privilege of working closely with a dedicated Council of Governors, an engaged Board of Directors, and, above all, a compassionate and hardworking staff team who continue to serve our community with commitment and care.

A major milestone this year has been the progress made toward the construction of our new hospital. After years of determined advocacy and planning, the reality of a new, state-of-the-art hospital is now firmly on the horizon. Governors have played an active role in ensuring that the voices of patients, staff, members and local residents are heard throughout this process. We are confident that the new build will not only address long-standing infrastructure challenges but also help future-proof healthcare services for generations to come.

Throughout the year, Governors have continued to perform their statutory duties with diligence – holding the Non-Executive Directors to account, representing the interests of our members and the wider public, and helping shape the strategic direction of the Trust. We have attended local GP surgeries Patient Participation Groups and helped these groups to form regional forums. The feedback we gather from the ground up helps bring focus to our work.

The Trust's focus on improving patient safety, quality of care, and operational performance remains clear. There have been notable improvements in key areas, including elective recovery, workforce wellbeing initiatives, and patient experience. However, we recognise that challenges persist, particularly around recruitment, retention, and sustaining performance amidst national pressures on the NHS.

As we look ahead, The QEH is now part of the Norfolk and Waveney University Hospital Group. Governance and key appointments are taking shape, and this will lead the strategic direction of the acute hospitals in Norfolk and Waveney. Improving population health because of better outcomes and more joined up working is a key benefit, as well as improvement of patient outcomes, safety and experience to rival the best global comparators. The role of Governors remains vital in providing informed oversight, promoting transparency, and ensuring that the Trust stays true to its values of Kindness, Wellness and Fairness.

In closing, I would like to extend sincere thanks to my fellow Governors for their time, insight, and unwavering dedication. On behalf of the Council of Governors, I would also like to thank the Executive and Non-Executive Directors for their openness and commitment to working collaboratively in service of our community.

We are proud of what has been achieved this year – and we remain steadfast in our shared mission to ensure that The QEH continues to deliver safe, high-quality care for all.

Dr Antonia Hardcastle

Lead Governor

Council of Governors Report 2024/25

Governor Elections

In January 2025, the Trust held elections across all public constituencies and staff classes in line with the routine electoral cycle. The newly elected Governors formally commenced their terms of office on 1 February 2025.

All Foundation Trust members are eligible to stand as a candidate and to vote in the Council of Governors elections. The election process is governed by the Trust's Constitution, which aligns with the Model Election Rules 2014. Civica Election Services served as the Returning Officer for the 2025 elections.

Following the conclusion of the election, all three staff clinical and both staff non-clinical Governor roles were filled, resulting in a full complement of six staff Governors. Of the seven available public Governor positions, six were filled, with one vacancy remaining in the Cambridgeshire / Fenland constituency. It is anticipated that the 2026 election cycle will secure all three Governors for that area.

Governors serve a three-year term or the remainder of a vacant term, as applicable.

Election results – 1 February 2025

Constituency / Staff class	Vacancies	Contested	Turnout	Name	Term
Public: West Norfolk	4	Yes	10%	Theresa Banks Sara Shaw (R) Bob King Andrew Riley	3 years to 31 January 2028
Public: Breckland, North Norfolk and Rest of England	1	Yes	8.1%	Dr Antonia Hardcastle (R)	3 years to 31 January 2028
Public: Cambridgeshire and Fenland	2	No	n/a	Mark Dyer	3 years to 31 January 2028
Public: South East Lincolnshire	1	No	n/a	Chris Brewis (R)	3 years to 31 January 2028

Staff: Non-Clinical	2	Yes	14.2%	Leanne Kendrick (R) Alasdair Willett	3 years to 31 January 2026
Staff: Clinical	1	Yes	9.9%	Ruth Overton	3 years to 31 January 2028
Staff: Clinical	2	Yes	9.9%	Dr Risa Birbal Karen Wilson	1 year to 31 January 2026

(R) = re-elected

Council of Governors Meetings

Information relating to the dates, venues, agendas, and minutes of the Council of Governors' public meetings is published on the Trust's website under the 'About Us' section. Members are encouraged to contact the Foundation Trust Office by email at FTMembership@qehkl.nhs.uk or by phone at 01553 613142 for further details.

Lead Governor

The term of office for the Lead Governor concluded on 31 January 2025. In accordance with the Council of Governors' Standing Orders, the Chair requested that the incumbent Lead Governor, Dr Antonia Hardcastle, remain in post until April 2025. This extension supported continuity during the preparation of the Group Model, in which lead governors from the region's three acute hospitals played a significant role. This decision was formally ratified by the Council at its meeting on 3 March 2025.

Dr Hardcastle is a member of the Membership, Communications and Engagement Group and also represents the Trust on the NHP Forum, alongside Governors from NNUH and JPUH. She has also contributed to the establishment of regional Patient Participation Group (PPG) forums.

Deputy Lead Governor

The Deputy Lead Governor is Mr Alan Maltby, who also serves as Chair of the Patient Experience Group.

Council of Governors Groups

While the Council of Governors cannot delegate its statutory responsibilities, it operates through three formal groups which provide support in defined areas and make recommendations to the Council. Each group met four times during the reporting period.

Membership, Communications and Engagement Group: this group supports Governors in discharging their duty to represent the interests of Trust members and the wider public. Its work focuses on developing and reviewing strategies for member engagement and recruitment.

The group also seeks to contribute to cultural improvement across the organisation, particularly in relation to staff engagement and empowerment, by reviewing feedback from the National Staff Survey, Pulse Surveys and the Trust's associated action plans.

Membership recruitment initiatives in 2024/25 included attendance at community and recruitment events such as GEAR 2024, RAF Marham Open Day, a staff recruitment event, and the Freshers' Fair at the College of West Anglia in King's Lynn and Wisbech.

In support of the Trust's paper-free initiative, the group contacted postal members to encourage digital engagement. As a result, postal membership has reduced significantly; however, total membership remains sustainable with 3,300 email members and 163 postal members.

Patient Experience Group: this group monitors and explores the quality of services provided by the Trust. It plays a key role in shaping the Trust's quality improvement agenda, particularly in the areas of safety, effectiveness, and patient experience.

Activities during 2024/25 included engagement with senior clinical and patient experience leads, as well as gathering intelligence from Patient Participation Groups, Quality Assurance visits, PLACE assessments, patient and staff feedback, and ward-based observations.

Strategy and Business Planning Group: this group contributes to the development of the Trust's medium- and long-term strategic direction. It provides oversight and seeks assurance from Non-Executive Directors and Executive Directors on a range of matters, escalating issues to the full Council as required.

Areas of focus include financial performance, capital programme delivery, strategic planning, risk management, and oversight of business decisions requiring Council approval.

Nominations and Remuneration Committee: this committee makes recommendations to the Council of Governors regarding the appointment, reappointment, remuneration, and terms of office for the Trust Chair and Non-Executive Directors. The Committee met three times in 2024/25. Its work included

making recommendations on the appointment of a Non-Executive Director to chair the Audit Committee, and on the appraisal outcomes for the Chair and Non-Executive Directors.

Trust Board Committee Observers: the Chairs and Deputy Chairs of the Council of Governors' groups, along with the Lead Governor, have observer status at key Trust Board committees, including the Quality Committee, the Finance and Performance Committee, and the People and Culture Committee.

Constitution Working Group: this working group is responsible for reviewing and proposing amendments to the Trust's Constitution. Following a comprehensive review undertaken in 2023, the group did not meet during 2024/25.

Contacting the Governors

Members of the public are welcome to contact the Council of Governors via the Foundation Trust Office:

Email: FTMembership@qehkl.nhs.uk

Phone: 01553 613142

Post: The Foundation Trust Office, The Queen Elizabeth Hospital King's Lynn NHS Foundation Trust, Gayton Road, King's Lynn, PE30 4ET

Council of Governors Composition 2024/25

The table shows governor meeting attendance, including the Annual Members' Meeting.

The Governors have made declarations of interest and have signed the Trust's Code of Conduct for Governors. The Register of Interests is taken to Council meetings twice a year and additionally when there are changes to report. It can be found in the meeting papers on The QEH website or by contacting the Foundation Trust Office, as above.

Constituency	Governor name, month appointed and term of office	Current term / period remaining (years)	Governors' Council meetings attended	Business Committee member	Patient Experience Committee member	Membership and communications Committee member	Nomination and remuneration Committee member
West Norfolk	Theresa Banks February 2025 1st term	3/3	1/1				
West Norfolk	Esmé Corner OBE February 2023 5th term	3/1	4/5	✓			
West Norfolk	Prudence Fox February 2023 1st term	3/1	4/5			✓	
West Norfolk	Bob King February 2025 1st term	3/3	1/1				
West Norfolk	Mike Press February 2023 2nd term	3/1	5/5	✓			✓
West Norfolk	Andrew Riley February 2025 1st term	3/3	1/1				
West Norfolk	Sara Shaw	3/3	5/5	✓			

	February 2025 2nd term						
West Norfolk	Barbara Turner February 2023 1st term	3/1	4/5		✓		✓
West Norfolk	Vacant	3/1					
Cambridgeshire / Fenland	Betty Lewis February 2020 5th term	3/1	2/5		✓		
Cambridgeshire / Fenland	Mark Dyer February 2025 1st term	3/3	1/1				
Cambridgeshire / Fenland	Vacant	3/1					
Breckland, North Norfolk, and the rest of England	Antonia Hardcastle (Lead Governor) February 2025 2nd term	3/3	5/5			✓	✓
Breckland, North Norfolk, and the rest of England	David Chittenden February 2023 2nd term	3/1	4/5	Chair			
South East Lincolnshire	Chris Brewis February 2025 2nd term	3/3	4/5		✓		
South East Lincolnshire	Alan Maltby (Deputy Lead Governor) February 2023 2nd term	3/1	5/6		Chair		
Staff Clinical	Ruth Overton February 2025 1st term	3/3	1/1				

Staff Clinical	Risa Birbal February 2025 1st term	1/1	1/1				
Staff Clinical	Karen Wilson February 2025 1st term	1/1	0/1				
Staff Non-Clinical	Sheena Johnson-Banks February 2023 2nd term	3/1	3/5		✓		✓
Staff Non-Clinical	Leanne Kendrick February 2025 2nd term	3/3	4/5			✓	✓
Staff Non-Clinical	Alasdair Willett February 2025 1st term	3/3	0/1				

Appointed Governor	Governor name and month appointed	Governors' Council meetings attended	Business Committee member	Patient Experience Committee member	Membership and communications Committee member	Nomination and remuneration Committee member
Borough Council of King's Lynn and West Norfolk	Alexandra Kemp December 2023	4/5			✓	
Breckland District Council	Peter Wilkinson June 2019	5/5				
College of West Anglia	Rachel Boast June 2023	2/5		✓		

Freebridge Community Housing	Matthew Brown September 2024	2/2	✓			
Norfolk County Council	Lesley Bambridge August 2021	3/5		✓		
University of East Anglia	Sue Madden November 2019	5/5			✓	✓
West Norfolk Carers	Jane Evans February 2017	4/5			✓	

Governors no longer serving at 31 March 2025

Constituency / Staff Class / Appointed	Name	Meetings attended	Leaving date
West Norfolk	Dr Julian Litten	2/3	19 October 2024
West Norfolk	Gilli Galloway	4/5	31 January 2025
West Norfolk	Kenneth Wicks	2/4	31 January 2025
West Norfolk	John Greyson (Chair: Membership, Engagement and Culture Group)	4/5	10 March 2025
Cambridgeshire and Fenland	Garry Monger	0/1	17 May 2024
Staff: Non-Clinical	Stewart Nimmo	3/4	31 January 2025
Freebridge Community Housing	Andy Walder	2/3	27 April 2023

Foundation Trust and public membership

Membership of the Foundation Trust is open to patients, the public, NHS staff and most people over 16 years of age, including those who live outside the area with an interest in the Trust.

Members receive the Trust's monthly 'Modernising our Hospital' newsletter via email and ad hoc emails about important matters and developments. Members are invited to attend the Annual Members' Meeting, healthcare events and some focus groups. They can vote in Governor elections and stand for election to sit on the Council of Governors. The level of engagement is entirely the choice of the individual and can include volunteering, fundraising and work placements.

The Trust's catchment area consists of four constituencies:

- West Norfolk
- Breckland, North Norfolk and the Rest of England
- Cambridgeshire/Fenland
- South East Lincolnshire

Staff and volunteer membership

We appreciate and value our staff and its many volunteers. Staff and volunteers automatically become members on joining the Trust. Anyone who does not wish to be a member can opt out.

To apply to be a member of the Foundation Trust, please:

Apply online using this link: https://secure.membra.co.uk/Join/QueenElizabeth

Send an email to FT.membership@qehkl.nhs.uk or call the Foundation Trust Office on 01553 613142 for an application form.

Write to **The Foundation Trust Office**, The Queen Elizabeth Hospital King's Lynn, Gayton Road, King's Lynn, PE30 4ET.

Public membership

The Trust achieved a public membership of 3,320 by the end of March 2025.

Gender	Members as at 31 March 2024	Members as at 31 March 2025
Male	2,271	1,183
Female	4,015	2,112
Not stated	12	23

Constituency	Members as at 31 March 2024	Members as at 31 March 2025
Breckland, North Norfolk and Rest of England	1,010	487
Cambridgeshire and Fenland	645	316
South East Lincolnshire	440	204
West Norfolk	4,195	2,313

Age	Members as at 31 March 2024	Members as at 31 March 2025
16-21	314	225
22-29	1,144	659
30-39	443	251
40-49	474	251
50-59	649	344
60-74	1,304	697
75+	1,572	768
Not stated	398	125

Ethnicity	Members as at 31 March 2024	Members as at 31 March 2025
White	5,784	2,977
Mixed	37	23
Asian or Asian British	72	55
Black or Black British	33	25

Other	16	8
Not stated	356	231

	Members as at 31 March 2024	Members as at 31 March 2025
Total	6,298	3,320

NHS System Oversight Framework

NHS England's NHS Oversight Framework provides the framework for overseeing systems, including providers, and identifying potential support needs. NHS organisations are allocated to one of four segments.

A segmentation decision indicates the scale and general nature of support needs, from no specific support needs (segment one) to a requirement for mandated intensive support (segment four). A segment does not determine specific support requirements. By default, all NHS organisations are allocated to segment two unless the criteria for moving into another segment are met. These criteria have two components:

- Objective and measurable eligibility criteria based on performance against the six oversight themes using the relevant oversight metrics. The themes are:
    - Quality of care, access and outcomes
    - People
    - Preventing ill health and reducing inequalities
    - Leadership and capability
    - Finance and use of resources
    - Local strategic priorities
- Additional considerations focused on the assessment of system leadership and behaviours, and improvement capability and capacity

An NHS Foundation Trust will be in segment three or four only where it has been found to be in breach or suspected breach of its licence conditions.

Segmentation

In 2024/25, NHS England placed the Trust in segment three.

This segmentation information is the Trust's position as at 31 March 2025. Current segmentation information for NHS Trusts and Foundation Trusts is published on the NHS England website: www.england.nhs.uk/publication/nhs-system-oversight-framework-segmentation/

Statement of Chief Executive's responsibilities as accounting officer of The Queen Elizabeth Hospital King's Lynn NHS Foundation Trust

The NHS Act 2006 states that the Chief Executive is the Accounting Officer of the NHS Foundation Trust. The relevant responsibilities of the Accounting Officer, including their responsibility for the propriety and regularity of public finances for which they are answerable, and for the keeping of proper accounts, are set out in the NHS Foundation Trust Accounting Officer Memorandum issued by NHS England.

NHS England has given Accounts Directions which require The Queen Elizabeth Hospital King's Lynn NHS Foundation Trust to prepare for each financial year a statement of accounts in the form and on the basis required by those directions. The accounts are prepared on an accruals basis and must give a true and fair view of the state of affairs of The Queen Elizabeth Hospital King's Lynn NHS Foundation Trust and of its income and expenditure, other items of comprehensive income and cash flows for the financial year.

In preparing the accounts and overseeing the use of public funds, the Accounting Officer is required to comply with the requirements of the Department of Health and Social Care Group Accounting Manual and in particular to:

- Observe the Accounts Direction issued by NHS England, including the relevant accounting and disclosure requirements, and apply suitable accounting policies on a consistent basis
- Make judgements and estimates on a reasonable basis
- State whether applicable accounting standards as set out in the NHS Foundation Trust Annual Reporting Manual (and the Department of Health and Social Care Group Accounting Manual) have been followed and disclose and explain any material departures in the financial statements
- Ensure that the use of public funds complies with the relevant legislation, delegated authorities and guidance
- Confirm that the Annual Report and Accounts, taken as a whole, is fair, balanced and understandable and provides the information necessary for patients, regulators and stakeholders to assess the NHS foundation trust's performance, business model and strategy
- Prepare the financial statements on a going concern basis and disclose any material uncertainties over going concern

The Accounting Officer is responsible for keeping proper accounting records which disclose with reasonable accuracy at any time the financial position of the NHS Foundation Trust and to enable them to ensure that the accounts comply with requirements outlined in the above mentioned act. The Accounting Officer is also responsible for safeguarding the assets of the NHS Foundation Trust and hence for taking reasonable steps for the prevention and detection of fraud and other irregularities.

As far as I am aware, there is no relevant audit information of which the Foundation Trust's auditors are unaware, and I have taken all the steps that I ought to have taken to make myself aware of any relevant audit information and to establish that the entity's auditors are aware of that information.

To the best of my knowledge and belief, I have properly discharged the responsibilities set out in the NHS Foundation Trust Accounting Officer Memorandum.

Professor Lesley Dwyer
Group Chief Executive

26 June 2025

Annual Governance Statement

Scope of responsibility

As Accountable Officer, I have responsibility for maintaining a sound system of internal control that supports the achievement of the NHS Foundation Trust's policies, aims and objectives, whilst safeguarding the public funds and departmental assets for which I am personally responsible, in accordance with the responsibilities assigned to me. I am also responsible for ensuring that the NHS Foundation Trust is administered prudently and economically and that resources are applied efficiently and effectively. I also acknowledge my responsibilities as set out in the NHS Trust Accountable Officer Memorandum.

This Annual Governance Statement outlines how The Queen Elizabeth Hospital NHS Foundation Trust (The QEH) has managed its governance, risk and internal control environment during the year ended 31 March 2025, and up to the date of approval of the Annual Report and Accounts. It sets out how assurance is obtained and how the Trust identifies and responds to areas of concern. The governance arrangements described support the Trust's delivery of its strategic objectives and statutory duties, including its obligations as an NHS Foundation Trust, as a provider of regulated services, and as an employer and corporate body.

The proposed transition to a group governance framework with the NNUH and JPUH provided the opportunity during 2024/25 to maintain and build upon areas of excellent practice in governance, risk management, internal control, and compliance. The Trust has approached this evolution with a focus on harmonising governance standards across the future Group, while continuing to discharge its statutory and regulatory responsibilities as an NHS Foundation Trust. This Annual Governance Statement reflects both the governance arrangements in place during the year, and the preparatory steps taken toward a shared governance framework.

The purpose of the system of internal control

The system of internal control is designed to manage risk to a reasonable level rather than to eliminate all risk of failure to achieve policies, aims and objectives; it can therefore only provide reasonable and not absolute assurance of effectiveness. The system of internal control is based on an ongoing process designed to identify and prioritise the risks to the achievement of the policies, aims and objectives of The QEH, to evaluate the likelihood of those risks being realised and the impact should they be realised, and to manage them efficiently, effectively and economically.

The system of internal control has been in place in The QEH for the year ended 31 March 2025 and up to the date of approval of the annual report and accounts.

Capacity to handle risk

The Trust's Board provides leadership for risk management through its established governance framework. Responsibility for risk oversight is discharged through its Board Assurance Framework (BAF), regular reporting to the Audit Committee, Quality Committee, People and Culture Committee, Finance and Performance Committee and the performance management structures which ensure that risks are identified, escalated, and managed at every level of the organisation.

Risk is embedded in operational and strategic decision-making processes. Each Executive Director is responsible for managing risks within their portfolio and for ensuring that mitigations and controls are in place and functioning effectively. Risk registers are reviewed regularly through divisional governance routes and escalated to the corporate risk register and BAF as appropriate.

Staff at all levels are equipped to identify and manage risk through a combination of mandatory and role-specific training, policy guidance, and the use of recognised frameworks such as the Three Lines of Defence model. During 2024/25, the Trust continued to invest in capability to support a just and learning culture, including enhanced use of incident reporting, safety huddles, and reflective learning forums at team level.

Risk management training is embedded into leadership development and divisional induction programmes, and clinical and corporate teams are supported by risk and governance leads. Learning from best practice and external review – including clinical audit, internal audit, CQC engagement, and regional networks – is used to improve and refine risk processes.

The Trust undertakes annual self-assessment of its risk maturity and governance effectiveness, most recently informed by an independent governance review completed in 2023. These assessments provide assurance to the Board and support the continuous improvement of the Trust's risk culture.

The Risk and Control Framework

The Trust has maintained a structured and effective approach to risk management and internal control throughout 2024/25. The system of risk management includes corporate, clinical, and operational elements and is embedded into all levels of the organisation. A comprehensive BAF underpins the Board's understanding of its principal risks and ensures the adequacy of mitigation and controls is regularly reviewed by relevant Board Committees.

Risk management strategy and risk appetite

The Trust's Risk Management Strategy (entitled Risk Management Policy and Procedure) was reviewed and updated in 2024. The Strategy provides a framework

for managing risk across the organisation and defines the roles, responsibilities and escalation thresholds for risk identification and management.

During 2024/25, the Trust refined its approach to risk appetite in preparation for future harmonisation with partner organisations in the proposed Group Model. The Audit and Risk Committee and Executive team led the development of a revised risk appetite statement, which informed the Trust's approach to strategic risk review and mitigation planning.

Major risks to strategic objectives

During 2024/25 the Board undertook a refresh of the BAF and moved away from describing principal risks to identifying and describing threats to delivery of strategic objectives.

At year-end, the BAF identified ten principal risks to strategic objectives. These covered clinical safety, performance delivery, workforce, digital resilience, estate sustainability, and financial control. Of these, eight were rated above the Board's stated risk appetite, including:

- SO1 - Patient Satisfaction
- SO3 - Operational efficiency and effectiveness
- SO4 - Making QEH a truly great place to work
- SO6 - Becoming digitally enabled
- SO7 - Having strong financial grip and control
- SO8 - Sustainability and environmental responsibility
- SO9 - Stronger relationships with individuals, groups and organisations
- SO10 - Safe and fit for purpose estate

Each of these was subject to enhanced assurance through targeted internal audit, external review or national programmes. Detailed actions and controls were in place and reviewed quarterly through Board committees.

Quality Governance

The Trust operates within the NHS Foundation Trust statutory and regulatory environment and its quality governance arrangements are regularly reviewed to ensure compliance with relevant regulatory (and other legal and professional) standards. This includes the NHS England and Care Quality Commission combined Well-Led Framework. The Trust has a well-defined quality governance structure in place, designed to provide 'Ward to Board' visibility, reporting and assurance across the quality agenda.

The Executive team and the Trust Board seek information and assurance on compliance. Section 31 notices that remained on the Trust's registration were reported to the CQC on a monthly and quarterly basis respectively, as agreed with the CQC. These updates were also reported to the Quality Committee for their

awareness and oversight. The Trust Management Group also received reports from the Evidence Assurance Group (EAG) relating to assurance of progress and evidence that actions have been effectively completed. These predominantly related to 'Must Do' actions and 'Should Do' recommendations from the CQC as part of the Trust's Compliance Plan.

Governance and licence compliance (provider licence section 4)

In May 2024, the Board self-certified compliance with Licence Conditions G6 (Systems for Compliance) and FT4 (Governance Arrangements). The declarations were based on internal review of the BAF, governance documentation, internal and external audits, and the Trust's Annual Report and Accounts. These statements were published on the Trust's website, in line with national guidance.

The Board confirmed that:

- Its governance structures, responsibilities, and reporting lines remained effective
- Oversight of organisational performance, risk, and quality was conducted rigorously
- Submissions of information were timely, accurate, and used to inform licence compliance and risk assessment

No material risks to compliance with licence conditions were identified.

Embedding risk management

All committees, Executive groups and reporting fora within the Trust's governance structure have responsibilities for risk identification and management. The governance structure has clear lines of accountability and reporting up to Board through Chairs' Assurance Reports to ensure risks are escalated as appropriate.

The Corporate Risk report received by the Trust Management Group is also received by the Trust Board on a bi-monthly basis. Corporate risk reports are received by the relevant Board Committees in accordance with the alignment of a responsible Committee. For example, the Quality Committee is responsible for risks aligned to the Trust's strategic objectives relating to quality.

The Trust has a Quality Impact Assessment (QIA) process in place to ensure that a change project is assessed for the impact on the quality of patient services before a project is authorised to proceed. All proposed cost and quality improvement schemes require a formal QIA to be evaluated by the relevant division, against seven domains prior to a review by the medical director and chief nurse. The Quality Committee received reports on QIAs for current programmes and projects in 2023/24.

Incident reporting

The Trust changed its assurance processes for the management of PSI in September 2023 when it transitioned from the previous Serious Incident Framework (2015) to the new NHSE PSIRF.

All incidents reported on Datix are reviewed within divisions and managed proportionately and in a timely way with local / immediate actions where appropriate. This includes divisionally led learning responses, for example, rapid reviews, round table meetings and after-action reviews. Divisions may also escalate any incidents where there is need for a more in-depth investigation or when a discussion / Executive oversight is needed to commission the most appropriate learning response. These incidents are discussed at the weekly executive led Safety Incident Review Forum (SIRF). In addition, the Executives review all incidents graded moderate and above on a weekly basis.

The patient safety team review all PSI and triangulates data from other sources such as patient experience and legal matters to proactively identify themes and trends. They also conduct retrospective thematic reviews of incidents to identify areas for improvement. Within the PSIRP there are three areas which have been identified as priorities for focused learning and improvement (based on the risk profile of the previous year). In 2023/24/25 these were:

- Nutrition and hydration
- Identification and escalation of the deteriorating patient
- Venous thromboembolism

Further analysis of patient safety related organisational data is underway to update our PSIRP for 2025/26 and inform the safety priorities that will undergo in-depth PSII. These will be agreed at Patient Safety and Experience Group and Quality Committee in April-May 2025.

The executive led PSII Sign Off Panel is responsible for the oversight and review of all PSIIs to assess the quality of the investigations, involvement and engagement of those affected, appropriate analysis of findings, and safety actions. The Evidence Assurance Group provides further oversight and assurance of PSII safety action completion and embedded learning for incidents meeting the criteria of a never event and those investigated by Maternity and Newborn Safety Investigations (MNSI).

The Quality Committee, Non-Executive Director led Committee of the Board, seeks assurance that the Trust has effective systems in place to respond to any issues identified within PSIs. The Quality Committee receives a quarterly report on thematic trends and learning from PSI, PSIIs, and never events, together with compliance assurance with Duty of Candour. The Committee reports through to the Board, escalating any issues as necessary, through the Chair's Assurance Report.

The Trust has continued its focus to promote a safety culture and proactive incident reporting. Learning from incidents, legal matters, patient experience and quality

improvement is regularly shared across the organisation. This is via patient safety alerts, bulletins, PSLE and a patient safety newsletter disseminated every two months (launched in Autumn 2024).

There were two PSLEs in 2024/25; one half day event focusing on nutrition and hydration, one full day event coinciding with the World Health Organisation (WHO) World Patient Safety Day. Attendees included colleagues from organisations across the ICS, subject matter experts from multiple disciplines across the Trust, Non-Executive Directors, colleagues from Norfolk and Waveney ICB, external partners, and it was available to all staff to attend. This event focused on the WHO global theme of improving diagnosis for patient safety – Get It Right, Make It Safe. Aligning with the PSIRP priority, identification and escalation of deteriorating patients, medicines optimisation, awareness of diagnostic overshadowing and innovations and research in diagnostic assessments. The themes underpinned the principles of PSIRF and supported a systems based approach to patient safety and elements of human factors.

During 2024/25 the governance processes continued to be strengthened and there has been a focus on improvement in several areas:

- Continued improvement in the oversight of PSIs through successful embedding of regular divisional huddles. This has also improved engagement with incident management at ward and service level
- Adopting a data analysis approach that triangulates multiple sources of organisational intelligence to enhance system-wide understanding of safety, thereby informing continuous improvement and learning
- Improvements in data quality and oversight of patient safety information, specifically identifying themes and trends, via the monthly Patient Safety Activity Report and Quarterly Safety Trends Report which are presented at the Patient Safety and Experience Executive Group and Quality Committee
- Development of the Datix that supports the review, investigation, and approval of incidents and safety actions. Continued work to improve how staff receive feedback on the outcome of reviews of incidents they have reported
- Implementation of LFPSE service within the local Datix platform. This supports learning and benchmarking for patient safety events reported by healthcare organisations nationally, helping to inform national strategies and patient safety alerts
- A robust and transparent process for approval of PSIIs at executive level is well established and attended regularly by Lead Investigators and divisional risk and governance leads
- Enhancement of compassionate engagement (in line with the NHSE Patient Safety Strategy 2019) with those affected by patient safety incidents, including patients, their families, and staff to understand their unique experience / perspective of PSI, thereby facilitating effective learning. This has been further supported through collaboration between the patient safety team and the

education faculty in the development of cross-system targeted training, planned for roll-out from April 2025

- Development of a multi-disciplinary approach which promotes psychological safety in all staff interactions to enhance the safety culture and collective ownership of patient safety. This has benefited from significant collaboration with colleagues in the education faculty FTSU team
- Use of Just Restorative Culture when staff are involved with patient safety events. The Trust's Patient Safety Partner attends all important patient safety meetings and contributes to 'the voice of the patient' to discussions and decisions
- Collaborative working between patient safety and improvement to ensure patient safety data, safety themes, and soft intelligence is used to inform risk profiles and proactively and proportionally manage resources to deliver improvements
- Continued monitoring of the Duty of Candour to ensure compliance with standards, ensuring findings are consistently shared with patients and families
- Associate director of patient safety and improvement achieved Level 3 and 4 of the Patient Safety Syllabus securing qualification as a Patient Safety Specialist (PSS) from Loughborough University fulfilling the NHS contract requirement for organisations to have PSS in post
- Trust's PSS continues to attend regular national, regional, and local system PSS meetings, developing key patient safety networks and partnerships to support the embedding of the NHS Patient Safety Strategy. The Trust also continued to work with system partners and NHS England to support the continued development of the NHS Learn from Patient Safety Events during the 2024/25 fiscal year

Involvement of public stakeholders in risk

Our engagement with our stakeholders produces an additional layer of scrutiny and challenge from broad representative areas of our population groups and therefore enables the Trust to remain grounded and responsive to the communities we serve.

Public stakeholders are involved in the management of risks which impact on them through public meetings of the Board, and our attendance at Health Overview and Scrutiny meetings.

Governors are involved in discussions about risks which impact on patients and members through regular meetings including the Council of Governors and Governor sub-committees. They are involved in the development of the Trust's strategy and annual strategic objective setting.

There is ICB and patient representation on the Trust's Serious Incident Review Forum.

The Trust has a valued and constructive working relationship with Healthwatch Norfolk and Healthwatch Cambridgeshire and Peterborough, the latter through the Fenland and East Cambridgeshire Health and Care Forum.

The Trust is engaged with partner organisations in the local health and care system in discussing quality and risk issues impacting on patients, in particular through work of the Norfolk and Waveney ICS, the Cambridgeshire and Peterborough ICS and the Lincolnshire ICS and through the Norfolk and Waveney Acute Hospital Collaborative.

Further information regarding patient and public engagement in the Trust is included in the Annual Report.

Workforce strategies and staffing systems

The People and Culture Committee, the non-executive director led committee of the Board which reviews, monitors, and reports to the Board on workforce KPIs, human resources management, key risks and medical and non-clinical staffing and education and research performance via the Chair's Assurance Report. The Committee also monitors performance against the aligned Corporate Strategy KPIs on a quarterly basis. The People Committee is also responsible for monitoring workforce metrics which are reported to Board through the Integrated Performance Report. The report also details Trust performance against workforce KPIs, and actions being taken to address underperformance. The Committee receives Chair's Action Reports from the People Executive Group which in term receives assurance from tier 4 groups which deliver and report on elements of the Trust's People related Corporate Objectives.

The People Committee has provided oversight of the People elements of the Trust's long term corporate strategy and the 2024/25 People Plan.

'Developing Workforce Safeguards' guidance (NHSI 2018), sets out a clear accountability framework for NHS organisations in relation to expectations for the delivery of best practice standards for workforce deployment and planning. As part of the workforce metrics the People Committee and Board also receive information in relation to recruitment activity, vacancies, and turnover. The People Directorate is fully engaged with the development of Trust finance, activity, and workforce planning as part of system annual planning submissions. The Trust also works with external stakeholders and partners across the ICS to review system workforce plans and deliver on system wide workforce initiatives.

The FTSU Guardian post is under the responsibility of a Board level director supported by a Non-Executive Director. The FTSU Guardian reports to the People Committee and the Board and reports quarterly to the National Guardian's Office. All FTSU cases are reported to the Board on a bi- annual basis.

The People and Culture Committee also receives information via the People Executive Group Chairs Assurance Report about pre-employment check compliance

and received specific items on National Staff Survey results, GMC survey results and the actions resulting from them.

The Care Quality Commission Registration Requirements

The Trust is registered with the CQC, and its current registration is 'Registered with Conditions'. The Trust last underwent an unannounced core service and Well-Led CQC inspection between December 2021 and January 2022. The ratings for well-led were based on the inspection at trust level, taking into account what CQC found in individual services. The inspection report, published in February 2022, recognised the significant progress the Trust had made and recommended that the Trust be removed from the Recovery Support Programme (formally known as special measures). On 14 April 2022, the National Medical Director for NHSEI confirmed the decision to approve the Trust's transition from System Oversight Framework (SOF) four – 'Mandated Intensive Support' to SOF three – 'Mandated Regional Support'.

Four conditions, imposed under Section 31 of the Health and Social Care Act 2008, remain on the Trust's registration. These relate to Urgent and Emergency Care, Diagnostic and Screening services and Maternity and Midwifery services.

Improvements have been made, and the Trust will apply for the removal of all four conditions during the first quarter of 2025/26.

The Maternity service was inspected in October 2023 as part of the CQC national maternity inspection programme. The programme aims to give an up-to-date view of hospital maternity care across the country and help understanding of what is working well to support learning and improvement at a local and national level.

This was a short notice announced focused inspection of the maternity service, looking at the safe and well-led key questions only. The rating for Maternity services improved to 'Good' overall, with Safe rated as 'Requires Improvement' and Well-Led rated as 'Good'. It was recognised staff worked well together for the benefit of women and birthing people and engaged with the community to plan and manage services. A significant improvement in culture was noted with staff feeling respected, supported, and valued. Leaders had the skills and abilities to run the service, with a focused vision and strategy on sustainability of services aligned to local plans within the wider health economy.

These ratings did not change the ratings for the hospital overall.

Throughout 2024/25, staff across the Trust have continued to work on improving patient care and experience. Regular open and transparent engagement with the CQC has also continued.

The Foundation Trust is not fully compliant with the registration requirements of the Care Quality Commission.

Conflicts of interest

The Foundation Trust has published on its website an up-to-date register of interests, including gifts and hospitality, for decision-making staff (as defined by the trust with reference to the guidance) within the past twelve months as required by the Managing Conflicts of Interest in the NHS guidance. The register for the Board can be found at www.qehkl.nhs.uk/register-of-interests.asp

NHS Pension Scheme

As an employer with staff entitled to membership of the NHS Pension Scheme, control measures are in place to ensure all employer obligations contained within the Scheme regulations are complied with. This includes ensuring that deductions from salary, employer's contributions and payments into the Scheme are in accordance with the Scheme rules, and that member Pension Scheme records are accurately updated in accordance with the timescales detailed in the Regulations.

Equality, diversity and human rights

Control measures are in place to ensure that all the organisation's obligations under equality, diversity and human rights legislation are complied with.

Climate change

The Foundation Trust has undertaken risk assessments on the effects of climate change and severe weather and has developed a Green Plan following the guidance of the Greener NHS programme. The Trust ensures that its obligations under the Climate Change Act and the Adaptation Reporting requirements are complied with.

Just two of the key projects achieved this year at The QEH are:

1. Two new food digestors have been installed at The QEH this year.
   This new equipment will support the Trust in monitoring its food waste, turning food waste into a sterile powder which weighs just 20% or less of its former weight. This powder can then either go onto an anaerobic digestion plant, where bacteria is used to breakdown the organic matter, for industrial composting or to a waste-to-energy plant where the waste will be burnt to generate energy.

   To give some context our food waste is an average 7,166 Kg of food waste per month, which is a combination of food waste across the Trust including approximately 2,000 uneaten meals from the wards of more than 43,500 patient meals served. This new investment will have a big impact on reducing our total waste.
2. Thanks to a successful bid to the NHS National Energy Efficiency Fund, the hospital has been awarded £585,792 to upgrade our lighting to the latest

energy-efficient LEDs. We already have approximately 80% LEDs throughout our estate, but some of the units are around a decade old and less efficient that more modern lighting.

With new super-efficient lights and complete LED coverage we will see some big energy savings of around 50% each year and financial savings of at least £224,000 per annum. Energy Efficient Solutions Group is carrying out installations between now and the end of March. This move supports our Green Plan and goal to significantly reduce our carbon footprint.

Information governance

Maintaining the security of the information that the Trust holds is the responsibility of the director of digital (formally chief digital and information officer). The director of finance undertakes the role of senior information risk owner (SIRO) who supports the Chief Executive and the Board in ensuring compliance with appropriate standards and managing information risks. The director of digital has overseen the implementation of a wide range of measures to protect the data held and information flows to underpin the Trust's Information Governance assurance statements and its assessment against the Data Security Protection Toolkit (DSPT).

The director of digital provides strategic oversight and accountability for the robustness of the Trust's clinical and non-clinical IT systems.

The Trust has a chief clinical Information Officer. Information Governance compliance is managed by the head of information governance who is the data protection officer, with responsibility for ensuring that appropriate procedures and processes are in place. The information governance manager provides support for the day-to-day management of Information Governance. There is an Information Governance and Cyber Security Forum which oversees compliance, issues and incidents, receives assurance and reports on action plans and projects. The SIRO chairs this meeting which has representatives from across the Trust. The Information Governance and Cyber Security Forum is accountable to the Audit Committee. The Information Governance and Cyber Security Forum regularly reports and informs on progress and compliance against the standards and the SIRO signs off the annual DSPT submission. During 2024/25 the Trust had four serious information governance reportable incidents that required reporting as a breach via the DPST to the Information Commissioners Office (ICO). A full investigation of each breach took place, and recommendations were introduced to mitigate the risk of reoccurrence. The ICO reviewed all incidents and confirmed there was no further action required on these breaches.

Data quality and governance

The Trust has established processes that ensure the accuracy of all performance data, including Elective Waiting Times. Methods employed include automated daily data quality reporting to operational services, alerting them to anomalies, enabling these to be resolved at the source. As a final check, all submissions are formally validated by the information owners before being released into the Trust performance reviews.

Data quality is a shared responsibility among all Trust employees. The Trust offers data quality guidance and support to all employees, aligning with good practices and standards observed by comparable NHS Trusts. Data quality training is integrated into the Trust's induction process.

Throughout the year, we have made progress on the future of the EPR across the ICS. Information has been included in these discussions to ensure the Trust is prepared to support implementation from a reporting and data quality perspective. This includes preparing our data and existing clinical systems for migration.

Furthermore, it is recognised that the introduction of EPR and the associated increase in data reliance will require robust Master Data Management. Digital is promoting the introduction of automated tools to ensure data quality for the future.

Review of economy, efficiency, and effectiveness of the use of resources

The Board of Directors has specified within the Trust's Standing Financial Instructions and the Scheme of Delegation, appropriate delegated authority levels throughout the Trust. Executive Directors and managers have responsibility for the effective management and deployment of their staff and other resources to optimise the efficiency of each division.

Each year, as part of the annual planning process, the Board approves the Trust's overall capital and financial budget that includes an efficiency improvement target. All efficiency, cost improvement and transformation plans are subjected to quality impact assessment led by the medical director and chief nurse. The progress and delivery of these efficiency improvements are monitored at divisional level and consolidated for an overall Trust position and reported as part of the monthly reporting cycle.

The Trust's financial performance is considered at both executive and non-executive committees, giving the opportunity to review and challenge the financial position. Regular performance meetings between Executive Directors and Divisional Leadership teams allow a full review of Financial and efficiency, activity and workforce performance against plan.

Our External Auditor considers the elements of the Trust's financial sustainability, governance and improving economy, efficiency, and effectiveness in its assessment of Value for Money as part of the annual audit.

The Board has considered its Going Concern position at its meeting on 26 June 2025 as part of the 2024/25 annual report and accounts approval process. After due consideration of the risks and uncertainties the Board have confirmed that the use of the Going Concern basis in preparation of the annual accounts is appropriate. There are no material uncertainties related to events or conditions that may cast significant doubt about the ability of the Trust to continue as a going concern as defined by the GAM.

For 2025/26, the Trust has followed the national guidance for financial planning and contracting. The Directors of the Licensee consider that the Trust will have adequate resources made available to it to deliver commissioner requested services during 2025/26.

The Trust reports monthly on our financial performance and delivery against its targets and plans to the Norfolk and Waveney system and regional teams through the national reporting submissions.

The Trust submitted a £9.5m deficit plan for 2024/25 which included a challenging £29.5m efficiency programme. ICB Deficit support was allocated to the Trust in September 2024 of £8.7m reducing the planned deficit to £0.8m. The Trust's actual financial performance for 2024/25 delivered a £38.5m deficit (before impairments), although this was within the agreed and approved revised financial forecast.

The scale of the deficit in the early parts of 2024/25 led to the Trust embarking on a significant financial recovery plan in October 2024. This programme consisted of additional capacity and focus to enable driving through of efficiencies to reduce the deficit. There have been 3 phases to the work undertaken:

- Ensuring strong grip and control including delivering through actions such as vacancy control, ensuring that agency and other forms of temporary workforce spend are used only when clinically necessary. Putting in place forward looks for key areas of spend such as temporary pay spend, to ensure adequate control
- Development of tactical CIP savings with each divisional and corporate areas identifying where they can make savings
- Development of themed, more strategic savings plans, including areas such as theatre and outpatient productivity, management of temporary workforce needs, ensuring appropriate patient flow on emergency pathways and ensuring strategic savings plans for procurement

A Quality Impact Assessment is undertaken on all savings that are identified. The Trust has established a Financial Improvement and Productivity forum and is overseeing the development and progression of recovery plans.

To date the recovery process has seen a reduction in the deficit from the average monthly deficit of £3.3m for the first half of 2024/25 to £2.3m in the second half of the year with an underlying deficit of £1.9m in March.

The actual performance for the year was a £38.5m deficit, this was in line with the revised forecast financial position developed in November 2024.

The financial environment for 2025/26 and beyond will remain challenging for the Trust, the ICS and the region.

The Trust's has agreed and submitted a breakeven plan for 2025/26, which includes £22.5m additional system support and an £18.3m efficiency target, this is a challenging but a realistic target and builds on the financial recovery progress made by the Trust in the second half of 2024/25.

Delivery of the Trust's breakeven plan will be contingent upon a robust efficiency programme, enhanced and embedded managements controls, and developing flexible and new ways of delivery patient care taking advantage of the opportunities presented through Group working.

The Trust has a range of systems and processes in place to provide assurance that resources are used economically, efficiently, and effectively. These include:

- Standing Financial Instructions and Scheme of Delegation
- Executive oversight of the Trust finance performance, activity plans and efficiency progress and delivery
- Anti-Fraud and Anti-Bribery Policy
- Benchmarking through the mandatory National Cost Collection process
- Financial sustainability through Service Line Reporting
- Management of Conflicts of Interest (including Gifts, Hospitality and Sponsorship) Policy
- 'Getting it Right First Time' (GIRFT) reviews

Assurance on financial controls is provided throughout the year by Internal and as part of the Annual Accounts process by External Audit.

Disclosure

We have received the Head of Internal Audit opinion which provides reasonable / moderate assurance that governance, risk management and control in relation to business-critical areas is generally satisfactory. No critical or high-risk findings have been raised. There are some medium risk findings in the framework of governance, risk management and control which potentially put the achievement of objectives at risk. Some improvements are required in those areas to enhance the adequacy and effectiveness of the framework of governance, risk management and control.

A total of five internal audit reviews have been reported to the Audit Committee during the year. This resulted in the identification of zero critical, zero high, 15 medium and five low risk findings to improve weaknesses in the design of controls and / operating effectiveness. Areas of good practice were also identified.

These findings are accepted by management and work has commenced to ensure improvement during 2025/26 and action plans will respond to these findings.

Through the Internal Audit programme for 2024/25 the Trust commissioned a range of audits to provide assurance on the system of internal control. These included:

- Key financial systems
- People and workforce planning
- Data security and protection toolkit
- Management of serious incidents
- Partnership working

In addition to the Internal Audit Programme the Trust commissioned separate areas of review and advisory work on:

- Run rate and balance sheet analysis

All internal audit recommendations are being addressed, and delivery progress is monitored by the Audit Committee.

Professor Lesley Dwyer
Group Chief Executive

26 June 2025

Financial Report

Annual Accounts for the year ended 31 March 2025

The accounts for the year ended 31 March 2025 have been prepared by the Board of Directors of The Queen Elizabeth Hospital King's Lynn NHS Foundation Trust in accordance with paragraphs 24 and 25 of schedule 7 within the National Health Service Act 2006.

Marcus Thorman,
Group Finance Director

26 June 2025

Independent Auditor's Report

INDEPENDENT AUDITOR'S REPORT TO THE COUNCIL OF GOVERNORS OF QUEEN ELIZABETH HOSPITAL KING'S LYNN NHS FOUNDATION TRUST

REPORT ON THE AUDIT OF THE FINANCIAL STATEMENTS

Opinion

We have audited the financial statements of Queen Elizabeth Hospital King's Lynn NHS Foundation Trust ("the Trust") for the year ended 31 March 2025 which comprise the Statement of Comprehensive Income and Expenditure, Statement of Financial Position, Statement of Changes in Equity and Statement of Cash Flows], and the related notes, including the accounting policies in note 1.

In our opinion the financial statements:

- give a true and fair view of the financial position of the Trust as at 31 March 2025 and of its income and expenditure for the year then ended; and
- have been properly prepared in accordance with the accounting policies directed by NHS England with the consent of the Secretary of State in February 2025 as being relevant to NHS Foundation Trusts and included in the Department of Health and Social Care Group Accounting Manual 2024/25; and
- have been prepared in accordance with the requirements of the National Health Service Act 2006 (as amended).

Basis for opinion

We conducted our audit in accordance with International Standards on Auditing (UK) ("ISAs (UK)") and applicable law. Our responsibilities are described below. We have fulfilled our ethical responsibilities under, and are independent of the Trust in accordance with, UK ethical requirements including the FRC Ethical Standard. We believe that the audit evidence we have obtained is a sufficient and appropriate basis for our opinion.

Going concern

The Accounting Officer has prepared the financial statements on the going concern basis as they have not been informed by the relevant national body of the intention to either cease the Trust's services or dissolve the Trust without the transfer of its services to another public sector entity. They have also concluded that there are no material uncertainties that could have cast significant doubt over its ability to continue as a going concern for at least a year from the date of approval of the financial statements ("the going concern period").

In our evaluation of the Accounting Officer's conclusions, we considered the inherent risks associated with the continuity of services provided by the Trust over the going concern period.

Our conclusions based on this work:

- we consider that the Accounting Officer's use of the going concern basis of accounting in the preparation of the financial statements is appropriate; and
- we have not identified and concur with the Accounting Officer's assessment that there is not, a material uncertainty related to events or conditions that, individually or collectively, may cast significant doubt on the Trust's ability to continue as a going concern for the going concern period.

However, as we cannot predict all future events or conditions and as subsequent events may result in outcomes that are inconsistent with judgements that were reasonable at the time they were made, the above conclusions are not a guarantee that the Trust will continue in operation.

Fraud and breaches of laws and regulations - ability to detect

Identifying and responding to risks of material misstatement due to fraud

To identify risks of material misstatement due to fraud ("fraud risks") we assessed events or conditions that could indicate an incentive or pressure to commit fraud or provide an opportunity to commit fraud. Our risk assessment procedures included:

- Enquiring of management, the Audit Committee and internal audit and inspection of policy documentation as to the Trust's high-level policies and procedures to prevent and detect fraud, including the internal audit function, and

the Trust's channel for "whistleblowing", as well as whether they have knowledge of any actual, suspected, or alleged fraud.

- Assessing the incentives for management to manipulate reported financial performance because of the need to achieve financial performance targets delegated to the Trust by NHS England.
- Reading Board and Audit Committee minutes.
- Using analytical procedures to identify any unusual or unexpected relationships.

We communicated identified fraud risks throughout the audit team and remained alert to any indications of fraud throughout the audit.

As required by auditing standards, and taking into account possible pressures to meet delegated targets, we performed procedures to address the risk of management override of controls in particular the risk that Trust management may be in a position to make inappropriate accounting entries. On this audit we did not identify a fraud risk related to revenue recognition due to the block nature of the funding provided to the Trust during the year. We therefore assessed that there was limited opportunity for the Trust to manipulate the income that was reported.

We also identified a fraud risk related to the cut off of non-pay, non-depreciation expenditure in response to incentives to manipulate the results of the Trust to meet their adjusted performance target for the year particularly in relation to accruals. We performed procedures including:

- Identifying journal entries and other adjustments to test based on risk criteria and comparing the identified entries to supporting documentation. These included those posted to unusual cash or unusual expenditure account combinations, and those journals that move costs from expenditure to capital March 2025.
- Assessing whether the judgements made in making accounting estimates are indicative of a potential bias.
- Selecting a sample of expenditure postings either side of the year end date and vouching to supporting evidence to ensure the expenditure has been recognised in the correct year.
- Selecting a sample of accruals meeting our high-risk criteria and vouching to supporting evidence to ensure existence and accuracy of accrued expenditure.

Identifying and responding to risks of material misstatement related to compliance with laws and regulations

We identified areas of laws and regulations that could reasonably be expected to have a material effect on the financial statements from our general sector experience and through discussion with the Accounting Officer and other management (as required by auditing standards), and discussed with the Accounting Officer and other management the policies and procedures regarding compliance with laws and regulations.

We communicated identified laws and regulations throughout our team and remained alert to any indications of non-compliance throughout the audit.

The potential effect of these laws and regulations on the financial statements varies considerably.

Firstly, the Trust is subject to laws and regulations that directly affect the financial statements, including the financial reporting aspects of NHS legislation. We assessed the extent of compliance with these laws and regulations as part of our procedures on the related financial statement items.

Secondly, the Trust is subject to many other laws and regulations where the consequences of non-compliance could have a material effect on amounts or disclosures in the financial statements, for instance through the imposition of fines or litigation. We identified the following areas as those most likely to have such an effect: health and safety, data protection laws, anti-bribery, employment law, contract law, climate change and environmental protection, and compliance with the Care Quality Commission (CQC) recognising the nature of the Trust's activities.

Auditing standards limit the required audit procedures to identify non-compliance with these laws and regulations to enquiry of the Accounting Officer and other management and inspection of regulatory and legal correspondence, if any. Therefore, if a breach of operational regulations is not disclosed to us or evident from relevant correspondence, an audit will not detect that breach.

Context of the ability of the audit to detect fraud or breaches of law or regulation

Owing to the inherent limitations of an audit, there is an unavoidable risk that we may not have detected some material misstatements in the financial statements, even though we have properly planned and performed our audit in accordance with auditing standards. For example, the further removed non-compliance with laws and regulations is from the events and transactions reflected in the financial statements, the less likely the inherently limited procedures required by auditing standards would identify it.

In addition, as with any audit, there remained a higher risk of non-detection of fraud, as fraud may involve collusion, forgery, intentional omissions, misrepresentations, or the override of internal controls. Our audit procedures are designed to detect material misstatement. We are not responsible for preventing non-compliance or fraud and cannot be expected to detect non-compliance with all laws and regulations.

Other information in the Annual Report

The Accounting Officer is responsible for the other information, which comprises the information included in the Annual Report, other than the financial statements and our auditor's report thereon. Our opinion on the financial statements does not cover the other information and, accordingly, we do not express an audit opinion or, except as explicitly stated below, any form of assurance conclusion thereon.

Our responsibility is to read the other information and, in doing so, consider whether, based on our financial statements audit work, the information therein is materially misstated or inconsistent with the financial statements or our audit knowledge. Based solely on that work:

- we have not identified material misstatements in the other information; and
- in our opinion the other information included in the Annual Report for the financial year is consistent with the financial statements.

Remuneration and Staff Reports

In our opinion the parts of the Remuneration and Staff Reports subject to audit have been properly prepared, in all material respects, in accordance with the NHS Foundation Trust Annual Reporting Manual 2024/25.

Accounting Officer's responsibilities

As explained more fully in the statement set out on page 166, the Accounting Officer is responsible for the preparation of financial statements that give a true and fair view. They are also responsible for: such internal control as they determine is necessary to enable the preparation of financial statements that are free from material misstatement, whether due to fraud or error; assessing the Trust's ability to continue as a going concern, disclosing, as applicable, matters related to going concern; and using the going concern basis of accounting unless they have been informed by the relevant national body of the intention to either cease the services provided by the Trust or dissolve the Trust without the transfer of its services to another public sector entity.

Auditor's responsibilities

Our objectives are to obtain reasonable assurance about whether the financial statements as a whole are free from material misstatement, whether due to fraud or error, and to issue our opinion in an auditor's report. Reasonable assurance is a high level of assurance, but does not guarantee that an audit conducted in accordance with ISAs (UK) will always detect a material misstatement when it exists. Misstatements can arise from fraud or error and are considered material if, individually or in aggregate, they could reasonably be expected to influence the economic decisions of users taken on the basis of the financial statements.

A fuller description of our responsibilities is provided on the FRC's website at www.frc.org.uk/auditorsresponsibilities.

REPORT ON OTHER LEGAL AND REGULATORY MATTERS

Report on the Trust's arrangements for securing economy, efficiency and effectiveness in its use of resources

Under the Code of Audit Practice, we are required to report if we identify any significant weaknesses in the arrangements that have been made by the Trust to secure economy, efficiency and effectiveness in its use of resources.

Except for the matters explained below we have nothing to report in this respect:

Significant Weakness - Financial sustainability

The Trust is going into 2025/26 with an underlying deficit of approximately £33m following the £38.5m adjusted performance deficit for the year ended 31st March 2025. It has submitted a break-even plan for 2025/26 which is only achievable with a £18.3m cost improvement programme ("CIP") target and if £22.5m of non-recurrent deficit support funding is received. Given the delivery of the majority of the identified efficiencies have been rated as high risk by the Trust and the Trust's historic performance in delivering its CIP targets, there is a risk that the CIP will not be achieved. This combined with the reliance of non-recurrent deficit support funding has resulted in us identifying a significant weakness over the arrangements the Trust has in place to achieve financial sustainability.

Recommendation:

We recommend the Trust take appropriate steps to action and embed the findings and recommendations from its financial recovery plan into the day-to-day operations of the Trust to reduce their underlying deficit and return to a break-even position that is not reliant upon non-recurrent deficit support funding.

Significant Weakness - Improving economy, efficiency and effectiveness

The Trust only achieved £6.8m of the planned £29.5m CIP for 2024/25, being 1.7% of total expenditure. In addition to being significantly less than plan, it is also less than the Trust has been able to achieve in previous years. We have therefore identified a significant weakness around the identification, monitoring, reporting and delivery of the Trust's Efficiency programme

Recommendation:

The Trust should engage and obtain buy-in from budget holders and clinicians to ensure that CIP targets can be realistically delivered. The Trust should review and challenge identified efficiencies to ensure that the CIP is sustainable without impacting the operational effectiveness of the Trust. Appropriate reporting should be provided to the Finance and Performance committee, as well as the Trust Board, to provide them with the assurance that the plans are achieving the expected efficiencies and allow them to identify and respond to any risks to delivery identified.

Respective responsibilities in respect of our review of arrangements for securing economy, efficiency and effectiveness in the use of resources

As explained more fully in the statement set out on page 166, the Accounting Officer is responsible for ensuring that the Trust has put in place proper arrangements for securing economy, efficiency and effectiveness in its use of resources.

Under Section 62(1) and paragraph 1(d) of Schedule 10 of the National Health Service Act 2006 we have a duty to satisfy ourselves that the Trust has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources.

We are not required to consider, nor have we considered, whether all aspects of the Trust's arrangements for securing economy, efficiency and effectiveness in its use of resources are operating effectively. We are also not required to satisfy ourselves that the Trust has achieved value for money during the year.

We planned our work and undertook our review in accordance with the Code of Audit Practice and related statutory guidance, having regard to whether the Trust had proper arrangements in place to ensure financial sustainability, proper governance and to use information about costs and performance to improve the way it manages and delivers its services. Based on our risk assessment, we undertook such work as we considered necessary.

Statutory reporting matters

We are required by Schedule 2 to the Code of Audit Practice to report to you if:

- we issue a report in the public interest under paragraph 3 of Schedule 10 of the National Health Service Act 2006; or
- we make a referral to the Regulator under paragraph 6 of Schedule 10 of the National Health Service Act 2006 because we have reason to believe that the Trust, or a director or officer of the Trust, is about to make, or has made, a decision which involves or would involve the incurring of expenditure which is unlawful, or is about to take, or has taken, a course of action which, if pursued to its conclusion, would be unlawful and likely to cause a loss or deficiency.

We have nothing to report in these respects.

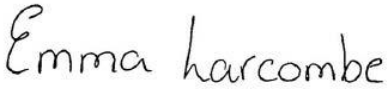
THE PURPOSE OF OUR AUDIT WORK AND TO WHOM WE OWE OUR RESPONSIBILITIES

This report is made solely to the Council of Governors of the Trust, as a body, in accordance with Schedule 10 of the National Health Service Act 2006. Our audit work has been undertaken so that we might state to the Council of Governors of the Trust, as a body, those matters we are required to state to them in an auditor's report and for no other purpose. To the fullest extent permitted by law, we do not accept or assume responsibility to anyone other than the Council of Governors of the Trust, as a body, for our audit work, for this report, or for the opinions we have formed.

DELAY IN CERTIFICATION OF COMPLETION OF THE AUDIT

As at the date of this audit report, we are unable to confirm that we have completed our work in respect of the trust accounts consolidation pack of the Trust for the year ended 31 March 2025 because we have not received confirmation from the NAO that the NAO's audit of the Department of Health and Social Care accounts is complete.

Until we have completed this work, we are unable to certify that we have completed the audit of Queen Elizabeth Hospital King's Lynn NHS Foundation Trust for the year ended 31 March 2025 in accordance with the requirements of Schedule 10 of the National Health Service Act 2006 and the NAO Code of Audit Practice.



Emma Larcombe

For and on behalf of KPMG LLP

Chartered Accountants

KMPG LLP

20 Station Road

Cambridge

CB1 2JD

27 June 2025

Statement of Comprehensive Income for the year ended 31 March 2025
£'000

	Note	2024/25	2023/24
Operating income from patient care activities	3.1	298,617	297,405
Other operating income	3.4	26,806	24,428
Operating expenses	4.1	(405,212)	(357,482)
Operating deficit from continuing operations		**(79,789)**	**(35,649)**
Finance income	8	909	1,796
Finance expenses	9	(6)	(16)
PDC dividends payable		(4,155)	(3,618)
Net finance costs		**(3,252)**	**(1,838)**
Other gains / losses	10	(39)	-
Deficit for the year from continuing operations		**(83,080)**	**(37,487)**
Deficit for the year		**(83,080)**	**37,487**
Other comprehensive income			
Will not be reclassified to income and expenditure:			
Revaluations	22	2,321	178
Total comprehensive expense for the year		**(80,759)**	**(37,309)**
Adjusted financial performance (control total basis):			
Deficit for the year		(83,080)	(37,487)
Remove expenditure impact of impairments		47,206	37,648
Remove net impact of DHSC centrally procured inventory		14	-
Remove I&E impact of capital grants and donations		(2,618)	(142)
Adjusted financial performance (deficit)/surplus		(38,478)	19

All income and expenditure is derived from continuing operations.

The accompanying notes from part of these accounts.

Statement of Financial Position as at 31 March 2025, £'000

	Note	31/03/2025	31/03/2024
Non-current assets			
Intangible assets	11	10,948	467
Property, plant and equipment	12	145,337	146,655
Right of use assets	12	231	409
Receivables	14	391	539
Total non-current assets		**156,907**	**148,070**
Current assets			
Inventories	13	3,247	3,637
Receivables	14	8,662	8,901
Cash and cash equivalents	15	21,974	28,399
Total current assets		**33,883**	**40,937**
Current liabilities			
Trade and other payables	16	(50,228)	(43,554)
Borrowings	18	(168)	(264)
Provisions	19	(195)	(120)
Other liabilities	17	(1,807)	(937)
Total current liabilities		**(52,398)**	**(44,875)**
Total assets less current liabilities		**138,392**	**144,132**
Non-current liabilities			
Provisions	19	(204)	(236)
Borrowings	18	(66)	(149)
Other liabilities	17	(909)	(1,185)
Total non-current liabilities		**(1,179)**	**(1,570)**
Total assets employed		**137,213**	**142,562**
Financed by			
Public dividend capital		390,517	315,107
Revaluation reserve	22	3,139	818
Income and expenditure reserve		(256,443)	(173,363)
Total taxpayers' equity		**137,213**	**142,562**

The accompanying notes form part of these accounts.

The financial statements on pages 183 to 241 were approved by the Board on 26 June 2025 and signed on its behalf by:

Marcus Thorman,
Group Finance Director

26 June 2025

Statement of Changes in Equity for the year ended 31 March 2025, £'000

	Public dividend capital	Revaluation reserve	Income and expenditure reserve	Total
Taxpayers' and others' equity at 1 April 2024 - brought forward	**315,107**	**818**	**(173,363)**	**142,562**
Revaluation	-	2,321	-	2,321
Deficit for the year	-	-	(83,080)	(83,080)
Public dividend capital received	75,410	-	-	75,410
Taxpayers' and others' equity at 31 March 2025	**390,517**	**3,139**	**(256,443)**	**137,213**

Statement of Changes in Equity for the year ended 31 March 2024, £'000

	Public dividend capital	Revaluation reserve	Income and expenditure reserve	Total
Taxpayers' and others' equity at 1 April 2023 - brought forward	**269,031**	**640**	**(135,876)**	**133,795**
Revaluation	-	178	-	178
Deficit for the year	-	-	(37,487)	(37,487)
Public dividend capital received	46,076	-	-	46,076
Taxpayers' and others' equity at 31 March 2024	**315,107**	**818**	**(173,363)**	**142,562**

The accompanying notes form part of these financial statements.

Information on reserves

Public Dividend Capital

Public dividend capital (PDC) is a type of public sector equity finance based upon the excess of assets over liabilities at the time of establishment of the predecessor NHS organisation. Additional PDC may also be issued to trusts by the Department of Health and Social Care (DHSC). A charge, reflecting the cost of capital utilised by the Trust, is payable to DHSC as the public dividend capital dividend.

Revaluation Reserve

Increases in asset values arising from revaluations are recognised in the revaluation reserve, except where, and to the extent that, they reverse impairments previously recognised in operating expenses, in which case they are recognised in operating income. Subsequent downward movements in assets valuations are charged to the revaluation reserve to the extent that the previous gain was recognised unless the downward movement represents a clear consumption of economic benefit or a reduction in service potential.

Income and expenditure reserve

The balance of this reserve is the accumulated surpluses and deficits of the Trust.

Statement of Cash Flows for the year ended 31 March 2025, £'000

	Note	2024/25	2023/24
Cash flows from operating activities			
Operating deficit		(79,789)	(35,649)
Non-cash income and expense:			
Depreciation and amortisation	4.1	11,811	10,497
Net impairments	12.1	47,206	37,648
Income recognised in respect of capital donations	3.4	(3,371)	(835)
(Increase) / decrease in receivables and other assets		420	9,909
(Increase) / decrease in inventories		390	(528)
Increase / (decrease) in payables and other liabilities		14,332	(16,885)
Increase / (decrease) in provisions		36	(77)
Net cash flows from operating activities		**(8,965)**	**4,080**
Cash flows from investing activities			
Interest received	8	910	1,796
Purchase of PPE		(69,129)	(63,849)
Net cash flows used in investing activities		**(68,219)**	**(62,053)**
Cash flows from financing activities			
Public dividend capital received		75,410	46,076
Cash flows used in other financing activities		1	97
Capital element of lease liability repayments		(453)	(460)
Interest element of lease liability repayments		(11)	(10)
PDC dividend (paid)		(4,188)	(3,618)
Net cash generated from financing activities		**70,759**	**42,085**
Increase in cash and cash equivalents		**(6,425)**	**(15,888)**
Cash and cash equivalents at 1 April 2024 – brought forward		**28,399**	**44,287**
Cash and cash equivalents at 31 March 2025	15.1	**21,974**	**28,399**

The accompanying notes form part of these accounts.

Notes to the accounts

1. Accounting policies and other information

1.1. Basis of preparation

NHS England has directed that the financial statements of the Trust shall meet the accounting requirements of the Department of Health and Social Care Group Accounting Manual (GAM), which shall be agreed with HM Treasury. Consequently, the following financial statements have been prepared in accordance with the GAM 2024/25 issued by the Department of Health and Social Care. The accounting policies contained in the GAM follow International Financial Reporting Standards to the extent that they are meaningful and appropriate to the NHS, as determined by HM Treasury, which is advised by the Financial Reporting Advisory Board. Where the GAM permits a choice of accounting policy, the accounting policy that is judged to be most appropriate to the particular circumstances of the Trust for the purpose of giving a true and fair view has been selected. The particular policies adopted are described below. These have been applied consistently in dealing with items considered material in relation to the accounts.

Accounting Convention

These accounts have been prepared under the historical cost convention modified to account for the revaluation of property, plant and equipment, intangible assets, inventories and certain financial assets and financial liabilities.

1.2. Going concern

These accounts have been prepared on a going concern basis. The financial reporting framework applicable to NHS bodies, derived from the HM Treasury Financial Reporting Manual, defines that the anticipated continued provision of the entity's services in the public sector is normally sufficient evidence of going concern. The directors have a reasonable expectation that this will continue to be the case. Long term planning and realistic plans for future transformation savings delivery provide the necessary assurance that the Trust is a going concern. There is an anticipated continuation of the provision of a service in the future, as evidenced by inclusion of financial provision for that service in published documents.

1.3. Critical judgements in applying accounting policies

The following are the judgements, apart from those involving estimations (see below), that management haves made in the process of applying the Trust's accounting policies and that have the most significant effect on the amounts recognised in the financial statements.

Valuation of land and buildings

The most significant estimate within the accounts is the value of land and buildings. A full site valuation for 2024/25 was performed by professional Chartered Surveyors Montagu Evans as at 31 March 2025.

The hospital roof is affected by issues with failing roof planks which will require substantial expenditure over the next one to seven years in order to make repairs, support the roof and provide protection for patients and staff. Survey work has been undertaken to understand the full extent of future safety works required and the associated cost.

It is expected that the hospital will continue to operate in its current form for the next seven years with remedial work being undertaken as necessary. The hospital has therefore been valued under the depreciated replacement cost basis. This has resulted in an impairment of £47.2m (31 March 2024 £37.6m) to the carrying value of the land and buildings which has been taken to SOCIE.

Non-consolidation of Charitable Funds

IFRS 10 requires production of consolidated accounts where there is a parent/subsidiary relationship. IFRS 10 defines a subsidiary as “an entity...that is controlled by another entity. Control is the power to govern the financial and operating policies of an entity so as to obtain benefits from its activities.” The Trust is the Corporate Trustee of the Charitable Fund and meets the definition of control.

Materiality is an overriding consideration in preparation of the accounts. The International Accounting Standards Board (IASB) states that “Information is material if its omission or misstatement could influence the economic decisions of users taken on the basis of the financial statements”.

The net assets of the Charitable Fund amount to approximately 3.2% of the Trust net assets. Charitable Fund income is approximately 0.3% of Trust income. The Directors therefore consider that the consolidation of the accounts of the Charitable Fund with those of the Trust is not justified on the grounds of materiality.

1.4.

1.4.1. Sources of estimation and uncertainty

The following are assumptions about the future and other major sources of estimation uncertainty that have a significant risk of resulting in a material adjustment to the carrying amounts of assets and liabilities within the next financial year:

1.4.2. Revenue from contracts with customers

Where income is derived from contracts with customers, it is accounted for under IFRS 15. The GAM expands the definition of a contract to include

legislation and regulations which enables an entity to receive cash or another financial asset that is not classified as a tax by the Office of National Statistics (ONS).

Revenue in respect of goods/services provided is recognised when (or as) performance obligations are satisfied by transferring promised goods/services to the customer and is measured at the amount of the transaction price allocated to those performance obligations. At the year end, the Trust accrues income relating to performance obligations satisfied in that year. Where the Trust's entitlement to consideration for those goods or services is unconditional a contract receivable will be recognised. Where entitlement to consideration is conditional on a further factor other than the passage of time, a contract asset will be recognised. Where consideration received or receivable relates to a performance obligation that is to be satisfied in a future period, the income is deferred and recognised as a contract liability.

1.4.3. Revenue from NHS contracts

The main source of income for the Trust is contracts with commissioners for health care services. Funding envelopes are set at an Integrated Care System (ICS) level. The majority of the Trust's NHS income is earned from NHS commissioners under the NHS Payment Scheme (NHSPS). The NHSPS sets out rules to establish the amount payable to trusts for NHS-funded secondary healthcare.

Aligned payment and incentive contracts form the main payment mechanism under the NHSPS. API contracts contain both a fixed and variable element. Under the variable element, providers earn income for elective activity (both ordinary and day case), out-patient procedures, out-patient first attendances, diagnostic imaging and nuclear medicine, and chemotherapy delivery activity. The precise definition of these activities is given in the NHSPS. Income is earned at NHSPS prices based on actual activity. The fixed element includes income for all other services covered by the NHSPS assuming an agreed level of activity with 'fixed' in this context meaning not varying based on units of activity. Elements within this are accounted for as variable consideration under IFRS 15 as explained below.

The Trust also receives income from commissioners under Commissioning for Quality Innovation (CQUIN) and Best Practice Tariff (BPT) schemes. Delivery under these schemes is part of how care is provided to patients. As such CQUIN and BPT payments are not considered distinct performance obligations in their own right; instead they form part of the transaction price for performance obligations under the overall contract with the commissioner and are accounted for as variable consideration under IFRS 15. Payment for CQUIN and BPT on non-elective services is included in the fixed element of API contracts with adjustments for actual achievement being made at the end

of the year. BPT earned on elective activity is included in the variable element of API contracts and paid in line with actual activity performed.

Where the relationship with a particular Integrated Care Board is expected to be a low volume of activity (annual value below £0.5m), an annual fixed payment is received by the provider as determined in the NHSPS documentation. Such income is classified as 'other clinical income' in these accounts.

Elective recovery funding provides additional funding to integrated care boards to fund the commissioning of elective services within their systems. Trusts do not directly earn elective recovery funding, instead earning income for actual activity performed under API contract arrangements as explained above. The level of activity delivered by the trust contributes to system performance and therefore the availability of funding to the trust's commissioners.

1.4.4. Revenue from research contracts

Where research contracts fall under IFRS 15, revenue is recognised as and when performance obligations are satisfied. For some contracts, it is assessed that the revenue project constitutes one performance obligation over the course of the multi-year contract. In these cases it is assessed that the Trust's interim performance does not create an asset with alternative use for the Trust, and the Trust has an enforceable right to payment for the performance completed to date. It is therefore considered that the performance obligation is satisfied over time, and the Trust recognises revenue each year over the course of the contract. Some research income alternatively falls within the provisions of IAS 20 for government grants.

1.4.5. NHS injury cost recovery scheme

The Trust receives income under the NHS injury cost recovery scheme, designed to reclaim the cost of treating injured individuals to whom personal injury compensation has subsequently been paid, for instance by an insurer. The Trust recognises the income when performance obligations are satisfied. In practical terms this means that treatment has been given, it receives notification from the Department of Work and Pension's Compensation Recovery Unit, has completed the NHS2 form and confirmed there are no discrepancies with the treatment. The income is measured at the agreed tariff for the treatments provided to the injured individual, less an allowance for unsuccessful compensation claims and doubtful debts in line with IFRS 9 requirements of measuring expected credit losses over the lifetime of the asset.

1.5. Income

Income in respect of services provided is recognised when, and to the extent that, performance occurs and is measured at the fair value of the consideration

receivable. The main source of income for the Trust is contracts with commissioners in respect of healthcare services.

Where income is received for a specific activity which is to be delivered in the following financial year, that income is deferred.

Income from the sale of non-current assets is recognised only when all material conditions of sale have been met and is measured as the sums due under the sale contract.

1.6. Other forms of income

Grants and donations

Government grants are grants from government bodies other than income from commissioners or trusts for the provision of services. Where a grant is used to fund revenue expenditure it is taken to the Statement of Comprehensive Income to match that expenditure. Where the grant is used to fund capital expenditure, it is credited to the Statement of Comprehensive Income once conditions attached to the grant have been met. Donations are treated in the same way as government grants.

Apprenticeship service income

The value of the benefit received when accessing funds from the Government's apprenticeship service is recognised as income at the point of receipt of the training service. Where these funds are paid directly to an accredited training provider from the Trust's apprenticeship service account held by the Department for Education, the corresponding notional expense is also recognised at the point of recognition for the benefit.

1.7. Expenditure on employee benefits

1.7.1. Short-term employee benefits

Salaries, wages and employment-related payments such as social security costs and the apprenticeship levy are recognised in the period in which the service is received from employees. The cost of annual leave entitlement earned but not taken by employees at the end of the period is recognised in the financial statements to the extent that employees are permitted to carry-forward leave into the following period.

1.7.2. Pension costs

NHS Pension Scheme

Past and present employees are covered by the provisions of the two NHS Pension Schemes. Both schemes are unfunded, defined benefit schemes that cover NHS employer, general practices and other bodies, allowed under the direction of Secretary of State for Health and Social Care in England and Wales. The scheme is not designed in a way that would enable employers to identify their share of the underlying scheme assets and liabilities. Therefore,

the scheme is accounted for as though it is a defined contribution scheme: the cost to the Trust is taken as equal to the employer's pension contributions payable to the scheme for the accounting period. The contributions are charged to operating expenses as they become due.

Additional pension liabilities arising from early retirements are not funded by the scheme except where the retirement is due to ill-health. The full amount of the liability for the additional costs is charged to the operating expenses at the time the Trust commits itself to the retirement, regardless of the method of payment.

1.8. Expenditure on other goods and services

Expenditure on goods and services is recognised when, and to the extent that they have been received, and is measured at the fair value of those goods and services. Expenditure is recognised in operating expenses except where it results in the creation of a non-current asset such as property, plant and equipment.

1.9. Property, plant and equipment

1.9.1. Recognition

Property, plant and equipment is capitalised where:

- it is held for use in delivering services or for administrative purposes
- it is probable that future economic benefits will flow to, or service potential to be provided to, the Trust
- it is expected to be used for more than one financial year
- the cost of the item can be measured reliably
- the item has a cost of at least £5,000

or

- collectively, a number of items have a cost of at least £5,000 and individually have a cost of more than £250, where the assets are functionally interdependent, they had broadly simultaneous purchase dates, are anticipated to have simultaneous disposal dates and are under single managerial control;

or

- items form part of the initial equipping and setting-up cost of a new building, ward or unit, irrespective of their individual or collective cost.

Where a large asset, for example a building, includes a number of components with significantly different asset lives e.g. plant and equipment, then these components are treated as separate assets and depreciated over their own useful economic lives.

1.9.2. Subsequent expenditure

Subsequent expenditure relating to an item of property, plant and equipment is recognised as an increase in the carrying amount of the asset when it is probable that additional future economic benefits or service potential deriving from the cost incurred to replace a component of such item will flow to the enterprise and the cost of the item can be determined reliably. Where a component of an asset is replaced, the cost of the replacement is capitalised if it meets the criteria for recognition above. The carrying amount of the part replaced is de-recognised. Other expenditure that does not generate additional future economic benefits or service potential, such as repairs and maintenance is charged to the Statement of Comprehensive Income in the period in which it is incurred.

1.9.3. Measurement

Valuation

All property, plant and equipment assets are measured initially at cost, representing the costs directly attributable to acquiring or constructing the asset and bringing it to the location and condition necessary for it to be capable of operating in the manner intended by management.

Assets are measured subsequently at valuation. Assets which are held for their service potential and are in use (i.e. operational assets used to deliver either front line services or back office functions) are measured at their current value in existing use. Assets that were most recently held for their service potential but are surplus with no plan to bring them back into use are measured at fair value where there are no restrictions on sale at the reporting date and where they do not meet the definitions of investment properties or assets held for sale.

Revaluations of property, plant and equipment are performed with sufficient regularity to ensure that carrying values are not materially different from those that would be determined at the end of the reporting period. Current values in existing use are determined as follows:

- land and non-specialised buildings - market value for existing use
- specialised buildings - depreciated replacement cost on a modern equivalent asset basis

For specialised assets, current value in existing use is interpreted as the present value of the asset’s remaining service potential, which is assumed to be at least equal to the cost of replacing that service potential. Specialised assets are therefore valued at their depreciated replacement cost (DRC) on a modern equivalent asset (MEA) basis. An MEA basis assumes that the asset will be replaced with a modern asset of equivalent capacity and location requirements of the services being provided.

The Trust conducted a valuation of land and buildings as at 31 March 2025 and 31 March 2024.

Properties in the course of construction for service or administration purposes are carried at cost, less any impairment loss. Cost includes professional fees. Assets are revalued and depreciation commences when they are brought into use.

IT equipment, transport equipment, furniture and fittings, and plant and machinery that are held for operational use are valued at depreciated historic cost where these assets have short useful lives or low values or both, as this is not considered to be materially different from current value in existing use.

1.9.4. Depreciation

Items of property, plant and equipment are depreciated over their remaining useful economic lives in a manner consistent with the consumption of economic or service delivery benefits. Freehold land is considered to have an infinite life and is not depreciated.

Property, plant and equipment which has been reclassified as ‘held for sale’ ceases to be depreciated upon reclassification. Assets in the course of construction contract are not depreciated until the asset is brought into use or reverts to the Trust.

1.9.5. Revaluation gains and losses

Revaluation gains are recognised in the revaluation reserve, except where, and to the extent that, they reverse a revaluation decrease that has previously been recognised in operating expenses, in which case they are recognised in operating expenditure.

Revaluation losses are charged to the revaluation reserve to the extent that there is an available balance for the asset concerned and thereafter are charged to operating expenses.

Gains and losses recognised in the revaluation reserve are reported in the Statement of Comprehensive Income as an item of ‘other comprehensive income’.

1.9.6. Transferring revaluation surplus to retained earnings

The depreciable amount of a revalued asset is based upon its revalued amount, not its cost. The depreciation charge for each period is recognised as an expense in the profit and loss.

However, the revaluation surplus may be transferred directly to retained earnings as the surplus is realised. Realisation of the surplus may occur through the use (and depreciation) of the asset or upon its disposal.

Where the Trust disposes of the asset, the whole of the revaluation reserve is transferred. Other than this no transfer of any part of the revaluation reserve will take place.

1.9.7. Impairments

In accordance with the GAM, impairments that arise from a clear consumption of economic benefits or of service potential in the asset are charged to operating expenses. A compensating transfer is made from the revaluation reserve to the income and expenditure reserve of an amount equal to the lower of (i) the impairment charged to operating expenses; and (ii) the balance in the revaluation reserve attributable to that asset before the impairment.

An impairment that arises from a clear consumption of economic benefit or of service potential is reversed when, and to the extent that, the circumstances that gave rise to the loss is reversed. Reversals are recognised in operating income to the extent that the asset is restored to the carrying amount it would have had if the impairment had never been recognised. Any remaining reversal is recognised in the revaluation reserve. Where, at the time of the original impairment, a transfer was made from the revaluation reserve to the income and expenditure reserve, an amount is transferred back to the revaluation reserve when the impairment reversal is recognised.

Other impairments are treated as revaluation losses. Reversals of ‘other impairments’ are treated as revaluation gains.

Montagu Evans was appointed as the valuer to the Trust in 2021. Montagu Evans conducted a full valuation of the land and buildings at 31 March 2025 and 31 March 2024. The valuation has resulted in an impairment of £47.2m being recognised in the accounts at 31 March 2025.

1.9.8. De-recognition

Assets intended for disposal are reclassified as ‘held for sale’ once the criteria in IFRS 5 are met. The sale must be highly probable and the asset available for immediate sale in its present condition.

Following reclassification, the assets are measured at the lower of their existing carrying amount and their fair value less costs to sell. Depreciation ceases to be charged, and the assets are not revalued, except where the 'fair value less costs to sell' falls below the carrying amount. Assets are de-recognised when all material sale contract conditions have been met.

Property, plant and equipment which is to be scrapped or demolished does not qualify for recognition as ‘held for sale’ and instead is retained as an operational asset and the asset’s economic life is adjusted. The asset is de-recognised when scrapping or demolition occurs.

1.9.9. Donated and grant funded assets

Donated and grant funded property, plant and equipment assets are capitalised at their fair value on receipt. The donation/grant is credited to income at the same time, unless the donor has imposed a condition that the future economic benefits embodied in the grant are to be consumed in a manner specified by the donor, in which case, the donation/grant is deferred within liabilities and is carried forward to future financial years to the extent that the condition has not yet been met.

The donated and grant funded assets are subsequently accounted for in the same manner as other items of property, plant and equipment.

Gifts

Gifts are items that are voluntarily donated, with no preconditions and without the expectation of any return. Gifts include all transactions economically equivalent to free and unremunerated transfers, such as the loan of an asset for its expected useful life, and the sale or lease of assets at below market value.

1.9.10. Useful lives of property, plant and equipment

Useful lives reflect the total life of an asset and not the remaining life of an asset. The range of useful lives are shown in the table below:

	Minimum life years	Maximum life years
Buildings, excluding dwellings	7	80
Plant and machinery	5	15
Transport equipment	7	7
Information technology	5	7
Furniture and fittings	5	15

It is not possible to determine the useful life of the land owned by the Trust.

The hospital roof is affected by issues with failing roof planks which will require substantial expenditure over the next 1-7 years in order to make repairs, support the roof and provide protection for patients and staff. Survey work has been undertaken to understand the full extent of future safety works required and the associated cost. It is expected that the hospital will continue to operate in its current form for the next 7 years with remedial work being undertaken as necessary.

1.10. Intangible assets

1.10.1. Recognition

Intangible assets are non-monetary assets without physical substance controlled by the Trust. They are capable of being sold separately from the rest of the Trust's business or arise from contractual or other legal rights. Intangible assets are recognised only where it is probable that future economic benefits will flow to, or service potential be provided to, the Trust and where the cost of the asset can be measured reliably.

1.10.2. Software

Software, which is integral to the operation of hardware, e.g. an operating system, is capitalised as part of the relevant item of property, plant and equipment. Software, which is not integral to the operation of hardware, e.g. application software, is capitalised as an intangible asset where it meets recognition criteria.

1.10.3. Measurement

Intangible assets are recognised initially at cost, comprising all directly attributable costs needed to create, produce and prepare the asset to the point that it is capable of operating in the manner intended by management.

Subsequently intangible assets are measured at current value in existing use. Where no active market exists, intangible assets are valued at the lower of depreciated replacement cost and the value in use where the asset is income generating. Revaluations gains and losses and impairments are treated in the same manner as for property, plant and equipment. An intangible asset which is surplus with no plan to bring it back into use is valued at fair value where there are no restrictions on sale at the reporting date and where they do not meet the definitions of investment properties or assets held for sale.

Intangible assets held for sale are measured at the lower of their carrying amount or fair value less costs to sell.

1.10.4. Amortisation

Intangible assets are amortised over their expected useful economic lives in a manner consistent with the consumption of economic or service delivery benefits.

1.10.5. Useful lives of intangible assets

Useful lives reflect the total life of an asset and not the remaining life of an asset. The range of useful lives are shown in the table below:

	Minimum life years	Maximum life years
Software licenses	5	7

1.11. Inventories

Inventories are valued at the lower of cost and net realisable value. The cost of inventories is measured using the weighted average cost method.

Between 2020/21 and 2023/24 the Trust received inventories including personal protective equipment from the Department of Health and Social Care at nil cost. In line with the GAM and applying the principles of the IFRS Conceptual Framework, the Trust has accounted for the receipt of these inventories at a deemed cost, reflecting the best available approximation of an imputed market value for the transaction based on the cost of acquisition by the Department. Distribution of inventories by the Department ceased in March 2024.

1.12. Cash and cash equivalents

Cash is cash in hand and deposits with any financial institution repayable without penalty on notice of not more than 24 hours. Cash equivalents are investments that mature in three months or less from the date of acquisition and that are readily convertible to known amounts of cash with insignificant risk of change in value.

In the Statement of Cash Flows, cash and cash equivalents are shown net of bank overdrafts that are repayable on demand and that form an integral part of the Trust's cash management. Cash, bank and overdraft balances are recorded at current values.

1.13. Financial assets and financial liabilities

1.13.1. Recognition

Financial assets and financial liabilities arise where the Trust is party to the contractual provisions of a financial instrument, and as a result has a legal right to receive or a legal obligation to pay cash or another financial instrument. The GAM expands the definition of a contract to include legislation and regulations which give rise to arrangements that in all other respects would be a financial instrument and do not give rise to transactions classified as a tax by the Office of National Statistics (ONS).

This includes the purchase or sale of non-financial items (such as goods or services), which are entered into in accordance with the Trust's normal

purchase, sale or usage requirements and are recognised when, and to the extent which, performance occurs, i.e., when receipt or delivery of the goods or services is made.

1.13.2. De-recognition

All financial assets are de-recognised when the rights to receive cash flows from the assets have expired or the Trust has transferred substantially all of the risks and rewards of ownership.

Financial liabilities are de-recognised when the obligation is discharged, cancelled or expires.

1.13.3. Classification and measurement

Financial assets and financial liabilities are initially measured at fair value plus or minus directly attributable transaction costs except where the asset or liability is not measured at fair value through income and expenditure. Fair value is taken as the transaction price or otherwise determined by reference to quoted market prices or valuation techniques.

Financial assets and liabilities are classified as subsequently measured at amortised cost.

1.13.4. Financial assets and financial liabilities at amortised cost

Financial assets and financial liabilities at amortised cost are those held with the objective of collecting contractual cash flows and where cash flows are solely payments of principal and interest. This includes cash equivalents, contract and other receivables, trade and other payables, rights and obligations under lease arrangements and loans receivable and payable.

After initial recognition, these financial assets and financial liabilities are measured at amortised cost using the effective interest method less any impairment (for financial assets). The effective interest rate is the rate that exactly discounts estimated future cash payments or receipts through the expected life of the financial asset or financial liability to the gross carrying amount of a financial asset or to the amortised cost of a financial liability.

Interest revenue or expense is calculated by applying the effective interest rate to the gross carrying amount of a financial asset or amortised cost of a financial liability and recognised in the Statement of Comprehensive Income and a financing income or expense.

1.13.5. Impairment of financial assets

For all financial assets measured at amortised cost including lease receivables, contract receivables and contract assets, the Trust recognises an allowance for expected credit losses.

The Trust adopts the simplified approach to impairment for contract and other receivables, contract assets and lease receivables, measuring expected

losses as at an amount equal to lifetime expected losses. For other financial assets, the loss allowance is initially measured at an amount equal to 12-month expected credit losses (stage one) and subsequently at an amount equal to lifetime expected credit losses if the credit risk assessed for the financial asset significantly increases (stage two).

For financial assets that have become credit impaired since initial recognition (stage three), expected credit losses at the reporting date are measured as the difference between the asset's gross carrying amount and the present value of estimated future cash flows discounted at the financial asset's original effective interest rate.

Expected losses are charged to operating expenditure within the Statement of Comprehensive Income and reduce the net carrying value of the financial asset in the Statement of Financial Position

De-recognition

Financial assets are de-recognised when the contractual rights to receive cash flows from the assets have expired or the Trust has transferred substantially all the risks and rewards of ownership.

Financial liabilities are de-recognised when the obligation is discharged, cancelled or expires.

1.14. Leases

A lease is a contract or part of a contract that conveys the right to use an asset for a period of time in exchange for consideration. An adaptation of the relevant accounting standard by HM Treasury for the public sector means that for NHS bodies, this includes lease-like arrangements with other public sector entities that do not take the legal form of a contract. It also includes peppercorn leases where consideration paid is nil or nominal (significantly below market value) but in all other respects meet the definition of a lease. The Trust does not apply lease accounting to new contracts for the use of intangible assets.

The Trust determines the term of the lease term with reference to the non-cancellable period and any options to extend or terminate the lease which the Trust is reasonably certain to exercise.

The Trust as lessee

Initial recognition and measurement

At the commencement date of the lease, being when the asset is made available for use, the Trust recognises a right of use asset and a lease liability.

The right of use asset is recognised at cost comprising the lease liability, any lease payments made before or at commencement, any direct costs incurred by the lessee, less any cash lease incentives received. It also includes any estimate

of costs to be incurred restoring the site or underlying asset on completion of the lease term.

The lease liability is initially measured at the present value of future lease payments discounted at the interest rate implicit in the lease. Lease payments includes fixed lease payments, variable lease payments dependent on an index or rate and amounts payable under residual value guarantees. It also includes amounts payable for purchase options and termination penalties where these options are reasonably certain to be exercised.

Where an implicit rate cannot be readily determined, the Trust's incremental borrowing rate is applied. This rate is determined by HM Treasury annually for each calendar year. A nominal rate of 4.72% applied to new leases commencing in 2024 and 4.81% to new leases commencing in 2025.

The Trust does not apply the above recognition requirements to leases with a term of 12 months or less or to leases where the value of the underlying asset is below £5,000, excluding any irrecoverable VAT. Lease payments associated with these leases are expensed on a straight-line basis over the lease term or other systematic basis. Irrecoverable VAT on lease payments is expensed as it falls due.

Subsequent measurement

As required by a HM Treasury interpretation of the accounting standard for the public sector, the Trust employs a revaluation model for subsequent measurement of right of use assets, unless the cost model is considered to be an appropriate proxy for current value in existing use or fair value, in line with the accounting policy for owned assets. Where consideration exchanged is identified as significantly below market value, the cost model is not considered to be an appropriate proxy for the value of the right of use asset.

The Trust subsequently measures the lease liability by increasing the carrying amount for interest arising which is also charged to expenditure as a finance cost and reducing the carrying amount for lease payments made. The liability is also remeasured for changes in assessments impacting the lease term, lease modifications or to reflect actual changes in lease payments. Such remeasurements are also reflected in the cost of the right of use asset. Where there is a change in the lease term or option to purchase the underlying asset, an updated discount rate is applied to the remaining lease payments.

The Trust as lessor

The Trust assesses each of its leases and classifies them as either a finance lease or an operating lease. Leases are classified as finance leases when substantially all the risks and rewards of ownership are transferred to the lessee. All other leases are classified as operating leases.

Where the Trust is an intermediate lessor, classification of the sublease is determined with reference to the right of use asset arising from the headlease.

Finance leases

Amounts due from lessees under finance leases are recorded as receivables at the amount of the Trust's net investment in the leases. Finance lease income is allocated to accounting periods to reflect a constant periodic rate of return on the Trust's net investment outstanding in respect of the leases.

Operating leases

Income from operating leases is recognised on a straight-line basis or another systematic basis over the term of the lease. Initial direct costs incurred in negotiating and arranging an operating lease are added to the carrying amount of the leased asset and recognised as an expense on a straight-line basis over the lease term.

1.15. Provisions

The Trust recognises a provision where it has a present legal or constructive obligation of uncertain timing or amount; for which it is probable that there will be a future outflow of cash or other resources; and a reliable estimate can be made of the amount. The amount recognised in the Statement of Financial Position is the best estimate of the resources required to settle the obligation. Where the effect of the time value of money is significant, the estimated risk-adjusted cash flows are discounted using HM Treasury's discount rates effective for 31 March 2025:

		Nominal rate	Prior year rate
Short-term	Up to 5 years	4.26%	3.27%
Medium-term	After 5 years up to 10 years	4.03%	3.20%
Long-term	Exceeding 10 years	4.72%	3.51%
Very long term	Exceeding 40 years	4.40%	3.00%

HM Treasury provides discount rates for general provisions on a nominal rate basis. Expected future cash flows are therefore adjusted for the impact of inflation before discounting using nominal rates. The following inflation rates are set by HM Treasury, effective from 31 March 2025:

	Inflation rate	Prior year rate
Year one	2.60%	3.60%
Year two	2.30%	1.80%
Into perpetuity	2.00%	2.00%

Early retirement provisions and injury benefit provisions both use the HM Treasury's post-employment benefits discount rate of 2.40% in real terms (prior year: 2.45%).

1.15.1. Clinical negligence costs

NHS Resolution operates a risk pooling scheme under which the Trust pays an annual contribution to NHS Resolution, which, in return, settles all clinical negligence claims. Although NHS Resolution is administratively responsible for all clinical negligence cases, the legal liability remains with the Trust. The total value of clinical negligence provisions carried by NHS Resolution on behalf of the Trust is disclosed at note 19 but is not recognised in the Trust's accounts.

1.15.2. Clinical negligence costs

The Trust participates in the Property Expenses Scheme and the Liabilities to Third Parties Scheme. Both are risk pooling schemes under which the Trust pays an annual contribution to NHS Resolution and in return receives assistance with the costs of claims arising. The annual membership contributions, and any 'excesses' payable in respect of particular claims are charged to operating expenses when the liability arises.

1.15.3. Contingencies

Contingent assets (that is, assets arising from past events whose existence will only be confirmed by one or more future events not wholly within the entity's control) are not recognised as assets, but are disclosed in note 25 where an inflow of economic benefits is probable.

Contingent liabilities are not recognised, but are disclosed in note 25, unless the probability of a transfer of economic benefits is remote.

Contingent liabilities are defined as:

- possible obligations arising from past events whose existence will be confirmed only by the occurrence of one or more uncertain future events not wholly within the entity's control; or

- present obligations arising from past events but for which it is not probable that a transfer of economic benefits will arise or for which the amount of the obligation cannot be measured with sufficient reliability.

1.16. Public dividend capital

Public dividend capital (PDC) is a type of public sector equity finance based on the excess of assets over liabilities at the time of establishment of the predecessor NHS Trust. HM Treasury has determined that PDC is not a financial instrument within the meaning of IAS 32.

The Secretary of State can issue new PDC to, and require repayments of PDC from, the Trust. PDC is recorded at the value received.

A charge, reflecting the cost of capital utilised by the Trust, is payable as public dividend capital dividend. The charge is calculated at the rate set by HM Treasury (currently 3.5%) on the average relevant net assets of the Trust during the financial year. Relevant net assets are calculated as the value of all assets less the value of all liabilities, with certain additions and deductions as defined in the PDC dividend policy issued by the Department of Health and Social Care. This policy is available at https://www.gov.uk/government/publications/guidance-on-financing-available-to-nhs-trusts-and-foundation-trusts.

In accordance with the requirements laid down by the Department of Health and Social Care (as the issuer of PDC), the dividend for the year is calculated on the actual average relevant net assets as set out in the “pre-audit” version of the annual accounts. The dividend calculated is not revised should any adjustment to net assets occur as a result the audit of the annual accounts.

1.17. Value Added Tax

Most of the activities of the Trust are outside the scope of VAT and, in general, output tax does not apply and input tax on purchases is not recoverable. Irrecoverable VAT is charged to the relevant expenditure category or included in the capitalised purchase cost of fixed assets. Where output tax is charged or input VAT is recoverable, the amounts are stated net of VAT.

1.18. Corporation Tax

The Trust is a Health Service Body within the meaning of s519A ICTA 1988 and accordingly in relation to specified activities of a Foundation Trust (s519 (3) to (8) ICTA 1988). None of the Trust’s activities in the period are subject to corporation tax liability.

1.19. Foreign Exchange

The functional and presentational currency of the Trust is sterling.

A transaction which is denominated in a foreign currency is translated into the functional currency at the spot exchange rate on the date of the transaction.

Where the Trust has assets or liabilities denominated in a foreign currency at the Statement of Financial Position date:

- monetary items are translated at the spot exchange rate on 31 March
- non-monetary assets and liabilities measured at historical cost are translated using the spot exchange rate at the date of the transaction and
- non-monetary assets and liabilities measured at fair value are translated using the spot exchange rate at the date the fair value was determined.

Exchange gains or losses on monetary items (arising on settlement of the transaction or on re-translation at the Statement of Financial Position date) are recognised in income or expense in the period in which they arise.

Exchange gains or losses on non-monetary assets and liabilities are recognised in the same manner as other gains and losses on these items.

1.20. Third party assets

Assets belonging to third parties (such as money held on behalf of patients) are not recognised in the accounts since the Trust has no beneficial interest in them. However, they are disclosed in a separate note to the accounts in accordance with the requirements of HM Treasury's Financial Reporting Manual (FreM).

1.21. Losses and special payments

Losses and special payments are items that Parliament would not have contemplated when it agreed funds for the health service or passed legislation. By their nature they are items that ideally should not arise. They are therefore subject to special control procedures compared with the generality of payments. They are divided into different categories, which govern the way that individual cases are handled. Losses and special payments are charged to the relevant functional headings in expenditure on an accruals basis.

The losses and special payments note is compiled directly from the losses and compensations register which reports on an accrual basis with the exception of provisions for future losses

1.22. Transfers of functions to / from other NHS bodies

For functions that have been transferred to the Trust from another NHS body, the transaction is accounted for as a transfer by absorption. The assets and liabilities transferred are recognised in the accounts using the book value as at the date of transfer. The assets and liabilities are not adjusted to fair value prior to recognition. The net gain corresponding to the net assets transferred is recognised within income, but not within operating activities.

For property, plant and equipment assets and intangible assets, the cost and accumulated depreciation / amortisation balances from the transferring entity's accounts are preserved on recognition in the Trust's accounts. Where the transferring body recognised revaluation reserve balances attributable to the

assets, the Trust makes a transfer from its income and expenditure reserve to its revaluation reserve to maintain transparency within public sector accounts.

For functions that the Trust has transferred to another NHS body, the assets and liabilities transferred are de-recognised from the accounts as at the date of transfer. The net loss/gain corresponding to the net assets/liabilities transferred is recognised within expenses/income, but not within operating activities. Any revaluation reserve balances attributable to assets de-recognised are transferred to the income and expenditure reserve.

1.23. Climate change levy

Expenditure on the climate change levy is recognised in the Statement of Comprehensive Income as Incurred, based on the prevailing chargeable rates for energy consumption.

1.24. Early adoption of standards, amendments and interpretations

No new accounting standards or revisions to existing standards have been early adopted in 2024/25.

Future standards

IFRS 17

IFRS 17 Insurance Contracts – The Standard is effective for accounting periods beginning on or after 1 January 2023. IFRS 17 has been adopted by the FReM from 1 April 2025. Adoption of the Standard for NHS bodies will therefore be in 2025/26. The Standard revises the accounting for insurance contracts for the issuers of insurance. Application of this standard from 2025/26 is not expected to have a material impact on the financial statements.

2. Segmental reporting

Under the definitions of operating segments contained within International Financial Reporting Standard 8, the Trust has a single operating segment where the revenues are derived from the provision of healthcare services. The products and services provided to external customers are identified in notes 3.1 and 3.2 below under the headings “Income from activities patient care” and “Other operating income”. All revenues from external customers are derived from within the UK, and all non-current assets are located in the UK. Revenues from transactions with entities under the control of the UK Government amount to £298.2m (2023/24 £297.4m) and are reported within the single healthcare segment.

3. Operating income from patient care activities

All income from patient care activities relates to contract income recognised in line with accounting policy 1.5.

3.1. Income from patient care activities (by nature) £'000

	2024/25	2023/24
Acute services		
Block contract / system envelope income	149,328	142,348
Aligned payment and incentive (API) income‡‡	67,083	54,888
High-cost drugs income from commissioners (excluding pass-through costs)	18,814	18,032
Other NHS clinical income	49,370	73,464
All services		
Private patient income	82	189
Additional pension contribution central funding§§	12,979	7,752
National Pay award central funding***	765	137
Other clinical income	196	595
Total income from activities	**298,617**	**297,405**

‡‡ Aligned payment and incentive contracts are the main form of contracting between NHS providers and their commissioners. More information can be found in the 2024/25 NHS payment scheme documentation https://www.england.nhs.uk/pay-syst/nhs-payment-scheme/

§§ The employer contribution rate for NHS pensions increased from 14.3% to 20.6% (excluding administration charge) from 1 April 2019. Since 2019/20, NHS providers have continued to pay over contributions at the former rate with the additional amount being paid over by NHS England on providers' behalf. The full cost and related funding have been recognised in these accounts.

*** Additional funding was made available by NHS England in 2024/25 and 2023/24 for implementing the backdated element of pay awards where government offers were made at the end of the financial year. 2023/24: In March 2024, the government announced a revised pay offer for consultants, reforming consultant pay scales with an effective date of 1 March 2024. Trade Unions representing consultant doctors accepted the offer in April 2024.

3.2. Income from patient care activities (by source)
£'000

	2024/25	2023/24
Income from patient care activities received from:		
NHS England	25,147	27,200
Integrated care boards	270,619	269,289
Non-NHS: other	2,573	-
Non-NHS: private patients	82	189
Non-NHS: overseas patients (chargeable to patient)	-	248
Injury cost recovery scheme	196	479
Total current assets	**298,617**	**297,405**
Of which:		
Related to continuing operations	298,617	297,405

3.3. Overseas visitors (relating to patients charged directly to the provider)
£'000

	2024/25	2023/24
Income recognised this year	-	248
Cash payments received in-year	47	64
Amounts added to provision for impairment of receivables	-	10
Amounts written off in-year	293	-

3.4. Other operating income
£'000

	2024/25			2023/24		
	Contract income	Non-contract income	Total	Contract income	Non-contract income	Total
Research and development	640	-	**640**	793	-	**793**
Non-patient care services to other bodies	3,819	-	**3,819**	5,353	-	**5,353**
Education and training	11,337	882	**12,219**	10,743	751	**11,494**
Receipt of capital grants and donations	-	3,371	**3,371**	-	835	**835**
Charitable and other contributions to expenditure	-	-	**-**	-	82	**82**
Other income**	6,757	-	**6,757**	5,871	-	**5,871**
Total other operating income	**22,940**	**4,253**	**26,806**	**22,760**	**1,668**	**24,428**
Of which:						
Related to continuing operations			26,806			24,428

**Analysis of other operating income: Other
£'000

	2024/25	2023/24
Car parking income	1,363	832
Catering	963	1,191
Pharmacy sales	460	-
Non-clinical services recharged to other bodies	2,485	2,452
Clinical tests	1,163	1,283
Clinical excellence awards	65	113
Other income not already covered	258	-
	6,757	**5,871**

4. Operating expenses

4.1. Operating expenses
£'000

	2024/25	2023/24
Purchase of healthcare from NHS and DHSC bodies	11,237	8,891
Purchase of healthcare from non-NHS and non-DHSC bodies	5,878	5,008
Staff and executive directors' costs	248,215	230,008
Remuneration of non-executive directors	193	156
Supplies and services – clinical (excluding drug costs)	20,798	10,387
Supplies and services – general	4,046	4,240
Drug costs (drugs inventory consumed and purchase of non-inventory drugs)	28,675	26,590
Consultancy costs	1,488	1,520
Establishment	1,767	2,498
Premises	10,322	8,932
Transport (including patient travel)	970	1,034
Depreciation on property, plant and equipment	11,729	10,415
Amortisation on intangible assets	82	82
(Decrease) / increase credit loss allowance: contract receivables / contract assets	99	170
Change in provisions discount rate(s)	(9)	(66)
Audit fees payable to the external auditor		
Audit services – statutory audit	213	208
Internal audit costs	164	38
Clinical negligence	6,123	4,900
Insurance	319	258
Education and training	1,493	1,611
Rentals under operating leases	25	16
Car parking and security	29	-
Losses, ex gratia and special payments	114	210
Loss on impairment of tangible fixed assets	47,206	37,648
Other	4,036	2,728
Total	**405,212**	**357,482**
Of which:		
Related to continuing operations	405,212	357,482

Auditors' remuneration for the year was £213,000, inclusive of VAT.

The external auditor audited the Queen Elizabeth Hospital Charitable Fund for the year ended 31 March 2024. Their fee exclusive of VAT was £16,000. The Charitable Fund was responsible for the payment of this fee.

4.2. Limitation on auditor's liability

The limitation on auditor's liability for external audit work is £1m (2023/24: £1m).

5. Employee benefits

	2024/25	2023/24
Salaries and wages	190,105	170,927
Social security costs	19,506	18,267
Apprenticeship levy	882	848
Employer's contributions to NHS pensions	32,831	25,577
Temporary staff (including agency)	8,915	17,422
Total gross staff costs	**252,239**	**233,041**
Recoveries in respect of seconded staff	-	-
Total staff costs	**252,239**	**233,041**
Of which		
Costs capitalised as part of assets	4,024	3,033

6. Pension costs

Past and present employees are covered by the provisions of the NHS Pension Schemes. Details of the benefits payable and rules of the schemes can be found on the NHS Pensions website at www.nhsbsa.nhs.uk/pensions. Both the 1995/2008 and 2015 schemes are accounted for, and the scheme liability valued, as a single combined scheme. Both are unfunded defined benefit schemes that cover NHS employers, GP practices and other bodies, allowed under the direction of the Secretary of State for Health and Social Care in England and Wales. They are not designed to be run in a way that would enable NHS bodies to identify their share of the underlying scheme assets and liabilities. Therefore, each scheme is accounted for as if it were a defined contribution scheme: the cost to the NHS body of participating in each scheme is taken as equal to the contributions payable to that scheme for the accounting period.

In order that the defined benefit obligations recognised in the financial statements do not differ materially from those that would be determined at the reporting date by a formal actuarial valuation, the FReM requires that "the period between formal valuations shall be four years, with approximate assessments in intervening years". An outline of these follows:

a) Accounting valuation

A valuation of scheme liability is carried out annually by the scheme actuary (currently the Government Actuary's Department) as at the end of the reporting period. This utilises an actuarial assessment for the previous accounting period in conjunction with updated membership and financial data for the current reporting

period and is accepted as providing suitably robust figures for financial reporting purposes. The valuation of the scheme liability as at 31 March 2024, is based on valuation data as 31 March 2023, updated to 31 March 2024 with summary global member and accounting data. In undertaking this actuarial assessment, the methodology prescribed in IAS 19, relevant FReM interpretations, and the discount rate prescribed by HM Treasury have also been used.

b) Full actuarial (funding) valuation

The purpose of this valuation is to assess the level of liability in respect of the benefits due under the schemes (taking into account recent demographic experience), and to recommend contribution rates payable by employees and employers.

The latest actuarial valuation undertaken for the NHS Pension Scheme was completed as at 31 March 2020. The results of this valuation set the employer contribution rate payable from April 2024. The Department of Health and Social Care has recently laid Scheme Regulations confirming the employer contribution rate will increase to 23.7% of pensionable pay from 1 April 2024 (previously 20.6%). The core cost cap cost of the scheme was calculated to be outside of the 3% cost cap corridor as at 31 March 2020. However, when the wider economic situation was taken into account through the economic cost cap cost of the scheme, the cost cap corridor was not similarly breached. As a result, there was no impact on the member benefit structure or contribution rates.

7. Operating leases

This note discloses costs and commitments incurred in operating lease arrangements where the Queen Elizabeth Hospital King's Lynn NHS Foundation Trust is the lessee.

	2024/25	2023/24
	£'000	£'000
Operating lease expense		
Minimum lease payments	25	16
Total	**25**	**16**

	31 March 2025	31 March 2024
	£'000	£'000
Future minimum lease payments due:		
• not later than one year;	**25**	**16**
• later than one year and not later than five years;	**-**	**-**
Total	**25**	**16**
Future minimum sublease payments to be received	**-**	**-**

8. Finance income

Finance income represents interest received on assets and investments in the period.

	2024/25	2023/24
	£'000	£'000
Interest on bank accounts	909	1,796
Total finance income	**909**	**1,796**

9. Finance expenditure

Finance expenditure represents interest and other charges involved in the borrowing of money or asset financing.

	2024/25	2023/24
	£'000	£'000
Interest expense:		
Loans from the Department of Health and Social Care	-	-
Interest on right of use leases	6	16
Total interest expense	6	16
Total finance costs	**6**	**16**

The Trust paid no amounts out for late payments of commercial debt (2023/24 nil).

10. Other gains and (losses)

	2024/25	2023/24
	£'000	£'000
Profits on disposal of assets	-	-
Losses on disposal of assets	(39)	-
Total other gains / (losses)	**(39)**	**-**

11. Intangible assets

11.1. Intangible assets - 2024/25

	Software assets	Intangible assets under construction	Total
	£'000	£'000	£'000
Valuation / gross cost at 1 April 2024 – brought forward	**1,454**	**-**	**1,454**
Additions	**-**	**10,563**	**10,563**
Valuation / gross cost at 31 March 2025	**1,454**	**10,563**	**12,017**
Amortisation at 1 April 2024 – brought forward	**987**	**-**	**987**
Provided during the year	82	-	**82**
Amortisation at 31 March 2025	**1,069**	**-**	**1,069**
Net book value at 31 March 2025	**385**	**10,563**	**10,948**
Net book value at 1 April 2024	**467**	**-**	**467**

11.2. Intangible assets - 2023/24

	Software assets	Intangible assets under construction	Total
	£'000	£'000	£'000
Valuation / gross cost at 1 April 2023 – brought forward	**1,454**	**-**	**1,454**
Reclassification	-	-	**-**
Valuation / gross cost at 31 March 2024	**1,454**	**-**	**1,454**
Amortisation at 1 April 2023 – brought forward	**905**	**-**	**905**
Provided during the year	82	-	**82**
Amortisation at 31 March 2024	**987**	**-**	**987**
Net book value at 31 March 2024	**467**	**-**	**467**
Net book value at 1 April 2023	**549**	**-**	**549**

12. Property, plant and equipment

12.1. Property, plant and equipment - 2024/25 (£'000)

	Land	Buildings excluding dwellings	Assets under construction	Plant and machinery	Transport equipment	Information technology	Total
Valuation / gross cost at 1 April 2024 – brought forward	**4,169**	**105,766**	**33,035**	**56,908**	**106**	**30,434**	**230,418**
Additions	-	148	63,453	1,823	-	6	**65,430**
Disposals	-	-	-	(61)	-	-	**(61)**
Transfer intangible asset (see note 11)	-	-	(10,563)	-	-	-	**(10,563)**
Reclassifications	-	44,614	(47,381)	1,929	-	838	**-**
Impairments	-	(25,878)	(21,328)	-	-	-	**(47,206)**
Revaluations	-	2,321	-	-	-	-	**2,321**
Valuation / gross cost at 31 March 2025	**4,169**	**126,971**	**17,216**	**60,599**	**106**	**31,278**	**240,339**
Accumulated depreciation at 1 April 2024 – brought forward	**-**	**32,474**	**-**	**33,136**	**105**	**18,048**	**83,763**
Provided during the year	-	4,437	-	4,681	-	2,149	**11,261**
Depreciation eliminated on disposal	-	-	-	(22)	-	-	**(22)**
Reclassifications	-	-	-	-	-	-	**-**
Accumulated depreciation at 31 March 2025	**-**	**36,911**	**-**	**37,789**	**105**	**20,197**	**95,002**
Net book value at 31 March 2025	**4,169**	**90,060**	**17,216**	**22,810**	**1**	**11,081**	**145,337**
Net book value at 1 April 2024	**4,169**	**73,292**	**33,035**	**23,772**	**1**	**12,386**	**146,655**

12.2. Property, plant and equipment - 2023/24 (£'000)

	Land	Buildings excluding dwellings	Assets under construction	Plant and machinery	Transport equipment	Information technology	Furniture and fittings	Total
Valuation / gross cost at 1 April 2023 – brought forward	**3,991**	**106,549**	**23,726**	**51,460**	**119**	**29,400**	**897**	**216,142**
Additions	-	140	54,802	578	-	34	-	**55,554**
Disposals	-	(418)	-	(293)	(13)	(3,084)	-	**(3,808)**
Reclassifications	-	27,205	(35,555)	5,163	-	4,084	(897)	**-**
Impairments	-	(27,710)	(9,938)	-	-	-	-	**(37,468)**
Revaluations	178	-	-	-	-	-	-	**178**
Valuation / gross cost at 31 March 2024	**4,169**	**105,766**	**33,035**	**56,908**	**106**	**30,434**	**-**	**240,340**
Accumulated depreciation at 1 April 2023 – brought forward	**-**	**29,374**	**-**	**28,152**	**118**	**19,241**	**743**	**77,628**
Provided during the year	-	3,518	-	4,534	-	1,891	-	**9,943**
Depreciation eliminated on disposal	-	(418)	-	(293)	(13)	(3,084)	-	**(3,808)**
Reclassifications	-	-	-	743	-	-	(743)	**-**
Accumulated depreciation at 31 March 2024	**-**	**32,474**	**-**	**33,136**	**105**	**18,048**	**-**	**83,763**
Net book value at 31 March 2024	**4,169**	**73,292**	**33,035**	**23,772**	**1**	**12,386**	**-**	**146,655**
Net book value at 1 April 2023	**3,991**	**77,175**	**23,726**	**23,308**	**1**	**10,159**	**154**	**138,514**

12.3. Property, plant and equipment financing - 2024/25 (£'000)

	Land	Buildings excluding dwellings	Assets under construction	Plant and machinery	Transport equipment	Information technology	Furniture and fittings	Total
Net book value (NBV)								
Owned – purchased	4,169	85,162	17,216	20,388	1	10,730	-	**137,666**
Owned – donated / granted	-	4,898	-	2,422	-	351	-	**7,671**
NBV total at 31 March 2025	**4,169**	**90,060**	**17,216**	**22,810**	**1**	**11,081**	**-**	**145,337**

12.4. Property, plant and equipment financing - 2023/24 (£'000)

	Land	Buildings excluding dwellings	Assets under construction	Plant and machinery	Transport equipment	Information technology	Furniture and fittings	Total
Net book value (NBV)								
Owned – purchased	4,169	69,631	33,035	22,773	1	11,988	-	**141,597**
Owned – donated / granted	-	3,661	-	999	-	398	-	**5,058**
NBV total at 31 March 2024	**4,169**	**73,292**	**33,035**	**23,772**	**1**	**12,386**	**-**	**146,655**

12.5. Right of use assets 2024/25 (£'000)

	Property (Land and buildings)	Plant and machinery	Transport equipment	Total
	£000	£000	£000	£000
Valuation/gross cost at 1 April 2024	**99**	**571**	**595**	**1,265**
Additions	-	143	143	**286**
Disposals	-	-	(738)	**(738)**
Valuation/gross cost at 1 April 2025	**99**	**714**	**-**	**813**
Accumulated depreciated at 1 April 2024	12	371	474	**857**
Provided during the year	21	178	264	**463**
Depreciation eliminated on disposal	-	-	(738)	**(738)**
Accumulated depreciation at 31 March 2025	**33**	**549**	**-**	**582**
Net book value at 31 March 2025	**66**	**165**	**-**	**231**
Net book value at 31 March 2024	**87**	**201**	**121**	**409**

12.6. Right of use assets 2023/24 (£'000)

	Property (Land and buildings)	Plant and machinery	Transport equipment	Total
	£000	£000	£000	£000
Valuation/gross cost at 1 April 2023	**99**	**546**	**559**	**1,105**
Additions	-	25	36	**160**
Valuation/gross cost at 1 April 2025	**99**	**571**	**595**	**1,265**
Accumulated depreciated at 1 April 2024	-	182	203	**385**
Provided during the year	12	189	271	**472**
Accumulated depreciation at 31 March 2025	**12**	**371**	**474**	**857**
Net book value at 31 March 2025	**87**	**201**	**121**	**409**
Net book value at 31 March 2024	**-**	**364**	**356**	**720**

12.7. Buildings excluding dwellings

The hospital roof is affected by issues with failing roof planks which will require substantial expenditure over the next six years in order to make repairs, support the roof and provide protection for patients and staff. Survey work is ongoing to understand the full extent of future costs required.

The Trust has commissioned a full valuation of the estate this year from its new valuers Montagu Evans. This valuation considered the life of the hospital estate and the Trusts estate strategy. This has resulted in an impairment of £47.2m to the carrying value of the land and buildings which has been taken to the SOCIE.

12.8. Donations of property, plant and equipment

	2024/25
	£000
Land and Buildings	1,375
IT equipment	6
Medical equipment	1,990
	3,371

13. Inventories

	31 March 2025	31 March 2024
	£'000	£'000
Drugs	1,639	1,395
Consumables	1,466	2,101
Energy	142	141
Total inventories	**3,247**	**3,637**
Of which:		
Held at fair value less cost to sell	**-**	**-**

14. Receivables

14.1. Receivables

	31 March 2025 £'000	31 March 2024 £'000
Current		
Contract receivables	3,179	4,092
Allowance for impaired contract receivables	(639)	(833)
Prepayments (non-PFI)	3,693	3,517
VAT receivable	812	706
Other receivables	1,617	1,419
Total current receivables	**8,662**	**8,901**
Non-current		
Contract receivables	391	539
Total non-current receivables	**391**	**539**
Of which receivable from NHS and DHSC group bodies:		
Current	**2,741**	**2,231**
Non-current	**-**	**-**

14.2. Allowances for credit losses

	2024/25 Contract receivables and contract assets £'000	2023/24 Contract receivables and contract assets £'000
Allowances as at 1 April – brought forward	**833**	**663**
New allowances arising	99	270
Reversals of allowance	-	(100)
Utilisation of allowances (write offs)	(293)	-
Allowances as at 31 March 2025	**639**	**833**

15. Cash and cash equivalents

15.1. Cash and cash equivalents movements

Cash and cash equivalents comprise cash at bank, in hand and cash equivalents. Cash equivalents are readily convertible investments of known value which are subject to an insignificant risk of change in value.

	2024/25	2023/24
	£'000	£'000
At 1 April 2024	**28,399**	**44,287**
Net change in year	(6,425)	(15,888)
At 31 March 2025	**21,974**	**28,399**
Broken down into:		
Cash at commercial banks and in hand	120	138
Cash with the Government Banking Service	21,854	28,261
Total cash and cash equivalents as in SoFP	**21,974**	**28,399**
Total cash and cash equivalents as in SoCF	**21,974**	**28,399**

15.2. Thid party assets held by the Trust

The Trust held cash and cash equivalents which relate to monies held by the Trust on behalf of patients or other parties and in which the Trust has no beneficial interest. This has been excluded from the cash and cash equivalents figure reported in the accounts.

	31 March 2025	31 March 2024
	£'000	£'000
Net change in year	4	2
Total third-party assets	**4**	**2**

16. Trade and other payables

	31 March 2025 £'000	31 March 2024 £'000
Current		
Trade payables	19,659	17,811
Capital payables	3,387	10,181
Accruals	19,695	8,092
Social security costs	2,205	2,273
Other taxes payable	2,550	2,648
Pension contributions payable	2,721	2,508
Other payables	11	41
Total current trade and other payables	**50,228**	**43,554**

17. Other liabilities

	31 March 2025 £'000	31 March 2024 £'000
Current		
Deferred income: contract liabilities	1,807	937
Total other current liabilities	**1,807**	**937**
Non-current		
Deferred income: contract liabilities	-	-
Trade and other payables	909	1,185
Total other non-current liabilities	**909**	**1,185**

18. Borrowings

18.1. Borrowings

	31 March 2025	31 March 2024
	£'000	£'000
Current		
Lease liabilities	168	264
Total current borrowings	**168**	**264**
Non-current		
Lease liabilities	**66**	**149**
Total non-current borrowings	**66**	**149**

18.2. Reconciliation of liabilities arising from financing activities - 2024/25

	Lease liabilities	Total
	£'000	£'000
Carrying value at 1 April 2024	413	413
Cash movements:		
Additions	284	284
Financing cash flows – payments and receipts of principal	(451)	**(451)**
Financing cash flows – payments of interest	(11)	**(11)**
Carrying value at 31 March 2025	**235**	**235**

18.3. Reconciliation of liabilities arising from financing activities - 2023/24

	Lease liabilities	Total
	£'000	£'000
Carrying value at 31 March 2023	723	723
Additions	160	**160**
Financing cash flows – payments and receipts of principal	(460)	**(460)**
Financing cash flows – payments of interest	(10)	**(10)**
Carrying value at 31 March 2024	**413**	**413**

19. Provisions for liabilities and charges

Provisions for liabilities and charges analysis

	Pensions: early departure costs	Injury benefits	Other	Total
	£000	£000	£000	£000
At 1 April 2024	**53**	**213**	**90**	**356**
Change in the discount rate	-	(9)	-	**(9)**
Arising during the year	(1)	24	68	**91**
Utilised during the year	(16)	(29)	-	**(45)**
Unwinding of discount	1	5	-	**6**
At 31 March 2025	**37**	**204**	**158**	**399**
Expected timing of cash flows:				
- Not later than one year;	11	26	158	195
- Later than one year and not later than five years	24	90	-	114
- Later than five years	2	88	-	90
Total	**37**	**204**	**158**	**399**

Provisions relate to claims for staff injury and early retirement.

Clinical negligence liabilities

At 31 March 2025, £75.8m was included in provisions of NHS Resolution in respect of clinical negligence liabilities of Queen Elizabeth Hospital King's Lynn NHS Foundation Trust (31 March 2024: £10.1m)

20. Financial instruments

20.1. Carrying values of financial assets

Carrying values of financial assets as at 31 March 2025	Held at amortised cost	Total book value
	£'000	£'000
Trade and other receivables excluding non-financial assets	3,138	**3,138**
Cash and cash equivalents	21,974	**21,974**
Total at 31 March 2025	**25,112**	**25,112**

Carrying values of financial assets as at 31 March 2024	Held at amortised cost	Total book value
	£'000	£'000
Trade and other receivables excluding non-financial assets	3,468	**3,468**
Cash and cash equivalents	28,399	**28,399**
	-	**-**
Total at 31 March 2024	**31,867**	**31,867**

20.2. Carrying values of financial assets

Carrying values of financial liabilities as at 31 March 2025	Total book value
	£'000
Loans from the Department of Health and Social Care	**234**
Trade and other payables excluding non-financial liabilities	**48,398**
Total at 31 March 2025	**48,632**

Carrying values of financial liabilities as at 31 March 2024	Total book value
	£'000
Loans from the Department of Health and Social Care	**413**
Trade and other payables excluding non-financial liabilities	**40,922**
	-
Total at 31 March 2024	**41,335**

20.3. Maturity of financial liabilities

The following maturity profile of financial liabilities is based on the contractual undiscounted cash flows. This differs to the amounts recognised in the statement of financial position which are discounted to present value.

	31 March 2025	31 March 2024
	£'000	£'000
In one year or less	47,590	41,186
In more than one year but not more than five years	1,042	149
Total	**48,632**	**41,335**

21. Losses and special payments

	2024/25		2023/24	
	Total number of cases	Total value of cases	Total number of cases	Total value of cases
	Number	£'000	Number	£'000
Losses				
Cash losses	-	-	3	1
Overpayment of salary	31	29	7	3
Fruitless payments and constructive losses	28	277	31	167
Bad debts and claims abandoned	178	293	-	-
Total losses	**237**	**599**	**41**	**171**
Special payments				
Compensation under court order or legally binding arbitration award	5	45	1	1
Ex-gratia payments	28	12	33	41
Total special payments	**33**	**57**	**34**	**42**
Total losses and special payments	**270**	**656**	**75**	**213**
Compensation payments received	**-**	**-**	**-**	**-**

22. Revaluation reserve

	31 March 2025		Total 2025	Total 2024
	Land	Buildings	Total	Total
	£'000	£'000	£'000	£'000
Balance at 1 April 2024	818	-	818	640
Revaluations	-	2,321	2,321	178
Balance at 31 March 2025	**818**	**2,321**	**3,139**	**818**

23. Related parties

The Queen Elizabeth Hospital King's Lynn NHS Foundation Trust is a body corporate established by order of the Secretary of State for Health.

During the year none of the Board Members or members of key management staff or parties related to them has undertaken any material transactions with the Foundation Trust.

The Department of Health and Social Care is regarded as a related party. It is the parent department for DHSC group bodies. Accordingly we are required to provide a note of the main entities within the public sector which the Trust has had dealings with. They are included in the table below. A deminimus £500k income or expenditure has been used:

	Income 2024/25 £'000	Expenditure 2024/25 £'000	Income 2023/24 £'000	Expenditure 2023/24 £'000
Value of transactions with board members	-	-	-	-
Value of transactions with key staff members	-	-	-	-
HM Revenue and Customs		19,506	-	18,266
NHS Pension Scheme		19,853	-	17,782
Cambridge University Hospital NHS Foundation Trust	1,096	3,357	743	3,288
Norfolk and Norwich University Hospital NHS Foundation Trust	3,638	8,655	2,576	6,481
NHS Cambridgeshire and Peterborough ICB	41,563	-	39,835	-
NHS Norfolk and Waveney ICB	214,236	-	214,805	-
Health Education England	6,360	-	8,744	-
NHS England	17,389	93	26,874	6
NHS Norfolk Community Health and Care Trust	2,426	847	644	269
NHS Resolution	-	6,547	-	5,921

	Receivables 2024/25	Payables 2024/25	Receivables 2023/24	Payables 2023/24
	£'000	£'000	£'000	£'000
Value of balances (other than salary) with related parties in relation to doubtful debt	82	-	80	-
HM Revenue and Customs	-	1,569	-	1,543
NHS Pension Scheme	-	1,638	-	1,512
Cambridge University Hospital NHS Foundation Trust	-	328	471	534
Norfolk and Norwich University Hospital NHS Foundation Trust	327	4,730	728	1,312
NHS Cambridgeshire and Peterborough ICB	5	4	47	-
NHS Norfolk and Waveney ICB	119	2,806	-	610
Health Education England	-	-	-	-
NHS England	-	238	355	70
NHS Norfolk Community Health and Care Trust	1,408	459	63	7

Remuneration of Key Management Personnel

The following table analyses the remuneration of Key Management Personnel (deemed to be the Board of Directors) in accordance with IAS 24.

	31 March 2025	31 March 2024
	£'000	£'000
Short-term employee benefits (pay)	1,255	1,011
Pension related benefits (Employers pension contribution)	120	111
Total	**1,375**	**1,122**

Further details on remuneration of the Board of Directors and the highest paid director can be found in the Remuneration Report.

The Trust has also received revenue and capital payments amounting to £1,969k (£196k 2023/24 from The Queen Elizabeth Hospital King's Lynn Trust Charitable Fund, the Trustees for which make up the Trust Board. A copy of The Queen Elizabeth King's Lynn NHS Trust Charitable Fund accounts can be obtained on request by telephoning the Charitable Fund team on 01553 613981.

At 31 March 2025 £414k (2024: £217k) was owed to the Trust by the Charitable Fund.

The Trust conducted transactions with other Health Authorities and NHS bodies, which individually are not regarded as material, during the normal course of the Trust's activities.

24. Financial risk management

International Financial Reporting Standard 7 and International Accounting Standard 32 requires disclosure of the role that financial instruments have had during the period in creating or changing the risks a body faces in undertaking its activities. Because of the continuing service provider relationship that the Trust has with Integrated Care Boards and the way those Integrated Care Boards are financed, the Trust is not exposed to the degree of financial risk faced by business entities. Also financial instruments play a much more limited role in creating or changing risk than would be typical of listed companies, to which the financial reporting standards mainly apply. The Trust has limited powers to borrow or invest surplus funds and financial assets and liabilities are generated by day-to-day operational activities rather than being held to change the risks facing the Trust in undertaking its activities.

The Trust's treasury management operations are carried out by the finance department, within parameters defined formally within the Trust's standing financial instructions and policies agreed by the board of directors. Trust treasury activity is subject to review by the Trusts internal auditors.

Currency risk

The Trust is principally a domestic organisation with the great majority of transactions, assets and liabilities being in the UK and sterling based. The Trust has no overseas operations. The Trust therefore has low exposure to currency rate fluctuations.

Interest rate risk

Because the majority of the Trust's income comes from contracts with other public sector bodies, the Trust has low exposure to credit risk. The maximum exposures as at 31 March 2024 are in receivables from customers, as disclosed in the trade and other receivables note.

Liquidity Risk

The Trust's operating costs are incurred under contracts with Integrated Care Boards, which are financed from resources voted annually by Parliament. The Trust funds its capital expenditure from funds obtained within its prudential borrowing limit. The Trust is not, therefore, exposed to significant liquidity risk.

25. Contingent liabilities

The Trust has no contingent liabilities.

26. Capital Commitments

The Trust has £26.8m (2024: £23.0m) of contractual capital commitments at 31 March 2025 predominantly related to intangible assets, building schemes in progress and our involvement in the New Hospital Programme.

27. Contingent Assets

VAT recovery on car parking charges (Brockenhurst Claim)

The Trust has submitted a claim to HMRC for the recovery of VAT on car parking charges following the principles established in the Northumbria Healthcare NHSFT case amounting to £1.32m. The case considers whether VAT is due on hospital car parking when provided by NHS Trusts.

While this matter has been subject to legal proceedings and found in favour of Northumbria Healthcare NHSFT, the final outcome and its implications for the Trust's claim are dependent on the pending judgment of the Supreme Court.

As the outcome of the case remains uncertain, the Trust has elected to defer recognition of these VAT recoveries in the financial statements for the year ended 31 March 2025.

In accordance with IAS 37, no amounts have been recognised in the financial statements for the year ended [date]. Any recoveries will be recognised in the financial statements only if and when the legal position is resolved in a manner that confirms the Trust's entitlement to these amounts.

The Trust continues to monitor developments in the case closely and will reassess the accounting treatment of these potential recoveries in future periods.

Glossary

A

Accountability – the requirement for organisations to report and explain their performance.

Acute – describes a disease of rapid onset, severe symptoms and brief duration. The majority of hospital services provide by QEH are for acute illnesses.

Admission – the point at which a person enters hospital as a patient.

Agency staff – staff working at QEH but employed by a private recruitment agency.

B

Board Assurance Framework (BAF) – A structured approach for identifying and managing risks to the achievement of an organisation's objectives.

Bank staff – staff who are available for short-term or flexible work to help manage vacancies more effectively.

Best practice – a way of working that is officially accepted as being the best to use.

C

Caldicott Guardian – a senior person responsible for protecting the confidentiality of patient and service-user information and enabling appropriate information-sharing. Each NHS organisation is required to have a Caldicott Guardian.

Capital expenditure – the money allocated for buildings, equipment or land, also known as fixed assets.

Care Quality Commission (CQC) – the independent regulator of health and social care in England. The CQC regulates care provided by the NHS, local authorities, private companies and voluntary organisations.

Clinical audit – The process of reviewing clinical processes to improve them.

Clinical governance – Processes that maintain and improve quality of patient care.

Clinical outcomes – the end result of a medical intervention, such as survival or improved health.

Clostridium difficile (C. diff) – a healthcare-associated intestinal infection that mostly affects elderly patients with other underlying diseases.

Commissioning for Quality and Innovation (CQUIN) – a system of reward payments made by commissioners to hospitals to encourage better experience, involvement and outcomes for patients.

Corporate Risk Register – A tool used by organisations to identify, assess, and manage risks at a corporate level.

Cost Improvement Programme (CIP) – Initiatives aimed at reducing costs and improving efficiency within an organisation.

D

Data Security Protection Toolkit (DSPT) - An online self-assessment tool that allows organisations to measure their performance against the National Data Guardian's data security standards.

Datix – A patient safety web-based incident reporting and risk management software for health and social care organisations.

Dementia – describes a set of symptoms that may include memory loss and difficulties with thinking, problem-solving or language. Dementia is caused when the brain is damaged by diseases, such as Alzheimer's Disease or a series of strokes.

Discharge to Assess – enabling patients to be assessed for their longer-term health and social care needs at home or in the community, rather than waiting for this to happen in hospital.

Dr Foster – A company that has developed a Hospital Standardised Mortality Rate and other data comparisons across the NHS.

Duty of Candour – A legal duty to be open and honest with patients when something goes wrong with their treatment or care that causes, or has the potential to cause, harm or distress.

E

Early Warning Score (EWS) – a categorisation that uses data taken from routine patient observation to calculate a score indicating potential severity of illness and to act as a prompt to nursing staff to request a medical review at specific trigger points. (PEWS is a specific type of early warning score designed to assess children).

Elective care – care that is planned. This is usually where the patient is referred by their GP or other healthcare professional. Appointments, treatments and admissions to hospital will be confirmed in advance.

Elective surgery – an operation that is planned in advance and for which the patient will be given a date to be admitted to hospital.

Electronic Patient Record (EPR) – medical records and notes that are stored in a digital format instead of traditional paper document bundles.

End-of-life care – ensuring that the care people receive at the end of life is compassionate, appropriate, and gives people choices regarding where they die and how they are cared for. This care is co-ordinated across health and social care services.

F

Financial control total – the maximum amount of deficit or surplus that an NHS organisation is required to achieve. This amount is set by NHS England and agreed with each organisation, or as part of the wider health and care community.

First attendance – the first or only time a patient attends hospital after being referred by their GP or health professional.

Follow-up attendances – the second and subsequent times patients attend hospital for assessment, diagnosis or treatment as an outpatient.

Foundation Trust – A public service organisation. Based on mutual traditions, they are established as 'public benefit corporations' with new freedoms to innovate and forge partnerships in the public interest and governance arrangements designed to help trusts better reflect the needs of the communities they serve.

'Friend and Family' Test (FFT) – the national patient satisfaction programme which gives every patient the opportunity to feedback on the quality of their care.

Full-Time Equivalent (FTE) – the measurement and calculation of total staff numbers, using a standard working day. Also known as Whole Time Equivalent (WTE)

G

Gram-negative bloodstream infections (GNBSIs) – infections which are caused by bacteria into the bloodstream and can cause serious complications or death. They include Escherichia coli (E. Coli), Klebsiella, and Pseudomonas aeruginosa.

H

Healthwatch Norfolk – the local service affiliated to Healthwatch England, the national consumer champion in health and care. It has statutory powers to ensure the voices of patients and service users are heard by those who commission, deliver and regulate health and care services.

Hospital Standardised Mortality Rates (HSMR) – and indicator of healthcare quality that measures if the death rate at a hospital is higher or lower than you would expect. The HSMR compares the expected rate of death in a hospital with the actual rate of death. Factors such as age and severity of illness are considered.

I

Information Governance – the set of multi-disciplinary structures, policies, procedures, processes and controls implemented to manage information to ensure an organisation's regulatory, legal, risk, environmental and operational requirements.

Inpatient – a patient who is admitted to hospital for a period of treatment or to undergo an operation. Inpatients are those that stay in hospital for 24 hours or more.

Integrated Care System (ICS) – partnerships of organisations that come together to plan and deliver joined up health and care services, and to improve the lives of

people who live and work in the area. The QEH is part of the Norfolk and Waveney ICS.

Integrated discharge – planning and managing a patient's discharge from hospital across all services and all parts of the hospital.

Intervention – any measure to improve health or alter or alter the course of disease.

L

Locum staff – nurses and doctors employed by the NHS on a temporary, fixed-term basis.

M

Methicillin Resistant Staphylococcus Aureus (MRSA) – is a type of bacteria that is resistant to a number of commonly used antibiotics. It lives on the skin and is mostly harmless unless it gets deeper into the body, for example, if it gets into a wound or where the skin in is broken.

Model Hospital – a digital information service designed to help NHS providers improve their productivity and efficiency by comparing and benchmarking performance against peers / other centres.

N

National emergency access standard – a national standard for all Emergency Departments / Accident and Emergency Departments. The standard measures the number of patients seen, admitted and discharged within four-hours; hospitals are expected to achieve 95%. It is often known as the 'four-hour' standard.

National Patient Survey – ensures patients and the public have a real say in how NHS services are planned and developed. Getting feedback from patients and listening to their views and priorities is vital for improving services. All NHS Trusts in England are legally required to carry out local surveys asking patients their views on their recent health care experiences. There are inpatient, maternity and outpatient surveys.

Never Events – serious, but largely preventable patient safety incidents that should not occur if the available preventative measures have been implemented.

Non-elective care – is provided when the patient is assessed as needing treatment or hospital admission urgently or in an emergency.

Non-Executive Director – a members of the Trust's Board of Directors who is not part of the Executive Team. A Non-Executive Director typically does not engage in the day-to-day management but is involved in policy making and planning exercises. Non-Executive Directors have voting rights on the Board.

P

Palliative care – services for people living with a terminal illness where a cure is no longer possible. Palliative care aims to treat or manage pain and other physical symptoms. It will also help with any psychological, social or spiritual needs.

Parliamentary Health Service Ombudsman (PHSO) – the Ombudsman makes final decisions on complaints that have not been resolved by the NHS in England, UK government departments and other public organisations.

Pathway of care – the planned and most efficient way to provide care from referral to diagnosis, treatment and follow-up. Pathways are in place for most common diseases and conditions and use evidence-based practice to determine the best-way for patients to be seen and treated.

Patient Administration System (PAS) – computerised system to record non-medical patient details such as name and address as well as appointments / visits to the hospital.

Patient Advice and Liaison Service (PALS) – provides information, advice and support to help patients, families and their carers.

PROM (Patient Reported Outcome Measures) – A national programme whereby patients having particular operations fill in questionnaires before and after their treatment to report the quality of care.

Q

Quality Account – every NHS Trust is required to publish a Quality Account, setting out how it continues to improve the quality of services it provides. It covers three key areas: patient safety, clinical effectiveness and patient experience.

Quality assurance – the maintenance of a desired level of quality in a service or product, especially by means of attention to every stage of the process of delivery or production.

Quality Governance Framework – a set of standards for Trusts to continuously monitor themselves against.

R

RAAC (Reinforced Autoclaved Aerated Concrete) – a form of lightweight concrete sometimes referred to as panels. It was used primarily in roof planks of some public buildings between the mid-1960s and mid-1990s, including The QEH.

Referral to Treatment (RTT) – national maximum waiting times set out in the NHS Constitution from the point a patient is referred to hospital by their GP.

S

Staff engagement – encouraging staff to be committed to their organisation's goals and values, motivated to contribute to organisational success, and enhance their own sense of job satisfaction.

Single Oversight Framework – sets out how our regulator oversee NHS Trusts and NHS Foundation Trusts, helping to determine the level of support they need based on a range of performance measures.

T

Tertiary care – there are three levels of healthcare in the NHS: primary care (the first point of contact for patients including GPs, dentists, pharmacists and opticians); secondary care (specialist services, often provided by a hospital, that patients are referred to from primary care); and tertiary care which is further specialised treatment and care provided by professionals with specific expertise in a given field, for example neurosurgery, cardiac surgery and cancer management.

Tertiary referrals – referrals for specialist care from consultant to consultant. These can be within the same hospital / service or between different hospitals and services.

Trust Management Group (TMG) – A group within an NHS Trust responsible for managing the day-to-day operations and implementing the strategic direction set by the Board.

V

VTE – Venous Thromboembolism is a condition in which a blood clot forms, most often in the deep veins of the leg, groin or arm (known as deep vein thrombosis or DVT) and travels in the circulation, lodging in the lungs (known as a pulmonary embolism).

W

Waiting times – the period that a patient may wait before being seen at a routine appointment or for admission to hospital. The standards and maximum waiting periods are set nationally under the NHS Constitution

Workforce Race Equality Standard (WRES) – A framework to ensure employees from black and ethnic backgrounds have equal access to career opportunities and receive fair treatment in the workplace.

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