The Queen Elizabeth Hospital King's Lynn
NHS Foundation Trust

Annual Report and Accounts

2025/26

The Queen Elizabeth Hospital King's Lynn NHS Foundation Trust

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For the period 1 April 2025 to 31 March 2026

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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 2025/26 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.

Group Chair's Foreword

2025/26 was a landmark year for our hospitals with the formal establishment of the Norfolk and Waveney University Hospitals Group (NWUHG) and I have the privilege of writing the first Chair's foreword for the new Group.

For many years, the three trusts within our Group - the Queen Elizabeth Hospital King's Lynn NHS Foundation Trust (the QEH), James Paget University Hospitals NHS Foundation Trust (JPUH) and Norfolk and Norwich University Hospitals NHS Foundation Trust, (NNUH) incorporating Cromer Hospital and the Jenny Lind Children's Hospital - have served as the primary acute providers and anchor institutions for our county. Together, they continue to care for a large and diverse population across Norfolk and Waveney and parts of Cambridgeshire, Lincolnshire and Suffolk.

While the three hospitals proudly retain their individual statutory identities and local community focus as statutory organisations, coming together under a single Group Board provides the collective strength needed to tackle shared, systemic challenges which no single hospital has been able to solve alone.

I joined the Group as Chair in November 2025 because I believe in the immense potential of our three hospitals and the benefits that greater integration can bring for patients. Our Group Board is now firmly established with new Group Non-Executive Directors working alongside the Executive Management Team under the leadership of Group Chief Executive, Professor Lesley Dwyer and trust specific Executive Managing Directors.

We face undeniable, deeply rooted challenges in access, finance and ageing infrastructure and we will not shy away from addressing them. Transparency and candour will be the hallmarks of our Board and we embrace fully our role of demonstrating through our unified leadership, the ethos and culture we wish to engender Group-wide – acting as a Group but with deeply local intensions.

We aim to ensure all three trusts deliver consistently the standard of care our patients and our population deserves and that our staff want to provide.

Our priorities are to:

- provide safe, high-quality care now and improve rapidly where standards are not yet where they should be
- design and deliver effective, needs-based and locally responsive services for the future
- provide care as close to home as is clinically appropriate

Facing challenges and pursuing improvement

In moving forward with our ambitions, it has inevitably meant navigating a challenging year for each of our hospitals, with particular difficulties affecting some individual services.

Nationally, our performance as measured by the National Oversight Framework (NOF) has not met the standards our patients deserve. During 2025 all three trusts were placed in the bottom tier of NOF performance, a position that does not sit well in the ambitions of our combined clinical and leadership teams. NNUH has subsequently improved its standing and achieved a higher tiering by the end of 2025/26.

In response to these challenges, the Group Board has consistently focused on performance improvement and recovery, a commitment which continues. The Board has also overseen important progress on strategic projects, including the New Hospitals Programme and the Electronic Patient Record. These initiatives form the foundation for delivering modern and equitable care across all of the services we provide.

Importantly, the Group Board has invested time and resources to look beyond operational matters and towards the future. In 2025/26, working with partners across the local health and social care system, and drawing on expertise in population health needs assessment, planning and neighbourhood development, the Group has started to shape a sustainable and responsive pattern of healthcare for the years ahead. This work is guided by a straightforward commitment: to frame every decision by the question, **“What is right for our patients?”** Further engagement in 2026/27 will focus on advancing these efforts in line with the NHS 10-Year Health Plan.

The Group Board is ambitious for both our population and our health system. We aim to take a leading role in developing a premier University Hospital System for Norfolk and Waveney. During 2025/26, partnerships have been deepened with the University of East Anglia, Norwich Research Park, the College of West Anglia, University of Suffolk, and other academic institutions. The goal is to embed research, education, and innovation within daily clinical practice, with ongoing efforts to create more opportunities for staff and students. This will continue to be a focus in 2026/27 and beyond.

Acknowledgements and gratitude

I would like, on behalf of the Group Board, to pay tribute to all our exceptional staff for their dedication and care, especially during periods of intense winter pressures and industrial actions. Their resilience has been invaluable in ensuring the best care is received from the services we provide.

Our thanks extend to the teams of volunteers and the hospital charities, whose daily efforts provide immeasurable benefit to our services and patients and staff.

During 2025/26, Mark Friend provided highly capable stewardship as Interim Chair during a complex transition phase. The Board acknowledges his contributions, as well as those of Tom Spink, Stephen Javes, and Graham Ward, outgoing chairs of the individual trusts, who continued to support during this period. Sincere thanks are also due to the former Non-Executive Directors of the three trusts who stood down last autumn, to all of our Governors and to our system partners for their unwavering commitment to the patients and residents of Norfolk and Waveney.

By uniting our leadership, the Group is laying the groundwork for a sustainable future for acute services, a robust University Hospital System, and a stronger foundation to help deliver the Government's 10-Year Health Plan for health and its three central objectives:

- hospital to community
- analogue to digital systems
- treatment to prevention

The agenda remains challenging, but the foundations are in place to support more effective and efficient acute care delivery firmly focused on delivering better care for our patients**.**

Signed

David Roberts
Group Chair, Norfolk and Waveney University Hospitals Group

Statement from the Group Chief Executive

This year has marked a period of leadership change as we transitioned into Norfolk and Waveney University Hospitals Group. I would like to begin by thanking Alice Webster, who held the position of CEO until May 2025, Chris Bown, Interim Executive Managing Director from June 2025 to January 2026 and Michelle Arrowsmith from January 2026 to June 2026, for their leadership during their time in post. Each of these leaders have provided the focus on improvement in the way care is delivered. Currently, Jo Segasby, an experienced CEO and NHS leader is providing the necessary leadership to the Queen Elizabeth King's Lynn NHS Foundation Trust (the QEH). Jo actually started her NHS leadership journey at the QEH as a trainee nurse and so knows both West Norfolk and the Trust well.

It is clear that it has been a challenging 12 months for the QEH and in September 2025 the NHS National Oversight Framework placed the QEH as 134 of 134 trusts. This is an uncomfortable position to be in and one that shocked and disappointed our staff, our community and caused concern for our patients. This is not what I or any of the staff want for our patients and is certainly not what they deserve. I and the leadership of the QEH fully accept that major improvement is needed urgently. I recognise that services must be improved to provide quality, safe and timely care for our community.

During the year the Trust faced significant regulatory and operational challenges, including increased oversight from NHS England and the Care Quality Commission (CQC), alongside the need to strengthen aspects of clinical governance, service quality and organisational performance. While these challenges are significant, they have provided a clear focus for improvement and have reinforced our commitment to delivering sustainable change for patients and staff. We will make improvements with the support of the Norfolk and Waveney University Hospitals Group (NWUHG), formed in May 2025, which brings three hospital trusts - James Paget University Hospitals (JPUH), Norfolk and Norwich University Hospitals (NNUH) and the Queen Elizabeth Hospital (the QEH), King's Lynn - under one Group.

By working more closely together as a Group, we can secure the long-term sustainability of all three acute hospitals and ensure they continue to provide healthcare that meets the needs of their local communities.

Our recovery programme is already in action and is focused on addressing urgent issues, improving performance, strengthening quality governance and delivering more consistent standards of care. Coming together as the Norfolk and Waveney University Hospitals Group also helps us to tackle shared performance, finance and workforce challenges, while providing greater opportunities to share expertise, strengthen clinical leadership and support improvement across services. As part of our planning for the next two years, we are looking at how we can adapt for excellence and embrace the 'left shift' of care from hospital to community, as part of the national 10 Year Health Plan. This includes putting in place strong

neighbourhood health partnerships and focusing on health inequalities. We will work with our stakeholder partners in West Norfolk, Lincolnshire and Cambridgeshire on how we can achieve this to best serve our local population and drive care closer to the community.

As we look to the future it is clear we must address the issues we face, including the findings from the invited Royal College of Surgeons review of General Surgery and the wider opportunities identified to strengthen clinical governance, organisational learning and service oversight. We must also respond positively to regulatory actions arising from CQC inspections, continue our work under NHS England improvement arrangements and ensure that the learning from the independent maternity and neonatal investigation led by Baroness Amos is fully embedded within our services. These actions form part of a wider programme of improvement designed to strengthen patient safety, quality of care and public confidence. Our challenges do not mean that we don't provide good care. We have much to do to improve however we have foundations to build on.

In July 2025 the QEH received Teaching Hospital status recognising the quality of our education and training provision. This is a significant step forward supporting our ability to attract, develop and retain a strong future NHS workforce at a time when workforce capacity and recruitment challenges continue to be experienced across the NHS. Research and innovation have continued to develop, with the QEH leading global clinical trials for heart failure patients and delivering significant health improvements.

We are proud of national recognition received this year by those that work in the organisation. Care has been recognised in stoma nursing care, digital health leadership, children's epilepsy psychology, endoscopy quality, our education faculty and the design of our Community Diagnostic Centre.

Progress has continued to bring a new hospital to King's Lynn with enabling works taking place including the move of a bus stop to make way for the multi-storey car park. Both of these are key pieces of work which take place before a new hospital can begin construction on the current site.

Whilst we recognise and accept the challenges we face, including those relating to regulatory compliance, service improvement, workforce sustainability and financial resilience, we are laying the foundations for long-term change. Through the support of the Norfolk and Waveney University Hospitals Group, our improvement programme and the commitment of our staff, we are taking the actions necessary to strengthen services and improve outcomes for our patients.

The QEH has a unique role to play as part of the future of healthcare provision within Norfolk and we remain committed to delivering the improvements our patients, staff and communities expect and deserve.

Signed

Professor Lesley Dwyer
Group Chief Executive

Our year in numbers

Purpose and activities of the Foundation Trust

The Queen Elizabeth Hospital King's Lynn NHS 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 served, the QEH is commissioned by Integrated Care Boards (ICBs) across Norfolk, Cambridgeshire and Lincolnshire, with NHS Norfolk and Waveney ICB (NHS Norfolk and Suffolk ICB as of 1 April 2026) acting as the lead commissioner.

The Trust works collaboratively with the Norfolk and Waveney, Cambridgeshire and Peterborough, and Lincolnshire Integrated Care Systems (ICSs), as well as with other Trusts within the Norfolk and Waveney University Hospitals Group, to deliver a number of services.

During 2025/26, the Trust continued to address significant challenges identified within General Surgery following external reviews and regulatory scrutiny, which highlighted areas requiring improvement in clinical governance, escalation processes, decision-making, communication, teamwork and organisational learning. In response, a new approach to General Surgery was introduced to strengthen operational pathways, enhance clinical oversight and provide an enhanced staffing model in partnership with Norfolk and Norwich University Hospitals NHS Foundation Trust (NNUH). This approach is also being implemented within audiology services in early 2026/27.

In alignment with the Clinical Strategy and the emerging Group 'One Strategy', integrated pathways are being developed 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, including the Community Diagnostic Centre (CDC)
- North Cambridgeshire Hospital (NCH)
- Swaffham Cottage Hospital
- St Augustine's Surgery (King's Lynn)
- Downham Market Midwifery Hub
- King's Lynn Health Hub

The Trust also commissions intermediate care and cognitive impairment beds within the local area. This enables earlier discharge from hospital for these patient groups, with structured ongoing care provided in a community setting for a defined period to support their transition home. This model of care has been recognised nationally and is now being adopted in other areas.

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 Queen Elizabeth Hospital King's Lynn NHS Foundation Trust (the QEH) is a district general hospital employing more than 4,000 staff and volunteers. It serves a population of around 375,000 people across West and North Norfolk, Breckland, Cambridgeshire and South Lincolnshire. The organisation is united by a shared commitment to delivering high-quality, safe and compassionate care to its communities.

Authorised as a Foundation Trust in 2011, the QEH has approximately 500 inpatient beds across 22 core wards. In 2025/26, the Trust cared for more than 96,200 people in its Emergency Department (ED), carried out over 39,900 day case procedures, delivered more than 1,710 babies and treated more than 30,600 elective and non-elective inpatients. As a research-active organisation, it plays an important role in clinical innovation, recruiting over 1,035 participants to National Institute for Health and Care Research (NIHR) portfolio studies during the year.

In May 2025, the QEH became part of the Norfolk and Waveney University Hospitals Group, alongside the Norfolk and Norwich University Hospitals NHS Foundation Trust (NNUH) and the James Paget University Hospitals NHS Foundation Trust (JPUH). This represents a significant milestone in its development, building on the strong partnership established through the Norfolk and Waveney Acute Hospital Collaborative since 2020. The move has also supported the Trust in responding to a number of significant challenges identified during the year, including concerns relating to General Surgery, improvement requirements arising from its position within the NHS National Oversight Framework, and participation in the independent maternity and neonatal investigation led by Baroness Amos.

The QEH is led by the Executive Managing Director who is a member of the Group Executive and the Group Board. As part of the Group, the QEH aligns strategic ambitions while remaining a distinct organisation focused on the needs of its local population. This model enables the benefits of working at scale, including improved resilience, shared expertise and strengthened research and training opportunities, while maintaining locally delivered, patient-centred care. It has also enabled strengthened clinical leadership, oversight and support arrangements in response to findings from external reviews, inspections and regulatory scrutiny.

Through the Group, collaboration is being enhanced to transform services, improve access and outcomes, and deliver consistent high-quality care across Norfolk and Waveney. This includes a coordinated approach to urgent and emergency care, cancer services and the implementation of a new Electronic Patient Record (EPR) system, development of new hospital facilities in King's Lynn and Gorleston, and a continued focus on prevention and proactive care for people with long-term conditions. Alongside these developments, the Trust continues to implement

improvement programmes designed to strengthen quality, governance, patient safety and organisational learning across all services.

Over the past three years, the Trust has undergone significant improvement. It is now rated ‘Good’ by the Care Quality Commission (CQC) in three domains - Caring, Well-Led and Effective - while the overall rating remains ‘Requires Improvement’. The Trust’s ‘Well-Led’ rating relates to the organisation as a whole; however, some individual services inspected by the CQC have received lower Well-Led ratings, reflecting variation in performance at service level. Maternity Services are also rated ‘Good’, with inspectors recognising meaningful progress in staff culture, communication and leadership. The Trust acknowledges that further improvement is required in a number of areas, including those identified through external reviews and oversight processes during 2025/26. These achievements nevertheless provide a strong foundation as the Trust continues its journey of improvement.

In May 2023, the QEH was included in the government’s New Hospital Programme (NHP), recognising the urgent need to replace ageing infrastructure. In January 2025, the government reaffirmed the replacement of Reinforced Autoclaved Aerated Concrete (RAAC)-constructed hospitals as a national priority. The QEH and Norfolk and Waveney University Hospitals Group remain committed to delivering the New QEH, ensuring modern, fit-for-purpose facilities that will support high-quality care for generations to come.

Progress and momentum in delivering a New QEH

Over the past year, the New QEH programme has continued to progress, moving from early development into a more assured and delivery-focused phase. Building on national confirmation of the scheme and its continued inclusion within the New Hospital Programme (NHP), the emphasis has increasingly been on demonstrating readiness to deliver a complex and nationally significant hospital as part of a wider, integrated Group model. The programme remains central to addressing the challenges associated with the Trust’s ageing estate and supporting the delivery of safe, sustainable healthcare for the population of West Norfolk.

A key milestone during the year was the formal approval of the Strategic Outline Case by the Secretary of State for Health and Social Care. This national endorsement marked a significant step forward, confirming both the urgent need for a new hospital in King’s Lynn and the robustness of the proposed solution. It provides assurance that the New QEH aligns with national policy, Hospital 2.0 principles and the future direction of the NHS, enabling the programme to progress with greater confidence and clarity. The approval also reflects the strategic importance of replacing infrastructure that presents ongoing estate challenges and supporting the long-term resilience of local healthcare services.

Alongside this approval, the programme has been shaped by the transition towards a Group hospital model, working closely with the Norfolk and Norwich University

Hospitals NHS Foundation Trust (NNUH) and the James Paget University Hospitals NHS Foundation Trust (JPUH). This approach recognises that the long-term success of the New QEH depends on how services, workforce and capacity are planned across the wider system. Alignment across the Group is now a core principle, ensuring the new hospital complements rather than duplicates provision elsewhere and supports sustainable models of care.

The programme has matured significantly over the year. Governance, assurance and programme controls have been strengthened, increasing confidence for the Group Board, the Norfolk and Waveney Integrated Care Board (ICB) (NHS Norfolk and Suffolk ICB as of 1 April 2026) and national partners. The programme team has expanded and stabilised, bringing together the clinical, technical, commercial and financial expertise required to deliver the scheme within a complex multi-organisation environment.

Detailed alignment work has been undertaken with colleagues at NNUH and JPUH to ensure consistency across key planning assumptions, including clinical strategy, activity and capacity modelling, workforce planning and service configuration. This work has been critical in ensuring that the New QEH is developed as part of a coherent Group strategy, supporting workforce resilience, reducing unwarranted variation and enabling specialist services to be planned effectively at scale.

Tangible progress has also been made on enabling works essential to both operational continuity and future construction. The multi-storey car park remains a key enabler and during the year, the relocation of the onsite bus stop commenced, marking the first visible step in preparing the site for delivery. While modest in isolation, this represents important progress and demonstrates that enabling activity is moving from planning into delivery. These enabling works are an important component of maintaining momentum towards a replacement hospital that will address the limitations and risks associated with the existing estate.

Clinical and operational engagement has continued to deepen, supported by collaboration across the Group and with national clinical leaders. Detailed modelling of demand, pathways and patient flows has enabled the Schedule of Accommodation to be refined and tested against population need, workforce availability and modern models of care. This ensures that the New QEH will be appropriately scaled, flexible and capable of supporting both physical and digital transformation over time.

Further progress has been made in strengthening programme assurance, including clearer approaches to procurement and commercial strategy, and a more detailed understanding of cost, phasing and risk. While less visible, these elements are critical to ensuring that the programme remains credible and deliverable as it approaches construction.

Looking ahead, the coming year will see further progress into detailed development and early delivery planning, undertaken in close collaboration with Group partners.

Detailed design, early works preparation and ongoing workforce and operational planning will continue to be shaped by system-wide thinking, ensuring decisions are taken consistently and in the best interests of our catchment population. Engagement with staff, patients and local communities will remain central to this work.

The New QEH represents a once-in-a-generation opportunity to transform healthcare in West Norfolk. It is also a critical component of the Trust's response to the significant estate challenges facing the current hospital and the need to provide a modern, resilient healthcare environment for future generations. Over the past year, the programme has secured national approval, strengthened system alignment and commenced visible enabling works on site. While challenges remain, the direction is clear. By working as part of a Group, aligning closely with NNUH and JPUH maintaining strong national assurance, the New QEH is moving decisively from planning into delivery, and from ambition into reality.

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 'Well-Led' rating shown above relates to the Trust overall. Individual services and locations may have different Well-Led ratings based on subsequent inspections. For example, Surgery is currently rated 'Requires Improvement' for Well-Led at service level, while the Trust's overall Well-Led rating remains 'Good'.

In March 2026, the CQC undertook an unannounced inspection of Surgical Care Services. The QEH currently awaits the final report. This inspection formed part of continued regulatory oversight during a year in which quality improvement, governance and service sustainability remained key organisational priorities.

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

During 2025/26, substantial work was undertaken to address the above Section 31 conditions, with all evidence submitted to the CQC to support their removal. The QEH currently awaits a response. While the Trust remains rated as 'Requires Improvement' overall and is not yet fully compliant with all registration requirements, addressing these regulatory conditions has remained a key focus of the Trust's quality improvement activity throughout the year.

In addition to CQC oversight, the Trust was subject to NHS England Enforcement Undertakings during 2025/26 and entered the National Provider Improvement Programme in March 2026. These arrangements have provided additional support and scrutiny to strengthen quality governance, service improvement and organisational oversight.

Quality improvement and service governance

The Trust's Integrated Quality Improvement Plan has continued to provide the framework through which quality, patient safety and clinical effectiveness improvements are identified, monitored and delivered. During the year, particular focus was placed on strengthening governance arrangements, improving organisational learning and supporting sustainable improvements in services subject to external review and regulatory oversight.

In October 2025, a Royal College of Surgeons review of General Surgery identified areas for improvement, including recognition of deterioration, surgical decision-making and escalation, handovers, consultant accountability, team culture and governance. In response, enhanced leadership, oversight and service arrangements were implemented as part of a move towards a shared service model with Norfolk and Norwich University Hospitals NHS Foundation Trust. This included strengthened clinical leadership and work to align standards, pathways and expectations across both organisations.

Alongside these service-specific actions, quality improvement activity during the year continued to be supported through strengthened patient safety learning, implementation of the Patient Safety Incident Response Framework, Trust-wide learning events and enhanced use of the Learn from Patient Safety Events service. Work also continued to strengthen quality governance and oversight arrangements as part of the wider Norfolk and Waveney University Hospitals Group model.

During 2025, the QEH participated in the CQC consultation, better regulation, better care. Following this consultation, the CQC plans to return to sector-specific frameworks, removing the quality statements and replacing them with a revised set

of supporting key lines of enquiry. As the CQC transitions to implementing these changes in 2026, the QEH will initiate a comprehensive internal readiness review. This will involve aligning quality governance and self-assessment processes with the draft secondary and specialist care framework to ensure readiness for the new regulatory cycle.

2024 CQC Inspection ratings for the QEH

The table below shows ratings for individual services. These service-level ratings may differ from the Trust-wide ratings shown above. In particular, while the Trust is rated ‘Good’ for Well-Led overall, some services, including Surgery, are rated ‘Requires Improvement’ for Well-Led.

	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 strategy

2025/26 - Year 2 of our strategy

This section summarises progress made by the Queen Elizabeth Hospital King's Lynn NHS Foundation Trust (the QEH) during 2025/26, the second year of the five-year strategy.

The strategy is structured around 10 Strategic Objectives (SOs) grouped under three themes: *Quality, Engagement and Healthy Lives.* Each objective is supported by key performance indicators (KPIs) agreed by the Senior Leadership Team and the Hospital Management Group. Quarterly reports track performance against each objective.

The QEH remains committed to delivering high-quality care for a growing and increasingly complex population, while being transparent about areas requiring improvement.

This report summarises each objective, outlining its importance, approach and Year 2 progress and learning.

As the QEH moves into 2026/27, the strategy is being aligned with the emerging Group Strategy. Review work has identified strong alignment in objectives and deliverables, which will inform next steps.

Quality - Strategic Objectives 1 to 3

Strategic Objective 1: Holistic and Person-Centred Care and Experience

Why this matters

Person-centred care ensures patients feel listened to, respected and involved in decisions. This improves safety, outcomes and trust.

Our approach

The QEH focuses on improving communication, acting on patient feedback and reducing barriers to access. Feedback is gathered through the Friends and Family Test (FFT), complaints, surveys and engagement with patient groups.

Progress in Year 2

- a new Civica FFT platform was implemented by August 2025, significantly increasing feedback volume and reach
- patient information was reviewed with the Readers Panel to ensure accessibility and clarity
- patient involvement expanded across workstreams, including clinical improvement initiatives and engagement with underrepresented groups

- monitoring of safety incidents related to information quality was strengthened, including escalation of histology delays

Looking ahead

Focus will be on using improved feedback data to drive service improvement and strengthening community engagement.

Strategic Objective 2: Clinical Excellence

Why this matters

Clinical excellence ensures safe, effective and evidence-based care supported by research, education and innovation.

Our approach

Priorities include achieving Teaching Hospital status, embedding continuous improvement, expanding research and strengthening digital capability.

Progress in Year 2

- Teaching Hospital status was formally confirmed in Quarter 2
- research recruitment increased, with collaborative Group work progressing towards a shared function
- simulation training capability expanded, including new equipment and accreditation progress

Looking ahead

The focus will be on strengthening academic partnerships, expanding research and improving access to innovation.

Strategic Objective 3: Operational Efficiency and Effectiveness

Why this matters

Efficient operations reduce waiting times and improve patient flow and experience.

Our approach

Performance is monitored across access standards, with improvement guided by national best practice.

Progress in Year 2

- Phase One Strategic Service Development Plans were approved, with further work ongoing in key specialties aligned to the One Recovery Programme
- theatre utilisation and elective productivity an area of focus
- cancer performance improved but remains below target
- Stroke Services saw initial improvements but remain high risk due to sustainability challenges with solutions being explored at a Gorup level
- Virtual Ward expanded to deliver five pathways

- emergency care improved early in the year, supported by Emergency Care Improvement Support Team (ECIST) input
- diagnostic performance saw overall improvements with capacity constraints being managed within two key specialties

Looking ahead

Improving access and flow remains a priority, requiring continued system-wide collaboration through the Group and the One Recovery Programme.

Engagement - Strategic Objectives 4 and 5

Strategic Objective 4: Our People

Why this matters

Staff experience directly affects patient care quality and safety.

Our approach

The People Strategy aligns with the NHS Long-Term Workforce Plan, supported by workforce data and staff feedback.

Progress in Year 2

- sickness absence was above target and improved on the previous year
- staff survey participation reached a record 51%, though results showed significant areas for improvement
- agency and bank usage reduced below plan
- over 180 managers completed leadership training
- appraisal compliance improved but remained below target
- People Policy renewal remains an area of focus aligned with the focus on development of Group policies
- mandatory training compliance standards improved

Looking ahead

Priorities include improving staff experience, reducing overdue policies and sustaining workforce improvements.

Strategic Objective 5: Governance and Leadership

Why this matters

Effective governance ensures accountability, informed decision-making and organisational safety.

Our approach

The QEH maintains clear accountability, strengthens leadership capability and ensures robust assurance, alongside the transition to the Group model.

Progress in Year 2

- the Group Operating Model and governance structures were implemented
- a strengthened governance framework is now in place
- joint policy development has progressed, though remains below target
- continuous improvement programmes and a standardised Project Management Office (PMO) framework were embedded and now form part of the One Recovery Programme

Looking ahead

Maintaining clarity and accountability within the Group model will remain a key focus.

Healthy Lives - Strategic Objectives 6 to 10

Strategic Objective 6: Becoming a Digitally Enabled and Data-Driven Organisation

Why this matters

Digital capability improves clinical decision-making, efficiency and patient outcomes.

Our approach

Priorities include Electronic Patient Record (EPR) implementation, digital strategy development, data governance and workforce capability.

Progress in Year 2

- a five-year digital strategy was developed
- development and implementation of a Single Digital team within the Group was approved
- the EPR programme progressed but timelines were revised and remain high risk
- digital maturity assessment and IT Service Management (ITSM) implementation were completed

Looking ahead

The EPR programme remains central, with a continued focus on delivery and benefits realisation.

Strategic Objective 7: Financial Sustainability

Why this matters

Financial stability underpins service delivery and long-term sustainability.

Our approach

The QEH aims for recurrent financial balance through efficiency, cost improvement and income generation.

Progress in Year 2

- financial performance remained a high risk, with variances during the year, but the Trust achieved a small surplus at year end
- the Trust had a significant capital programme which was delivered in line with plan
- work progressed to develop a Group finance function ahead of transition in April 2026

Looking ahead

Achieving sustainable financial balance remains a key challenge and priority.

Strategic Objective 8: Sustainability and Environmental Responsibility

Why this matters

Reducing carbon emissions supports environmental and population health while improving efficiency.

Our approach

Focus areas include energy use, travel, waste reduction and staff engagement.

Progress in Year 2

- solar panels, heat pumps and Light-Emitting Diode (LED) upgrades were implemented
- carbon reporting capability was established
- sustainable travel schemes were expanded
- recycling rates improved but remain below target

Looking ahead

Embedding sustainability into routine decision-making remains a priority.

Strategic Objective 9: Community and Stakeholder Partnerships

Why this matters

Effective partnerships are essential to improving population health and reducing inequalities.

Our approach

The QEH works with system partners to develop integrated care, reduce inequalities and strengthen networks.

Progress in Year 2

- place-based care communication and system wide planning for health inequalities training progressed
- Specialty Clinical Networks delivered Phase One of their ambitions. Further development will take place in line with One Recovery Programme priorities

- urgent care model development is progressing including an urgent treatment centre development aligned to development of service delivery from the King's Lynn Health Hub
- New QEH operating model planning continues supported by the transition of the programme to Group
- Anchor institution work has progressed, supporting local communities, specifically in relation to workforce development and opportunities

Looking ahead

Partnership working will continue to develop as Group governance matures.

Strategic Objective 10: Community and Stakeholder Partnerships

Why this matters

Safe, modern facilities are essential for patient care and staff experience.

Our approach

Focus includes maintaining the existing estate and progressing the New QEH programme.

Progress in Year 2

- critical infrastructure funding supported safety improvements
- the Strategic Outline Case for the New QEH was approved
- public and clinical engagement was strong
- sustainability and digital integration are embedded in design
- workforce planning for Estates and Facilities is progressing

Looking ahead

Maintaining estate safety while progressing the New QEH remains a priority.

Looking ahead: our priorities for Year 3

Year 2 has delivered significant progress alongside ongoing challenges. Achievements include achieving Teaching Hospital status, strengthened governance, improved workforce metrics, progress in sustainability and advancement of the New QEH programme.

Challenges remain for the Trust and we will move forward with Our Strategy in line with development of the Group's One Strategy to ensure that we continue to deliver care in the best way that we can for our local populations.

These reflect a Trust in transition, building strong foundations while addressing complex issues. In Year 3, the focus will be on consolidating progress, accelerating delivery where needed and ensuring the strategy delivers measurable improvements for patients, staff and partners.

Pictured above: Group Chief Executive Professor Lesley Dwyer and Director of Strategy and Integration Carly West-Burnham presented certificate of the QEH's revalidation for the Defence Employer Recognition Scheme (ERS) Gold Award by HM Lord Lieutenant The Lady Dannat MBE in March 2026.

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.

The Group Audit Committee in Common considered its going concern position at its meeting on 22 June 2026 and consideration of risks and uncertainties agreed that the use of a going concern basis is appropriate.

Performance analysis: Our finances

Overview of 2025/26 financial performance

The financial plan for 2025/26 was submitted in accordance with the national planning timeframes during April 2026. The plan was initially set at a £22.5m deficit and included a £18.3m Cost Improvement Programme (CIP). Deficit support funding was allocated to the Trust during the planning process, reducing the planned deficit to a break-even position.

Financial sustainability remained a key organisational priority throughout the year. The Trust continued to operate in a challenging financial environment and maintained enhanced oversight of financial recovery, liquidity management and delivery of efficiency programmes in order to support the achievement of its financial plan.

During 2025/26, the work of the Financial Recovery team continued to focus on strengthening financial resilience, supporting delivery of the financial plan and maintaining robust control arrangements in response to ongoing financial pressures. Key areas of focus included:

- 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 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 Recovery meeting that continues to oversee the development and progression of CIP plans.

The actual performance for the year was a £1.7m surplus, this was in line with the revised financial position which included deficit support funding of £22.5m, agreed with NHSE during the financial planning process and the release of a further £1.6m of deficit support funding towards the end of the financial year.

This performance was achieved through a combination of delivery of efficiency programmes, strengthened expenditure controls and nationally allocated deficit support funding. Financial performance continued to be subject to close monitoring throughout the year given the wider financial challenges facing the Trust and the NHS.

The Trust spent £67.6m 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 £7.5m lower than the planned expenditure. Capital investment continued to be carefully prioritised to support essential estate, digital and strategic transformation programmes while operating within the constraints of the wider financial environment.

Performance against our financial plan

The Trust delivered a surplus of £1.7m (excluding impairments) for the year compared to a breakeven plan for 2025/26.

The Trust's position includes some notional accounting adjustments of £15.0m 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 for deficit support of £22.5m.

	Plan (£'000)	Actuals (£'000)	Variance (£'000)
Income	(334,714)	(368,345)	33,631
Pay	226,319	235,716	(9,397)
Non-Pay	92,047	114,477	(22,428)
Earnings before interest, tax, depreciation and amortisation (EBITDA)	**(16,348)**	**(18,152)**	**1,806**
Below EBITDA	16,348	16,500	(152)
Total (Surplus) / Deficit	**0**	**(1,652)**	**1,654**

Note: The table above excludes £4.9m of capitalised staff cost and building impairments.

While the Trust delivered a year-end surplus position, financial sustainability remained a significant area of focus throughout 2025/26. The Trust continued to operate within a challenging financial environment characterised by cost pressures, workforce constraints, capital investment requirements and the need to deliver substantial efficiency savings. Financial performance, liquidity and recovery actions were therefore subject to enhanced oversight through established Trust and Group governance arrangements.

Analysis of Trust's income and expenditure

Income: We received £368.3m income for 2025/26 (2024/25 £325.4m), an increase of £42.9m (13%), which includes the nationally allocated deficit support funding of £24.1m (£22.5m initially agreed plus £1.6m additionally agreed).

Pay expenditure: The Trust spent £254.9m on staff costs which includes capitalised staffing costs of £4.9m, which is £2.7m more than was incurred in 2024/25. Included in the increase are nationally agreed pay awards, impacts of agenda for change amendments and additional costs to manage periods of industrial action. Temporary staffing was also used to cover vacancies and sickness absences across all staff groups.

Non-pay expenditure: The Trust incurred £114.5m of non-pay expenditure, which was an increase of £17.7m 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.

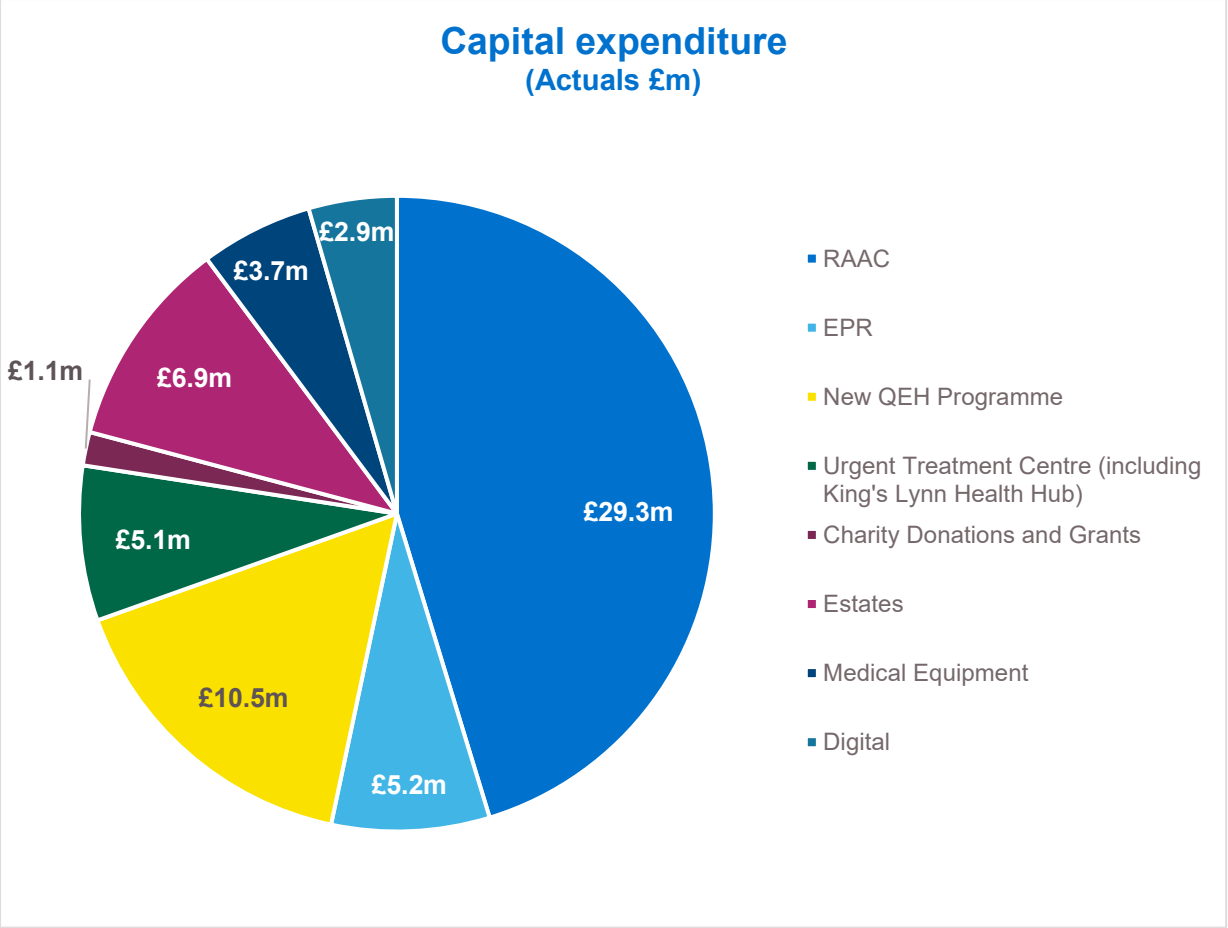
Financial resilience

During 2025/26, the Trust continued to operate within a challenging financial environment. Financial resilience, liquidity management and delivery of efficiency programmes remained key areas of organisational focus and were subject to enhanced oversight through the Trust's financial recovery arrangements and wider governance framework. The Trust continued to work closely with NHS England and Group partners to support delivery of its financial plan while maintaining safe, high-quality patient care.

Capital expenditure

Our capital expenditure for 2025/26 was £64.73m, a £0.53m decrease on the 2024/25 spend total of £65.26m. Our spend included £29.3m for the on-going Reinforced Autoclaved Aerated Concrete (RAAC) failsafe programme, £10.5m for the development of the New QEH hospital and £5.1m for Electronic Patient Record (EPR). During the year we opened the King's Lynn Health Hub with a £4.5m investment in the project.

A record of that spend is shown in the following chart.



Our efficiency programme

The Trust set a challenging and ambitious efficiency target for 2025/26 of £18.3m (2024/25: £29.5m).

Throughout the year, delivery of efficiency programmes was subject to regular review through established financial recovery and governance processes to ensure that savings plans remained achievable and that quality and patient safety considerations were appropriately assessed through the Quality Impact Assessment process.

The work of the Financial Recovery team continues to deliver significant reductions across all aspects of the Trust's cost base through strengthened grip and control and improving productivity. Financial recovery remains a priority for the Trust as we enter 2026/27.

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 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 annual reports.

TCFD recommended disclosures, as interpreted and adapted for the public sector by HM Treasury's TCFD-aligned application guidance, are being 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 calculated nationally by NHS England.

The phased approach incorporates disclosure requirements across the governance, risk management, and metrics and targets pillars for 2025/26. These disclosures are provided below.

Governance

The Group Board monitors climate-related issues through integrated governance, risk and strategic planning frameworks, with responsibilities delegated where appropriate to other committees including the Finance and Performance Committee and the Hospital Management Group to report back to the Group Board on all relevant matters.

The Trust receives quarterly updates via its Finance and Performance Management Group reports that monitor progress against goals and targets for addressing climate related issues specifically in relation to the Green Plan. Our Care Groups, will in time, take some responsibility regarding sustainability management but given their relatively new status this has been difficult to achieve to date.

Broader organisational plans and performance monitoring with respect to sustainability will be reviewed once the Norfolk and Waveney Hospitals Group governance has been established.

A member of the Hospital Leadership Team is assigned as Senior Responsible Officer to:

- create and oversee the programme of work to deliver the Trusts Green Plan
- support the embedding of sustainability into the day-to-day operations and decision-making of the Trust
- provide a forum that encourages Trust wide/Board to ward engagement for sustainability across the Trust
- oversee and manage accurate reporting of the Trust's net zero emissions targets set by NHS England and the Norfolk and Waveney Integrated Care System (ICS)

Other areas of escalation are taken via Hospital Leadership Team as appropriate/required.

In response to NHS England and NHS Improvement's increased expectations for action on climate change and sustainability, as well as our role as a major institution within Norfolk, we recognise that we must take a more proactive action on driving sustainability, decarbonisation and social value across our organisation and supply chain through working with our Partners.

Strategy

The actual and material impact of climate related risk and opportunities on the organisation's operations, strategy and financial planning is an area that the Trust is always looking to consider further. In terms of the risk and opportunities that have been developed over the short, medium and long term the organisation has its Green Plan as its guiding principal document for change.

In terms of the impact on operations, the Trust recognises the relevance of the warming world and how this affects our staff, visitors and patients as well as our estate and digital infrastructure. As such these are both identified in our risk register where necessary and reviewed regularly, in line with their impact, likelihood and control effectiveness. The Trust's Divisional Leadership Teams consider heatwave and flooding risk to the organisation and in the future will consider heat impact on pharmaceuticals, theatre operations, Health and Safety/security and Infection, Prevention and Control in particular.

When it comes to Clinical Strategy, the Trust, with its Norfolk and Waveney University Hospital Group Partners does look at trends around changing patterns in intensity, treatment and behaviours but recognises that climate driven adjustments might need to be embedded more in future work as materiality increases.

Financial planning this year has looked at the longer-term trends regarding carbon fines and offset them against the increased revenue costs of heat decarbonisation. This financial risk is regularly reviewed given the impact and likelihood of occurrence.

In a two-degree celsius warming world scenario those areas that support operations, strategy and financial planning such as products and services delivered, supply chain and value chain, adaptation and mitigation activities, investment in research, development and access to capital/funding will likely be affected, with the effects increasing over time. The Trust will continue to work with our Partners including NHS Supply Chain to mitigate any effects. While in the first instance this work will involve the Climate Change Risk Assessment, in time the work will be extended to cover all these elements to ensure the value chain is managed throughout our operations, strategy and financial planning.

For the avoidance of doubt, the materiality of these challenges will increase over time and will be monitored regularly by our Group Sustainability Management Meeting.

Risk management

Sustainability Management Meeting identifies and assesses climate-related risks and escalates within the organisation as appropriate. The Trust recognises that this requires careful consideration of future performance and delivery, particularly with respect to operations, strategy and financial planning.

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 (at least in the short to medium term), **then** the Trust will continue to see increasing fines with respect to carbon emissions and volatile utility prices **resulting in** funding having to be diverted from other areas of spend.

The Trust is mitigating this risk by progressing the decarbonisation of heat project mentioned previously.

Risks are escalated to Finance and Performance Management Group and Hospital Leadership Team thereafter, as part of reporting alongside other Trust risks as appropriate.

Our Green Plan

Our Green Plan outlines our aims, plans, and outcomes for 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 socio-economic inequality.

We are committed to minimising our environmental impact and embedding sustainability into everything we do. Our Green Plan sets out 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 that 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. As a healthcare provider, we continue to respond to the effects of an unprecedented health crisis that has challenged the resilience of our sector and required changes to the way we serve our community.

Carbon reduction initiatives during 2025/26

Various schemes have been implemented to reduce our carbon impact. These include:

Estates and Facilities

- assessing and identifying further opportunities in the use of buildings and facilities to reduce our carbon footprint
- monitoring and managing the Trust's energy usage
- supporting the introduction of reduced water usage taps and sensor lighting
- eliminating unnecessary single-use plastic and packaging in the catering department
- reviewing and reporting on energy and water usage to identify ways of reducing our carbon footprint
- reducing the amount of waste produced across the Trust

Our estate

The Trust has made a successful bid to the NHS National Energy Efficiency Fund and has been awarded £586k to upgrade lighting to energy-efficient Light-Emitting Diodes (LEDs), supporting our Green Plan and reducing our carbon footprint.

Switch-off campaign

Turning off lights in unoccupied areas and offices at the end of the day can reduce lighting costs by up to 20%.

Travel and transport

- using survey data to support ongoing work to reduce traffic to and from the hospital and promote alternative transport options
- improving pedestrian infrastructure, including better signage around the hospital
- introducing a staff walking club to encourage physical activity
- raising awareness of the health benefits of walking and promoting journey planning tools such as 'Walkit'
- improving cycling infrastructure and promoting the Cycle to Work scheme
- reviewing cycle shelters to improve safety, security, and accessibility
- promoting cycling initiatives such as National Bike Week and working with Cycling UK
- providing up-to-date public transport information via QR codes across the site
- liaising with bus operators to explore discounted travel and improved services
- promoting public transport offers and discounts

- supporting car sharing through MobilityWays, including designated parking for participants

Other initiatives

- promoting the use of Electric Vehicle (EV) chargers, with plans to install approximately 10 additional chargers (20 bays)
- hosting sustainable travel awareness days
- working with Dash to support Cycle To Work schemes
- developing a new car park strategy, including increased EV provision

Supply chain and procurement

- working with suppliers to reduce the overall carbon footprint
- reviewing supplier framework arrangements as standard practice

Workforce and system leadership

- working with the wider system to support sustainability across the NHS
- collaborating with partner trusts through bi-monthly sustainability meetings
- hosting bi-monthly ‘The QEH Goes Green’ forums

General

- expanding the Green Champions Network (currently 15 champions)
- promoting staff wellbeing through walking routes and nature trails across the site

Waste services

The Trust has invested significantly in recycling infrastructure, with at least 69% of departments now recycling, reducing the amount of waste sent to landfill.

Catering services

The Trust has purchased two state-of-the-art food digesters, supporting an approximate 80% reduction in food waste. Food waste from patients and meal production is converted into compost for biofuel use and collected monthly, reducing emissions from daily waste collection.

Priorities for 2026/27

Over the coming year, we will continue:

- expanding the use of heat source pumps in new buildings to improve energy efficiency

- improving control of heating and ventilation systems out of hours
- increasing recycling rates in line with national policy requirements
- expanding EV infrastructure across the site
- promoting sustainable travel options such as walking, cycling, and car sharing

Governance

The Group Board receives periodic updates via the Trust's Finance and Performance Committee. Reports monitor progress against climate-related goals and targets and consider the impact on wider organisational plans and performance.

A member of the Hospital Leadership Team acts as Senior Responsible Officer and oversees a sustainability group responsible for delivering the Green Plan.

Risk management

The Hospital Management Group is accountable for identification and assessment of climate-related risks. A key risk relates to financial exposure from continued reliance on fossil fuels and volatile energy pricing.

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

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	Executive Managing Director
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 requirement in all relevant procurements	All relevant procurements are performed in compliance with the 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 2026/27

The Trust submitted a final financial plan and three-year medium-term plan on 18 March 2026 for 2026/27 which is in line with the timeline requirements of the national planning guidance.

For financial year 2026/27 the Trust submitted a break-even plan, which includes £16.1m of non-recurrent deficit support funding. The assumptions included regarding inflation (2.03%) and efficiency (-2.0%) are consistent with national guidance.

The plan contains a £27.4m efficiency target, this equates to 7.6% of operating expenditure.

There remains a degree of delivery risk that is acknowledged within the overall programme, reflecting the scale of the efficiency requirement and the continuing financial challenges facing the NHS. Delivery of the efficiency programme will remain a significant focus for the Trust during 2026/27 and will be supported through robust programme management, strengthened oversight arrangements and regular monitoring through Trust and Group governance structures.

Financial sustainability continues to be recognised as a principal organisational risk, and the Trust will maintain a strong focus on productivity, transformation, workforce optimisation and procurement efficiencies to support delivery of its medium-term financial plans.

Our charity

The net assets of the QEHKL Charity on 31 March 2026 were £2.6m (2024/25: £2.2m), an increase of 17%, this reflects the charity's continued support for our staff and patients across the hospital. In 2025/26 initiatives included the refurbishment of the Macmillan Unit (£200K), Stroke Unit Garden redevelopment (£35K) and the purchase of baby training simulator for our education department (£50K). 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 take on virtual LEJOG (Lands End to John O'Groats) ride to fund special library for stroke patients.*

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	2024/25	2025/26	Increase / decrease	Percentage change
Emergency attendances	94,033	96,202	2,169	2.3%
Emergency admissions *(excluding Same Day Emergency Care activity)*	26,946	26,592	-354	1.3%
Patients waiting longer than four hours from arrival in ED to admission, transfer or discharge	31,867	35,200	3,333	10.5%

Operational performance summary

The Trust recognises that its performance during 2025/26 did not meet the standards expected by patients, staff or stakeholders. During the year, the Trust moved from Segment 3 to Segment 4 of the NHS National Oversight Framework (NOF), reflecting deterioration across a number of quality, access, productivity and financial measures. In September 2025, the Trust was ranked 134 out of 134 NHS trusts within the NOF. This position highlighted the significant challenges facing the organisation and reinforced the need for urgent and sustained improvement across operational performance, quality and governance.

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

- significant additional investment in our Emergency Department (ED) consultant staffing in Quarter 3 to support early senior decision making, particularly out of hours
- improvement support from NHS England alongside internally sourced support for a six-month period to strengthen oversight of improvement work in ED and

across the acute floor, including redesign of the acute care model to be completed in 2026/27

- alongside operational improvement activity, the Trust continued to strengthen quality governance and regulatory compliance arrangements during the year. This included focused improvement work in response to regulatory oversight, implementation of actions arising from specialty reviews, and support through NHS England improvement programmes to strengthen patient safety, clinical governance and service performance
- realignment of short stay bed capacity to the Acute Medical Unit (AMU) footprint
- relocation and development of the Surgical Assessment Unit (SAU) to a larger, fit-for-purpose space to support development of a Surgical Same Day Emergency Care (SDEC)
- relocation of Frailty SDEC in response to increased demand
- further investment, through winter funding, in the GP Front Door Service to ensure more patients are streamed away from ED where appropriate

The impact of urgent and emergency care pressures on the Trust and the wider NHS has remained significant, with sustained growth in demand throughout the year. These pressures contributed to the Trust's performance challenges and formed part of the context for its position within the NHS National Oversight Framework and the support and improvement arrangements put in place during the year.

The Reinforced Autoclaved Aerated Concrete (RAAC) decant programme continued to cause operational disruption, with ongoing failsafe works requiring multiple ward moves and impacting elective theatre capacity. The decant of the Delivery Suite to Wolferton Ward, which commenced in 2024/25, required the emergency maternity theatre to be relocated into one of the elective inpatient theatres. The Delivery Suite returned to its original location at the beginning of June 2025.

The Rudham Ward move in September displaced paediatric services. Further ward moves across the Emergency Care and Acute Medicine (ECAM) division were managed operationally to minimise disruption.

Four-hour emergency access standard

The Trust has focused on maintaining safety within ED while improving patient flow and overall experience. Significant changes to patient flow include:

- relocation of the acute floor and short stay in November 2025 to align services within a single footprint and ensure bed numbers are consistent with Getting It Right First Time (GIRFT) and Model Hospital recommendations
- redesign of the acute care model commenced in 2025/26 and will be completed in 2026/27
- introduction of new rapid assessment processes in ED to support timely ambulance handovers, reducing delays and improving ambulance availability
- relocation of SAU to a larger, fit for purpose space

- significant investment in additional ED consultant capacity (five whole-time-equivalent (WTE)
- relocation of Frailty SDEC to a larger area to support patients on the frailty pathway who do not require admission

During the year, 63.4% of patients were admitted, discharged or transferred within four hours of arrival in ED. Delivery of urgent and emergency care improvements remained a key organisational priority throughout 2025/26. The Trust continued to work closely with regulators and system partners to address the requirements associated with ongoing Care Quality Commission (CQC) oversight and NHS England improvement support, recognising the importance of improving patient flow, reducing delays and strengthening quality of care. This is below the national standard of 95% and the 2025/26 operational planning objective of 78%.

Year	Attendances	Breaches	Performance	Variance	Growth
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%
2025/26	96,202	35,200	63.4%	2,169	2.3%

Emergency Department attendances

ED performance has been affected by several factors, including a 2.3% increase in attendances compared to the previous year and an increase of over 20% over the past five years. The design of ED at the Trust has not accommodated this growth in demand, resulting in high numbers of patients waiting for a hospital bed.

Performance was weaker in the first six months of the year but improved in the latter half. Four-hour performance in March was over 7% higher than in March of the previous year.

The Trust continues to work with Norfolk and Waveney Integrated Care System (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 above 12% and addressing this will be a priority for 2026/27.

Discharge

Flow and timely discharge remain priorities. In 2025/26, the Intermediate Care Bed contract, which transferred from the Norfolk and Waveney Integrated Care Board (ICB) (NHS Norfolk and Suffolk ICB as of 1 April 2026) to the Trust in 2024/25, was expanded by a further 10 beds for patients with cognitive impairment. This brings the total number of care home beds directly commissioned by the Trust to 40 across two local care homes.

The contract with Xyla provides a brokerage service to source up to 30 discharge placements per month, primarily care home beds but also, where appropriate, packages of care to support patients returning to their own homes. The Trust pays Xyla for this brokerage service and separately funds the discharge placements secured. These placement costs are recharged to EECHC on a monthly basis. The recurrent funding allocated in 2024 has supported the Trust's discharge programme, contributing to a sustained reduction in the number of patients occupying acute beds who no longer meet Criteria to Reside and enabling the continued closure of the two wards closed in 2024.

Winter planning

The NHS anticipates increased demand for urgent and emergency care during winter months, driven by seasonal conditions such as respiratory, gastrointestinal and cardiovascular illness. Cold weather exacerbates existing health conditions, increasing pressure on inpatient beds and ED capacity.

To mitigate these pressures, the Trust implemented the following measures during winter 2025/26:

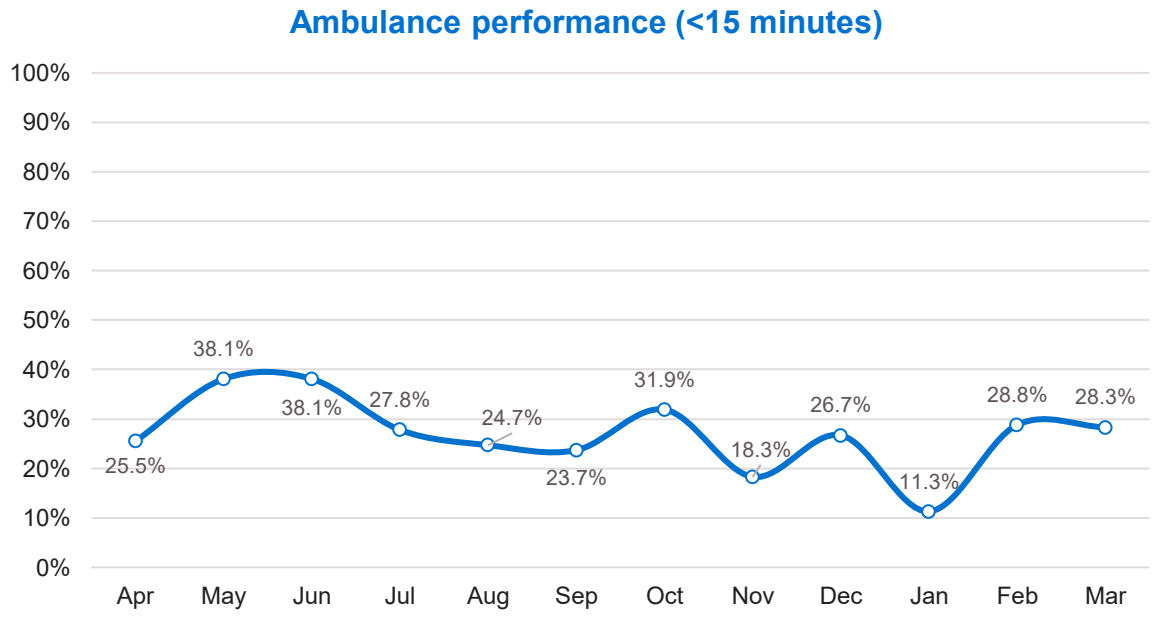
- engagement of a private transport provider to support discharges and reduce delays
- increased capacity in the GP Front Door Service, including extended evening hours and additional capacity during peak periods
- additional funding to support the frailty service, including increased weekend capacity
- flexible capacity for complex discharges through Xyla, contributing to a significant increase in discharges in January 2026
- introduction of a discharge consultant role within ECAM at weekends
- relocation of the SAU to Feltwell Ward to support development of a Surgical SDEC

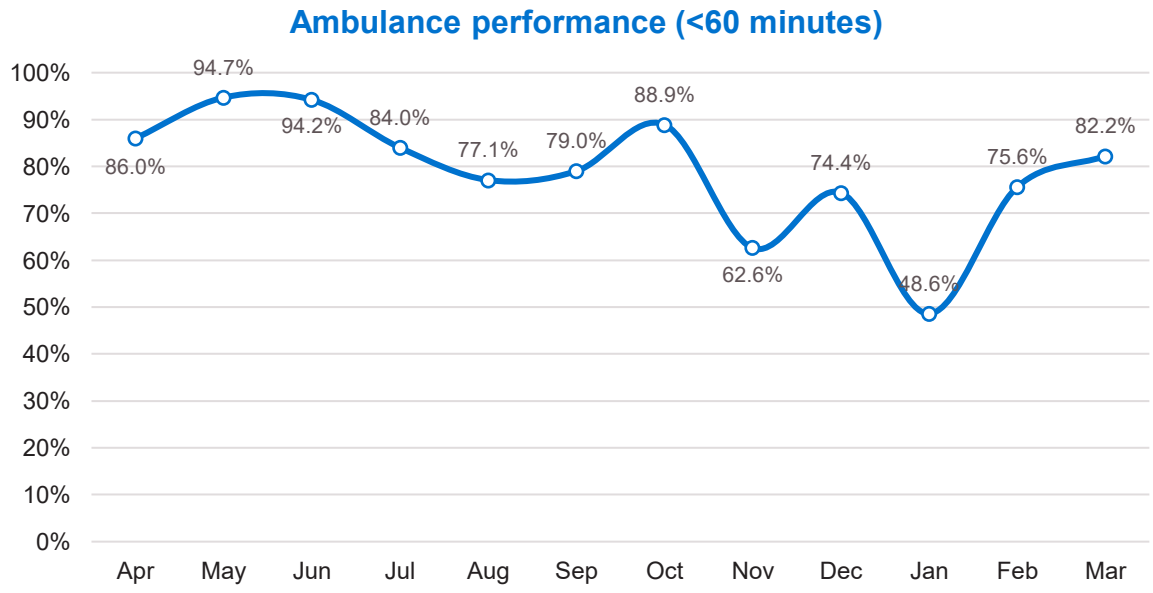
Ambulance handovers

Timely ambulance handovers are critical to achieving the four-hour emergency access standard. The national target is for handovers to occur within 15 minutes.

In 2025/26, over 61% of handovers occurred within 30 minutes and over 79% within 60 minutes. Performance deteriorated during winter but improved in Q4.

The Trust continues to work with East of England Ambulance Service (EEAST) and ICS partners to reduce handover delays, improve patient experience and support the management of community risk.





Monthly ambulance conveyances by EEAST

	0-15 minutes	15-30 minutes	30-60 minutes	60-120 minutes	120+ minutes	Total
Apr	448	707	356	136	109	1,756
May	658	712	263	61	31	1,725
Jun	702	792	240	67	40	1,841
Jul	545	696	407	205	110	1,963
Aug	470	604	394	257	179	1,904
Sep	425	646	344	215	161	1,791
Oct	576	712	317	145	56	1,806
Nov	317	435	332	310	339	1,733
Dec	498	547	342	242	235	1,864
Jan	188	328	290	284	569	1,659
Feb	367	560	340	240	169	1,676
Mar	735	593	308	216	138	1,990

Cancer access standards

Demand for cancer services remained high in 2025/26, with continued year-on-year increases in urgent referrals. Focus has been maintained on developing best practice timed pathways to support delivery of the Faster Diagnosis Standard (FDS) and improve patient experience. However, sustained demand has made delivery of access standards more challenging. The Trust and Group have continued to work with partners to support improvements in the Histopathology service, commissioned at Norfolk and Norwich University Hospitals (NNUH), as a key enabler of faster cancer diagnosis and treatment.

The Dermatology pathway was most affected, with performance declining significantly in the first half of the year. Additional funding secured in the second half supported consistent improvement in Quarters 3 and 4.

Cancer performance

	28-day general FDS	31-day general treatment standard	62-day general standard
Apr	63.98%	92.24%	42.11%
May	64.96%	88.43%	44.59%
Jun	69.39%	81.16%	51.19%
Jul	68.84%	85.93%	41.34%
Aug	59.35%	85.37%	47.06%
Sep	68.85%	85.71%	43.38%
Oct	66.83%	86.61%	54.90%
Nov	72.11%	92.79%	43.59%
Dec	70.47%	88.10%	50.38%
Jan	60.83%	88.79%	52.08%
Feb	72.85%	95.92%	52.55%
Mar	70.18%	98.99%	50.74%

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 2026 - 58.5%

March 2025 - 57.9%

March 2024 - 58.6%

March 2023 - 64.7%

March 2022 - 62.8%

March 2021 - 58.2%

	Total incomplete waiting list number	Patients waiting under 18 weeks	Patients waiting over 18 weeks and over	Performance
Apr	26,884	15,692	11,192	58.37%
May	27,301	16,021	11,280	58.68%
Jun	27,265	15,619	11,646	57.29%
Jul	28,041	15,759	12,282	56.20%
Aug	28,493	16,544	11,949	58.06%
Sep	28,052	15,446	12,606	55.06%
Oct	27,123	15,009	12,114	55.34%
Nov	26,307	14,628	11,679	55.60%
Dec	26,281	14,214	12,067	54.08%
Jan	26,144	14,092	12,052	53.90%
Feb	25,345	13,704	11,641	54.07%
Mar	25,030	14,634	10,396	58.47%

The Trust has continued to make progress in line with 2025/26 national planning guidance. The number of patients waiting over 52 weeks has reduced from 548 to 326. The total waiting list has reduced from 25,521 to 25,030 and RTT 18-week performance has improved to 58.5%. The Trust has maintained its position of having no patients waiting over 65 weeks due to capacity.

During the year, the Trust also continued to strengthen data quality and assurance processes across operational performance reporting. This included targeted work to improve the accuracy and completeness of clinical data, supporting more reliable performance monitoring and informed decision-making across services.

Quality, governance and improvement

Alongside improvements in operational performance, the Trust continued to focus on strengthening clinical governance, quality oversight and organisational learning during 2025/26.

In October 2025, an externally commissioned review of General Surgery identified a number of areas requiring improvement, including clinical governance, escalation processes, multidisciplinary working, communication and organisational learning. While mortality outcomes remained within expected ranges and the review did not identify evidence of widespread harm, it highlighted opportunities to strengthen governance arrangements and ensure concerns are identified and addressed at an earlier stage.

In response, the Trust implemented a comprehensive programme of improvement, including strengthened clinical leadership, enhanced oversight arrangements and closer working with Norfolk and Norwich University Hospitals NHS Foundation Trust to support the delivery of emergency surgical services and the sharing of best practice.

The Trust also continued to develop its wider quality governance arrangements through implementation of the Patient Safety Incident Response Framework (PSIRF), Trust-wide patient safety learning events and strengthened mechanisms for sharing learning from incidents and patient safety events. This work forms part of a broader programme of quality improvement designed to support safe, effective and responsive care.

During the year, the Trust identified and addressed a significant backlog in non-elective clinical coding which had affected the accuracy of reported mortality indicators. The backlog was cleared by March 2026 and additional assurance processes were introduced to strengthen data quality, support accurate reporting and provide greater confidence in performance information used to monitor quality and outcomes.

Research, innovation and development

In 2025/26, 37% of 1,032 National Institute for Health and Care Research (NIHR) participants were recruited to interventional studies, a significant increase from previous years where this figure was 10% or less. Interventional trials outnumbered observational studies, with 25% commercially funded.

The QEH has strengthened study set-up processes through collaboration across clinical and research teams and is now within the top 10 NHS trusts for set-up within 60 days and recruitment within 30 days.

Attracting commercial research remains a priority. Key contributors included:

- **Cardiology:** Dr Rudolf Duehmke and Dr Fady Magdy

- **Dermatology:** Dr Simina Stefanescu and Dr Boyana Beshanska-Pederson
- **Renal:** Dr Manoj Thomas
- **Rheumatology:** Dr Sarah Bingham

The Trust has also played a leading role in the POP-I study, led by the University of Nottingham, focusing on older patients with hip fractures and anaemia. The Trust recruited over 160 participants, representing more than 10% of the national cohort across 42 centres. This reflects strong clinical engagement and alignment with local population needs.

The continued development of research capability complements the Trust's wider quality improvement ambitions by supporting evidence-based practice, clinical innovation and improved patient outcomes across services.

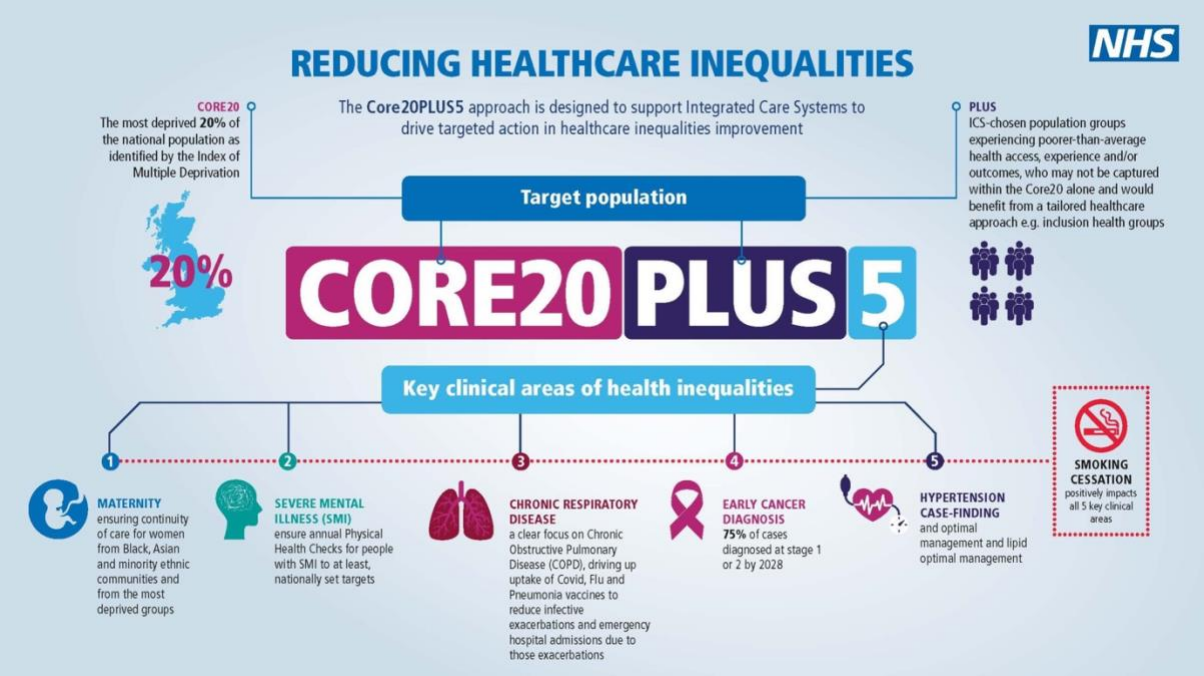
Developing our approach to health inequalities

Health inequalities are avoidable and unfair differences in health status, access, experience and outcomes between groups. These differences relate to factors such as deprivation, geography, protected characteristics and social exclusion. Addressing inequalities requires a coordinated, system-wide approach and, over the past year, there has been increased clarity on expectations at both local and national levels.

The Core20PLUS5 approach

The QEH has adopted the Core20PLUS5 national framework for reducing health inequalities. This approach targets the most deprived 20% of the population (Core20), additional locally identified groups (PLUS) and five clinical priority areas: maternity, severe mental illness, chronic respiratory disease, early cancer diagnosis and hypertension, with smoking cessation as a cross-cutting priority.

A similar framework has been adopted for children and young people, focusing on asthma, diabetes, epilepsy, oral health and mental health as the five key clinical areas.



Understanding health inequalities in Norfolk and Waveney

System-wide analysis highlights persistent inequalities when compared with what would be expected for the area's population.

Elective care

Women, Core20 (the most deprived 20%) and inclusion health groups (for example homeless people, refugees, sex workers, travellers and veterans) are more likely to be on waiting lists, whereas people from non-White British ethnic groups are less likely to be on waiting lists. Core20 and inclusion health groups are more likely to be waiting longer than 18 weeks. Outpatient attendance rates are higher for women and inclusion health groups and lower in Core20 areas and across all ethnic minority groups.

For elective admissions, Core20 patients have higher rates than those from less deprived areas, which is also reflected in emergency admission rates. All ethnic minority groups appear to have lower emergency admission rates.

Urgent and emergency care

Core20 and inclusion health groups experience higher rates of attendance at the Emergency Department (ED), with women also having higher ED attendance rates and a higher proportion of four-hour breaches.

Cancer diagnosis

For early-stage diagnosis of cancer (stages 1 and 2), women have a higher percentage of cancers diagnosed early compared with men. However, inclusion health groups and Black or Black British people experience a lower percentage of cancers diagnosed early.

When age is taken into account, these differences remain and early-stage diagnosis for Asian or Asian British ethnic groups is lower than for White British people.

Maternity

In 2024, the Maternity Continuity of Care team expanded its support to provide complete continuity of care for all women from Black, Asian and minority ethnic backgrounds, women whose first language is not English and those living in Index of Multiple Deprivation (IMD) 1 and 2 areas. This targeted approach helps improve access, build trusted relationships and reduce inequalities for women and families most at risk of poorer maternity outcomes. The work supports wider efforts across Norfolk and Waveney to address health inequalities, including reducing pre-term births and improving perinatal outcomes.

Pre-term births are higher in inclusion health groups and among Black or Black British mothers, and perinatal mortality rates are higher for Black or Black British mothers.

Changes from last year

In comparison with data for 2024/2025, there have been both positive and negative changes.

Positive developments

There is now a higher proportion of Core20 patients on the waiting list and a higher proportion of Core20 patients receiving elective inpatient admissions. Female emergency admission rates are no longer significantly different from those of males, compared with last year when they were significantly higher.

The previous difference in cancer diagnosis by areas of deprivation is no longer present, meaning that those from the most deprived communities are now as likely to be diagnosed early. A previously significant association between deprivation and poorer maternity outcomes is also no longer evident, with more deprived communities now experiencing similar outcomes.

Areas for improvement

Core20 and inclusion health groups remain more likely to be waiting longer than non-Core20 and non-inclusion health groups. The significant difference in emergency attendance rates among people from areas of deprivation also remains.

Further developments

Reducing health inequalities is now a statutory requirement for NHS organisations. The QEH is strengthening its approach through improved data, workforce development, community engagement and system collaboration.

Data and insight

Work is underway to improve analysis by deprivation and ethnicity, supported by the development of a dashboard. Improving data completeness, particularly for ethnicity, remains a priority and a system-wide data repository is also in development.

Workforce awareness and training

Plans are in place to expand staff training through national e-learning and integration into induction and development programmes, supported by a system-wide approach.

Community engagement and patient insight

Engagement with underrepresented groups is being strengthened. Work with the Norfolk and Waveney Community Voices Project has provided valuable insight into barriers affecting local populations.

Action planning and maturity

The QEH will refresh its Health Inequalities Action Plan, building on previous work to strengthen governance, data, training and partnerships. Future plans will include clear and measurable objectives aligned to local needs. This work sits alongside the Trust's wider programme of quality improvement, service development and regulatory improvement activity, ensuring that improvements in access, experience and outcomes are delivered consistently across all communities served by the Trust.

Pictured above: *The QEH has launched a new Full Body Mole Mapping clinic, designed to help detect skin cancer earlier in people who are at higher risk. Pictured left to right: Dr Boyana Pederson, Laura Shaw and Dr Simina Stefanescu*

Directors' Report

The Board of Directors

This Directors' Report forms part of the Accountability Report and should be read with the Remuneration Report, Staff Report, Code of Governance disclosures, NHS Oversight Framework section, Statement of the Accounting Officer's responsibilities, and Annual Governance Statement.

This section explains how the Trust was governed during 2025/26. It describes the role and composition of the Board of Directors, the responsibilities and independence of Non-Executive Directors, Directors' interests, Board and committee attendance, committee arrangements, the relationship between the Board of Directors and the Council of Governors, and the governance context in which the Trust operated during the year.

Board and Group Governance Framework

The Trust remained a sovereign NHS Foundation Trust throughout 2025/26, with its own Board of Directors, Constitution, Council of Governors, provider licence, Annual Report and Accounts, and Accounting Officer responsibilities.

During the year, the Trust worked with the other two acute NHS Foundation Trusts in Norfolk and Waveney to establish the Norfolk and Waveney University Hospitals Group. The Group model is not a merger. It provides shared strategic leadership through a General Purpose Joint Committee, known as the Group Board, which exercises agreed Joint Functions on behalf of the three statutory Trust Boards under the Provider Collaboration Agreement.

Each Trust Board retains its Reserved Functions and remains accountable for statutory duties, including approval of the Annual Report and Accounts, constitutional matters, significant transactions, provider licence compliance, risk and internal control, and the quality, safety, performance, and sustainability of services provided by the Trust. The Group Board acts only within the authority delegated to it by the three Trust Boards.

During the transition period from September to November 2025, the three trusts moved from their previous separate Board and committee arrangements into the approved Group governance model. During this period, existing Trust Board and committee arrangements continued where required, and decisions remained with the relevant statutory Trust Board unless properly reserved, delegated, or assigned through the approved Group Governance Framework. From November 2025, the Group Board became the principal forum for shared strategic leadership and oversight of Joint Functions, while each statutory Trust Board continued to retain and discharge its Reserved Functions.

The Group model distinguishes between Board governance and executive management. The Trust Board and the Group Board govern through approved functions, delegations, scrutiny, assurance, and accountability. Executive Directors, the Executive Managing Director, the Group Executive, Hospital Management Groups, and specialist management groups manage services and operate internal controls within the authority delegated to them. Hospital Management Groups are management arrangements and are not committees of the Board.

The governance narrative in this Annual Report should be read alongside the Annual Governance Statement, which describes the Trust's significant internal control issues during 2025/26. Those issues related to General Surgery service quality and escalation controls, Freedom of Information Act compliance, data quality, clinical coding and mortality reporting controls, and financial resilience, liquidity management and associated control discipline.

Chair, Vice Chair and Senior Independent Director

The Chair leads the Board of Directors and the Council of Governors, supporting effective strategic leadership, clear accountability, constructive Board debate, and effective communication between the two bodies. The Chair is responsible for ensuring that the Board and Council of Governors work together effectively, while preserving the distinct statutory role of each.

The Trust Constitution makes provision for the appointment of a Senior Independent Director. In consultation with the Council of Governors, the Board appoints an independent Non-Executive Director to act as Senior Independent Director. The Senior Independent Director provides a sounding board for the Chair and acts as an intermediary for Directors and Governors where it would be inappropriate or impractical for the Chair to do so.

The Board also appoints one or more Vice Chairs to deputise for the Chair and support the effective leadership of the Board as required. Details of the Chair, Vice Chair, Senior Independent Director, and their appointments during 2025/26 are set out in the Trust-specific Board disclosures below.

Board Committees

The Group governance model distinguishes clearly between Board committees and executive management groups.

Board committees form part of the formal governance structure. They support Board scrutiny, challenge, assurance, and decision-making within approved terms of reference. During 2025/26, the Board committee architecture included statutory Committees in Common and designated Group Board committees established under the Group Governance Framework.

The statutory Committees in Common comprised the Group Audit Committees in Common and the Group Nomination and Remuneration Committees in Common. These arrangements enabled the relevant statutory committee business of the three Trusts to be considered in common, while preserving each committee's accountability to its own Trust Board and, where relevant, its own Council of Governors.

Designated Group Board committees were established to support the Group Board in discharging delegated Joint Functions. These committees provided structured Non-Executive Director scrutiny, challenge, and assurance in relation to matters within their approved remit. Details of the designated Group Board committees operating during 2025/26 are set out in the Trust-specific disclosures below.

Audit Committees in Common

The Group Audit Committees in Common seek and scrutinise assurance on behalf of the Trust Boards in relation to governance, risk management, internal control, financial reporting, audit, counter fraud, and related assurance arrangements.

The Committees are constituted as statutory Committees in Common. Each Audit Committee remains accountable to its respective Trust Board, while considering common matters together where this supports consistency, efficiency, and effective oversight across the Group. Membership comprises independent Non-Executive Directors, with relevant financial and governance expertise represented within the Committee arrangements.

In discharging their responsibilities, the Audit Committees in Common draw on the work of Internal Audit, External Audit, Local Counter Fraud Services, executive management, and other sources of assurance. The Committees also review the effectiveness, independence, and objectivity of audit arrangements, including the external audit process and any non-audit services provided by the external auditor. The Committees meet privately with Internal and External Auditors as required to support unrestricted dialogue.

During 2025/26, the Audit Committees in Common considered the Trust's significant internal control issues, the Head of Internal Audit opinion, audit findings, risk management, internal control, financial reporting, the Annual Report and Accounts, and the Annual Governance Statement.

External Audit Independence

The Audit Committees in Common considered the independence, objectivity, and effectiveness of the external audit process during 2025/26. This included consideration of the Trust's external auditor's audit plan, audit risks, audit findings, communication with management, reporting to the Committee, professional

scepticism, and the auditor's compliance with relevant ethical and independence requirements.

The Audit Committees in Common also considered whether any non-audit services had been provided by the external auditor during the year. Where non-audit services are provided, auditor independence and objectivity are safeguarded through prior consideration of the nature and value of the work, separation from the statutory audit, compliance with ethical standards, and Audit Committee oversight. Where no non-audit services were provided, the final Annual Report will state this explicitly.

The significant issues considered by the Audit Committees in Common in relation to the financial statements included the going concern assessment, valuation of land and buildings, capital accounting, management judgements and estimates, remuneration disclosures, financial resilience and liquidity, and the fair, balanced, and understandable assessment of the Annual Report and Accounts. The Committee considered management's response to these matters, received External Audit findings, and reviewed whether the final Annual Report and Accounts provided a fair, balanced, and understandable account of the Trust's position.

Nomination and Remuneration Committees in Common

The Group Nomination and Remuneration Committees in Common support the statutory Trust Boards in relation to executive appointments, succession planning, remuneration, terms and conditions, and related governance matters within their approved terms of reference.

The Committees are constituted as statutory Committees in Common. Each Committee remains accountable to its respective Trust Board, while considering common executive appointment, remuneration, and succession matters together where this supports consistency across the Group. Decisions remain subject to the requirements of the NHS Act 2006, the Trust Constitution, the Code of Governance for NHS Provider Trusts, and the approved Scheme of Reservation and Delegation.

The appointment of the Group Chief Executive is made by the Non-Executive Directors and is subject to approval by the Council of Governors where required. The appointment of other Executive Directors is determined in accordance with statutory requirements, the Trust Constitution, and the approved Group governance arrangements. The Committees also oversee executive remuneration policy, having regard to applicable NHS pay frameworks, national benchmarking, performance, affordability, and relevant statutory and regulatory requirements.

Hospital Operating Model and Management Arrangements

The Hospital Operating Model forms part of the management arrangements supporting the Group governance model. It is designed to balance unified strategic

oversight with responsive, safe, and effective operational control at each hospital site.

Below the Group Board, the Group Executive translates Board strategy into operational management, supported by the Executive Risk Assurance Group and the Executive Quality Standards Group. These are executive management arrangements, not Board committees.

At hospital level, earned autonomy and day-to-day operational control are exercised through the Hospital Management Group, chaired by the Executive Managing Director. The Hospital Management Group is the core leadership forum for hospital-wide coordination and is supported by designated specialist management groups. These groups operate internal controls, review evidence, manage performance and risk, implement the Group risk management framework within their specialist fields, and escalate matters through the executive route where required.

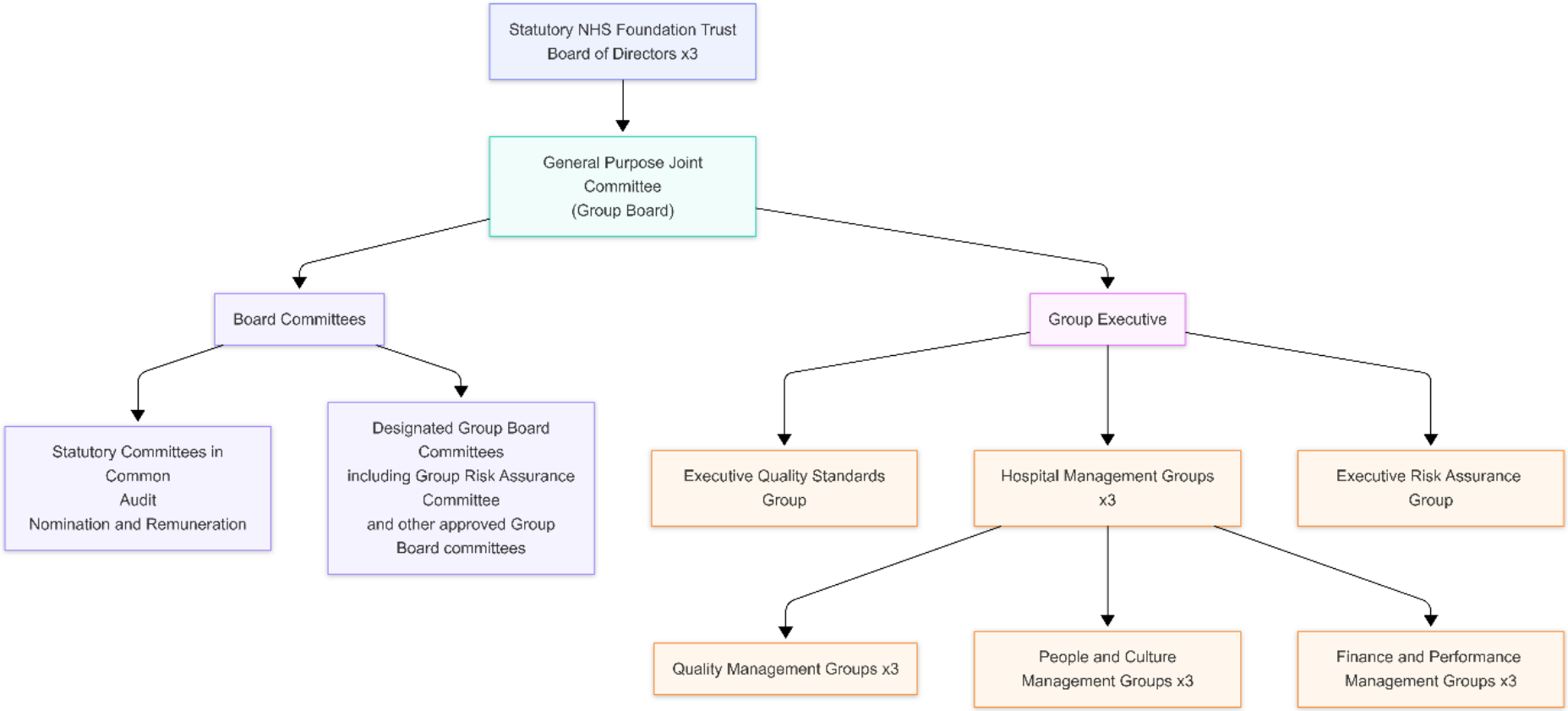
The specialist management groups include:

- People and Culture Management Group, responsible for workforce planning, staff experience, cultural development, safe staffing controls, employment-related compliance, and implementation of risk management in relation to workforce, culture, and people-related controls
- Finance and Performance Management Group, responsible for internal financial control, operational performance monitoring, efficiency, alignment with Group strategic priorities, financial recovery, liquidity management, productivity, and implementation of risk management in relation to finance, performance, and operational recovery
- Quality Management Group, responsible for clinical effectiveness, patient safety, care quality standards, patient outcomes, quality improvement oversight, and implementation of risk management in relation to quality, safety, clinical effectiveness, patient experience, regulatory compliance, and service-specific improvement

Local risk management and oversight are embedded within the Hospital Management Group and its specialist management groups. Significant site-based risks, control vulnerabilities, and matters outside tolerance are escalated through the Executive Risk Assurance Group to the Group Risk Assurance Committee, where Non-Executive Directors scrutinise risk, control, and assurance on behalf of the Group Board.

Hospital Management Groups and specialist management groups are management arrangements, not Board committees. They do not include Non-Executive Directors. This preserves clear separation between those who manage services and those who govern, scrutinise, and seek assurance.

Common governance and management architecture



Board composition, succession, appointment and development

During 2025/26, Board composition, succession, and development were shaped by the transition to the Norfolk and Waveney University Hospitals Group and the establishment of the General Purpose Joint Committee, known as the Group Board.

The transition required a redesigned Board specification. The three trusts needed a Board capable of governing across a shared Group model while preserving the statutory accountability of each sovereign NHS Foundation Trust. This required Non-Executive and Executive Director capability across quality, finance, strategy, workforce, digital, estates, transformation, population health, academic partnership, risk, internal control, and public accountability.

For the Queen Elizabeth Hospital King's Lynn NHS Foundation Trust, this capability requirement was particularly important given the Trust's regulatory and improvement context during 2025/26, including Care Quality Commission conditions, NHS England Enforcement Undertakings, National Provider Improvement Programme support, and the significant internal control issues disclosed in the Annual Governance Statement.

The trusts therefore undertook a planned Board redesign and appointment process to support the new Group governance model. This included defining the capability requirements of the Group Board, confirming statutory and constitutional appointment routes, and using executive search capability and external recruitment support to identify and appoint Directors with the skills, experience, independence, and judgement required for the new model.

This work was prospective and developmental in nature. The principal Board effectiveness task during 2025/26 was not a conventional retrospective evaluation of predecessor Board arrangements that were being superseded. It was the design, appointment, induction, and development of the Board required to operate the General Purpose Joint Committee safely and effectively while maintaining the statutory accountability of each Trust Board.

The appointment process took account of the need to maintain an appropriate balance between Executive and Non-Executive Directors, ensure strong independent scrutiny, support the development of the Group Board, and preserve clear accountability to each Council of Governors where required by statute and the Trust Constitution.

New and continuing Directors were supported through induction and development activity focused on the Group governance model, statutory duties, Reserved Functions, Joint Functions, the Provider Collaboration Agreement, the Scheme of Reservation and Delegation, Board committee arrangements, risk and internal

control, the Annual Governance Statement, regulatory oversight, and the role of the Council of Governors.

Further Board development will continue during 2026/27 as the Group Board, statutory Committees in Common, designated Group Board committees, and Hospital Operating Model become further embedded.

Board effectiveness and evaluation

The Board kept its effectiveness under review during 2025/26 in the context of major governance transition. Because the trusts were moving from separate predecessor Board arrangements to a common Group Board model, the principal effectiveness work during the year focused on Board redesign, appointment, induction, role clarity, and safe transition rather than a separate retrospective evaluation of the predecessor Boards.

This approach reflected the practical reality of the year. Existing Trust Boards continued to discharge statutory duties during the transition period, while the three trusts developed the Group governance model, established the General Purpose Joint Committee, appointed the Group Chair and Directors, and approved the governance instruments required to support the new arrangements.

The Board effectiveness approach included defining the capability requirements of the Group Board, appointing Directors to meet the needs of the new GPJC model, clarifying the distinction between Reserved Functions, Joint Functions, Board committees, and executive management arrangements, developing the Group Governance Framework, establishing the statutory Committees in Common and designated Group Board committees, supporting induction and development for Directors operating within the Group model, and using audit, regulatory oversight, legal advice, Well-Led evidence, and the Annual Governance Statement to inform the assessment of governance effectiveness.

The Board recognises that the Group model requires further embedding during 2026/27. Future Board effectiveness work will focus on how well the Group Board discharges delegated Joint Functions, how effectively each Trust Board retains and discharges Reserved Functions, how well Board committees scrutinise risk and assurance, and whether the overall model provides clear, timely, and evidence-based oversight of quality, performance, finance, workforce, risk, internal control, regulatory improvement, and strategic change.

Members of the Trust Board of Directors

During 2025/26, the Trust transitioned to a formal collaborative model alongside Norfolk and Norwich University Hospitals NHS Foundation Trust and James Paget University Hospitals NHS Foundation Trust to establish the Norfolk and Waveney University Hospitals Group (NWUHG). Under this Group model, statutory Directors

hold office concurrently on the Boards of all three NHS Foundation Trusts. The composition of the Board of Directors is set out in the Trust's Constitution and ensures that the number of voting Non-Executive Directors exceeds the number of voting Executive Directors.

The Board of Directors during 2025/26 included the following:

Group Board Membership and Designated Roles

Name	Group Board role and designated portfolios	Voting status
David Roberts	Interim Group Chair; Chair, Group Nomination and Remuneration Committees in Common, by virtue of being Group Chair	Voting
Sally Collier	Group Non-Executive Director; Senior Independent Director; Designated Non-Executive Director for Maintaining High Professional Standards	Voting
Stephen Javes	Group Non-Executive Director; Chair, Group Audit Committees in Common	Voting
Nikki Gray	Group Non-Executive Director; Chair, Group Risk Assurance Committee	Voting
Professor Philip Baker	Group Non-Executive Director; Chair, Group Research, Innovation and Education Committee	Voting
William Van't Hoff	Group Non-Executive Director; designated Non-Executive Director for Freedom to Speak Up	Voting
Jo Churchill	Group Non-Executive Director; Board Perinatal and Maternity Safety Champion	Voting
Jack Bowman	Group Non-Executive Director; Digital and Technology Transformation Lead	Voting
Professor Lesley Dwyer	Group Chief Executive	Voting
Joanne Segasby	Group Chief Delivery Officer and Deputy Group Chief Executive	Voting
Marcus Thorman	Group Chief Finance Officer	Voting
Dr Rob Sherwin	Group Chief Medical Officer	Voting
Rachael Cocker	Interim Group Chief Nurse	Voting
Dr Shane Gordon	Executive Managing Director, Norfolk and Norwich University Hospitals	Voting
Jonathan Gardner	Executive Managing Director, James Paget University Hospitals	Voting
Michelle Arrowsmith	Executive Managing Director, the Queen Elizabeth Hospital King's Lynn	Voting
Ian Walker	Interim Group Director of Governance	Non-voting
Dr Ed Prosser-Snelling	Group Director of Digital	Non-voting
Charlie Helps FRSA	Group Secretary	Non-voting

Group Committee Membership Grid: Non-Executive Directors

Committee	Chair	Non-Executive members
Group Audit Committees in Common	Stephen Javes	Jo Churchill; Nikki Gray
Group Nomination and Remuneration Committees in Common	David Roberts, as Group Chair and Chair in Common	All voting Non-Executive Directors, with membership configured according to the function being exercised
Group Risk Assurance Committee	Nikki Gray	Sally Collier; William Van't Hoff
Group Research, Innovation and Education Committee	Professor Philip Baker	Jack Bowman; William Van't Hoff

Executive attendance at committees

The Group Research, Innovation and Education Committee also includes executive participation, including the Group Chief Nurse, Group Chief Medical Officer, and one rotational Executive Managing Director.

Executive attendance at the Group Audit Committees in Common, Group Risk Assurance Committee, and other Board committees is by role, invitation, or Terms of Reference. Executives attend to account for management action, risk ownership, controls, evidence, performance, and improvement, but do not displace the Non-Executive character of Board scrutiny.

NWUHG Group Board (GPJC) Attendance: December 2025 to March 2026

Name	Group Board Role	17 Dec 2025 (Public)	17 Dec 2025 (Private)
David Roberts	Interim Group Chair	Present	Present
Sally Collier	Group Non-Executive Director	Present	Present
Stephen Javes	Group Non-Executive Director	Present	Present
Professor Philip Baker	Group Non-Executive Director	Present	Present
Jack Bowman	Group Non-Executive Director	Present	Present
Johanna (Jo) Churchill	Group Non-Executive Director	Present	Present
William Van't Hoff	Group Non-Executive Director	Present	Present
Nikki Gray	Group Non-Executive Director	Absent	Absent

Professor Lesley Dwyer	Group Chief Executive Officer	Present	Present
Jo Segasby	Group Chief Delivery Officer	Present	Present
Marcus Thorman	Group Chief Finance Officer	Present	Present
Dr Rob Sherwin	Group Chief Medical Officer	Present	Present
Rachael Cocker	Interim Group Chief Nurse	Present	Present
Dr Shane Gordon	Executive Managing Director, NNUH	Present	Present
Chris Bown	Interim Executive Managing Director, QEHKL	Present	Present
Jonathan Barber	Interim Executive Managing Director, JPUH	Present	Present
Dr Ed Prosser-Snelling	Group Director of Digital (Non-voting)	In Attendance	In Attendance
Ian Walker	Interim Group Director of Governance (Non-voting)	In Attendance	In Attendance
Jo Hannam	Group Communications Lead (Non-voting)	In Attendance	In Attendance
Charlie Helps	Group Secretary (Non-voting)	In Attendance	In Attendance

The Queen Elizabeth Hospital King's Lynn: Hospital Management Group and Hospital Leadership changes during the year

Through the transition to the formal Group model during 2025/26, the Queen Elizabeth Hospital King's Lynn has been led at hospital level through its Hospital Management Group, chaired by the Executive Managing Director. The current hospital leadership arrangements are as follows:

Executive Managing Director	Michelle Arrowsmith (Appointed January 2026)
Interim Director of Finance	Sarah Kelk (Appointed August 2025)
Interim Chief Operating Officer	Richard Parker (Appointed November 2025)
Medical Director	Dr Rebecca Martin (Appointed September 2023)
Interim Chief Nurse	Dawn Collins (Appointed March 2026)
Director of People	John Syson (Appointed July 2023)
Director of Strategy and Integration	Carly West-Burnham (Appointed January 2020)

Directors' interests and independence

The Trust maintains arrangements for declaring, recording, and managing Directors' interests in accordance with the Trust Constitution, Managing Conflicts of Interest in the NHS guidance, and the Group governance arrangements.

Directors are required to declare relevant interests on appointment and to update declarations during the year where circumstances change. Declarations are reviewed through the Trust's established processes and published in accordance with applicable requirements. The Trust-specific register of Directors' interests and any relevant in-year changes are set out below.

The Board also considers the independence of its Non-Executive Directors. Non-Executive Directors are expected to provide independent judgement, constructive challenge, and scrutiny of executive management. In considering independence, the Board has regard to tenure, relationships, interests, and any circumstances that could affect, or appear to affect, independent judgement.

The register of Directors' interests is published in the public domain on the Trust's website and can be viewed at any time for the most up-to-date declarations.

The Board considers all of the Non-Executive Directors to be independent within the definition provided in the applicable Code of Governance.

Board and committee attendance

Board and committee attendance is reported to provide transparency on Director participation in the governance of the Trust during 2025/26.

Because 2025/26 included a transition from predecessor Trust Board arrangements to the Group Board model, attendance is presented in a way that reflects the governance arrangements operating at the relevant time. Attendance before establishment of the Group Board is reported for the relevant statutory Trust Board and its committees. Attendance after establishment of the Group Board and associated Group committee arrangements is reported in accordance with the approved Group Governance Framework.

Where a Board or committee was established, reconstituted, or did not operate during part of the year, this is identified in the relevant table or accompanying note.

Directors (voting Board members) 1 April 2025 – 31 March 2026	Date of end of NED terms of office	Audit Committee 5 meetings		Nomination and Remuneration Committee (ED Appointments) 6 meetings		Meetings attended out of 5 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 to June 2025	June 2025					3/4	3/4	1/3	0/3
Mark Friend Trust Chair From: May 2025 to October 2025				2/6		2/5	2/5	2/3	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 to December 2025	31 December 2025			1/6		7/7	7/7	2/3	1/3
Simon Roberts – NED From: 20 May 2019 Reappointed: 20 May 2022 Chair: People Committee	19 May 2025	✓	2/2			4/4	4/4	0/3	0/3
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 to December 2025	31 December 2025			1/6		6/7	6/7	3/3	2/3
Sue Hayter – NED From: 1 May 2021 Reappointed from 1 May 2024 for three-year period Chair: Quality Committee (from September 2023 to December 2025)	31 December 2025					7/7	7/7	1/3	0/3
William Van't Hoff – NED From: 1 February 2024	31 January 2027	✓	5/5	1/6		7/7	7/7	3/3	0/3
Saqhib Ali – NED From: 22 July 2024 to December 2025 Chair: Audit Committee	31 December 2025	✓	5/5			3/7	7/7	3/3	0/3
Alice Webster Chief Nurse from May 2021 Acting CEO from October 2022 CEO from March 2023 to November 2025						2/2	2/2	1/3	0/3
Chris Bown Interim Executive Managing		✓	1/2			2/3	2/3	2/3	0/3

Director From June 2025 to February 2026									
Sarah Kelk Interim Director of Finance From July 2025		✓	2/2			2/3	2/3		
Lorraine Hooper Interim Director of Finance From 7 October 2024 to July 2025		✓	4/5			6/7	6/7		
John Syson Director of People From 1 August 2023 (Interim from 20 March 2023)						6/7	6/7		
Pippa Street Chief Nurse From 21 August 2023 to February 2026						6/7	6/7		
Dr Rebecca Martin Medical Director From 1 September 2023						6/7	6/7		
Simon Illingworth Chief Operating Officer From 28 August 2023 to July 2025						3/5	3/5		
Richard Parker Interim Chief Operating Officer From October 2025						0/0	0/0	1/3	0/3
Carly West-Burnham Director of Strategy & Integration From October 2025						7/7	7/7		
Charlie Helps Interim Trust Secretary January 2025		✓	1/5	6/6		4/7	4/7	1/3	1/3
KEY:	✓ **=** Committee Member	Transition to Group September 2025 - only Board members remained until their end dates as detailed							
		Remained as a Group Board Member							

Committee activity during the year

The shared Board committee architecture is described earlier in this Directors' Report. This section summarises the Trust-specific membership, attendance, and principal activity of the Board committees operating during 2025/26.

The statutory Committees in Common remained accountable to their respective statutory Trust Boards while considering common business together where appropriate. Designated Group Board committees supported the Group Board in relation to delegated Joint Functions within their approved terms of reference.

Audit Committees in Common

The Audit Committees in Common met to schedule during 2025/26 and discharged their approved Terms of Reference in accordance with their statutory responsibilities, the Trust Constitution, the Code of Governance for NHS Provider Trusts, and relevant good practice, including the HFMA Audit Committee Manual dated March 2025.

Each Audit Committee remained accountable to its own statutory Trust Board, while meeting in common to consider matters where shared scrutiny supported consistency, efficiency, and effective oversight across the Norfolk and Waveney University Hospitals Group.

During the year, the Committees considered matters including internal audit, external audit, local counter fraud, financial reporting, the Annual Report and Accounts, the Annual Governance Statement, significant internal control issues, risk management, internal control, and the effectiveness of audit and assurance arrangements.

For the Queen Elizabeth Hospital King's Lynn NHS Foundation Trust, the Committees' work included scrutiny of the significant internal control issues disclosed in the Annual Governance Statement, including General Surgery service quality and escalation controls, Freedom of Information Act compliance, data quality, clinical coding and mortality reporting controls, and financial resilience, liquidity management and associated control discipline.

Nomination and Remuneration Committees in Common

The Nomination and Remuneration Committees in Common met as necessary during 2025/26 and discharged their approved Terms of Reference in accordance with their statutory responsibilities, the Trust Constitution, the Code of Governance for NHS Provider Trusts, and relevant NHS employment and remuneration frameworks.

Each Committee remained accountable to its own statutory Trust Board, while meeting in common to consider matters where shared scrutiny supported

consistency, transparency, and effective decision-making across the Norfolk and Waveney University Hospitals Group.

During the year, the Committees considered matters including executive appointments, succession planning, senior leadership structure, executive remuneration, terms and conditions, Very Senior Manager pay framework requirements, and the appointment route for the Group Chief Executive.

The appointment of the Group Chief Executive was made by the Non-Executive Directors and was subject to approval by the Council of Governors where required by statute and the Trust Constitution.

Group Risk Assurance Committee

The Group Risk Assurance Committee met during 2025/26 and discharged its approved Terms of Reference as a designated Group Board committee.

The Committee scrutinised risk, control, assurance, escalation, and evidence in relation to the Joint Functions delegated to the Group Board, while preserving the statutory accountability of each Trust Board for its Reserved Functions. Its work was informed by the Group Risk Management Policy, the Group Risk Appetite Statement, the agreed risk scoring and control assurance methodology, and reports escalated through the Executive Risk Assurance Group.

During the year, the Committee considered principal risks including quality standards variation, maternity improvement, access, flow and productivity, financial sustainability, workforce capacity and engagement, digital capability, cyber security, data readiness, estates and infrastructure, Electronic Patient Record implementation, New Hospitals Programme risks, transformation capacity, corporate governance, public and stakeholder confidence, and research, innovation, and education.

For the Queen Elizabeth Hospital King's Lynn NHS Foundation Trust, the Committee's scrutiny was particularly relevant to the Trust's regulatory and improvement context, including Care Quality Commission section 31 conditions, Surgical Care concerns, General Surgery improvement, clinical coding and mortality reporting controls, financial resilience, liquidity management, the RAAC-affected estate, NHS England Enforcement Undertakings, and National Provider Improvement Programme support.

The Committee sought and scrutinised assurance on the effectiveness of controls, the adequacy of mitigations, the consistency of escalation, the quality of evidence supporting reported risk positions, and the actions required where assurance gaps, control weaknesses, or matters outside risk appetite were identified. Its scrutiny supported the Group Board's oversight of Board-level risk and assurance reporting, significant control issues, and the further embedding of risk-based assurance across the Group.

Board effectiveness, induction, appraisal and development

During 2025/26, Board effectiveness, induction, appraisal, and development activity was undertaken in the context of the transition to the Norfolk and Waveney University Hospitals Group and the establishment of the General Purpose Joint Committee, known as the Group Board. The focus during the year was on supporting Directors to operate effectively within the approved Group governance model, while preserving the statutory accountability of each Trust Board.

Directors received induction and development support covering statutory duties, the Provider Collaboration Agreement, Reserved Functions, Joint Functions, the Scheme of Reservation and Delegation, Board committee arrangements, risk management, internal control, the Annual Governance Statement, significant internal control issues, regulatory oversight, and the role of the Council of Governors. Group Board development also supported shared understanding of the distinction between Board governance, executive management, hospital management arrangements, and the role of Committees in Common and designated Group Board committees.

Chair and Non-Executive Director appraisal arrangements continued to be managed in accordance with the Trust Constitution, the Code of Governance for NHS Provider Trusts, and the statutory role of the Council of Governors. Executive Director appraisal was undertaken through the relevant executive accountability and remuneration arrangements.

Further Board development during 2026/27 will focus on embedding the Group Board and committee cycle, strengthening evidence and assurance flows, clarifying escalation between hospital management arrangements and Board committees, supporting the scrutiny of regulatory improvement and significant control issues, and ensuring that each Trust Board retains clear sight of its Reserved Functions.

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 2025/26
- 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 2025/26 is shown in the following tables:

Non-NHS	Number	£'000
Total bills paid in the year	47,293	200,007
Total bills paid within target	45,314	189,274
Percentage of bills paid within target	95.8%	94.6%

NHS	Number	£'000
Total bills paid in the year	1,119	15,881
Total bills paid within target	956	9,936
Percentage of bills paid within target	85.4%	62.6%

Total	Number	£'000
Total bills paid in the year	48,412	215,888
Total bills paid within target	46,270	199,210
Percentage of bills paid within target	95.6%	92.3%

Pictured above: *More than 450 local people attended a series of in-person and virtual events to find out more about exciting plans to bring a new state-of-the-art hospital to King's Lynn*

Remuneration report

Trust Remuneration Report

The remuneration report has been audited.

1 Trust annual statement on remuneration

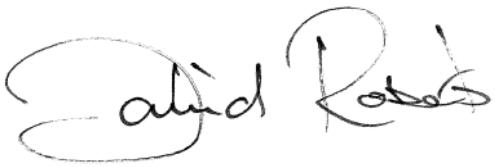
The Remuneration Report summarises The Trust's remuneration policy and its application in connection with the Trust's Executive Directors.

The Nomination and Remuneration Committee (Executive Appointments) considers and acts with delegated authority from the Trust 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 was disbanded when the Trust joined the Norfolk and Waveney University Hospitals Group in November 2026.

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.

The Nomination and Remuneration Committee ceased to exist on the 31 October 2025 when the Trust became part of the Norfolk and Waveney University Hospitals Group (NWUHG).



David Roberts
Interim Group Chair

25 June 2026

2 Trust senior managers' remuneration policy for the period 1 April to 31 October 2025

Item	Salary / fees	Taxable benefits	Annual performance 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	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	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	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	Not applicable
Performance period	Tailored to individual posts	None disclosed	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	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	Any sums paid in error may be recovered

3 Group annual statement on remuneration

In 2025/26, the Norfolk and Waveney University Hospitals Group was formally established, bringing together the Norfolk and Norwich University Hospitals NHS Foundation Trust (NNUH), the Queen Elizabeth Hospital King's Lynn NHS Foundation Trust (the QEH) and the James Paget University Hospitals NHS Foundation Trust (JPUH) under a shared leadership framework. The creation of the Group enables a more integrated approach to executive leadership, strengthens collective decision-making, and supports greater consistency in the delivery of clinical and operational priorities across the three organisations.

As part of this structure, a number of senior executives now hold Group-wide roles with responsibilities spanning all three trusts. To support this shared leadership model, a cost-sharing arrangement has been implemented under which remuneration for Group executive roles is apportioned between the organisations. The agreed apportionment reflects the scale and scope of activity undertaken at each Trust, with the NNUH, JPUH, and the QEH each contributing 33.3%. This ensures that costs are allocated transparently and proportionately, and that each trust contributes in line with the operational and strategic benefits derived from Group leadership.

The Group has a Nominations and Remuneration Committee whose purpose is to develop, apply and monitor the remuneration and terms of service for executive directors. The aim of the Nominations and Remuneration Committee is to ensure that there is a transparent process for determining pay for the Chief Executive and other Executive Directors. The remit covers an annual salary review and contracted terms of employment.

Major decisions on senior managers' remuneration

Remuneration for the Trust's most senior managers, determined as being executive directors who are members of the Group Board of Directors, is decided by the Group Board of Directors' Nominations and Remuneration Committee.

The only non-cash element of senior managers' remuneration packages is pension-related benefits accrued under the NHS Pensions Scheme. Contributions are made by both the employer and employee in accordance with the rules of the national scheme which applies to all NHS staff in the scheme.

The Group's strategy and business planning process sets key business objectives which in turn inform individual objectives for senior managers. Performance is closely monitored and discussed through both an annual and ongoing appraisal process.

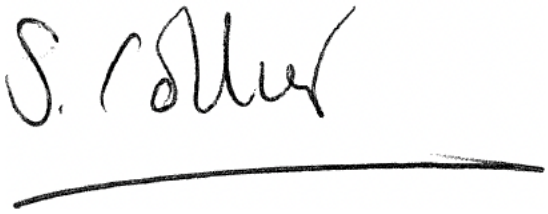
Senior managers are employed on contracts of service and are substantive employees of the Trust. Their contracts are open-ended employment contracts which

can be terminated by either party with six months' notice. All executive directors are subject to periodic appraisal and are accountable to the Board of Directors for performance in those areas to which they provide executive leadership. The Group's normal disciplinary policies apply to senior managers, including the sanction of summary dismissal without notice for gross misconduct. The Trust's redundancy policy is consistent with NHS redundancy terms for all staff.

Substantial changes relating to senior managers' remuneration made during the year

During 2025/26, two group directors received part of their remuneration via a bonus scheme. No other substantial changes to senior managers' remuneration were made during 2025/26.

Signed by the Chair of Remuneration Committee on 25 June 2026.



Sally Collier
Group Non-Executive Director

4 Senior managers' remuneration policy effective 1 November 2025

The table below summarises each of the components of the remuneration package for senior managers which comprises the senior managers' remuneration policy.

Remuneration component	Applicable to	Jurisdiction	Relevance to Trust's long- and short-term objective	Amount payable
Basic salary	All senior managers	Nominations and remuneration committee	Recommendations in respect of basic salary are made to the Nominations and Remuneration Committee by the Chief Executive (for executive directors) and the Chairman (for the Chief Executive) on the basis of assessment of performance at annual appraisal, and specifically achievement of agreed personal objectives that reflect the long- and short-term objectives of the Trust.	Any increases are agreed with reference to the NHS VSM Pay Framework and advice as required.
Pension	All senior managers	Terms of membership as specified by the NHS Pension Scheme administered by the NHS Pensions Agency	Not applicable	Determined by the NHS Pensions Agency
NNUH Pension Contributions Alternative Reward Policy	Senior managers who opt in (who are not making pension contributions)	Nominations and renumeration committee	A separate cash payment of up to 12.5% of an employee's basic salary where they have opted out of the NHS Pension Scheme	Payment is made at up to 12.5% of gross basic pay.
Clinical Impact Award (formerly Clinical Excellence Award) scheme	Group Chief Medical Director only	Determined by Local Awards Committee in accordance with medical and dental employment contract; not awarded by Nominations and Remuneration Committee. The Scheme ended on 1st April 2024. Existing awards granted prior to 1st	Awards are determined by the Local Awards Committee in accordance with an agreed scheme that recognises clinical excellence across five domains. Analysis of the scheme demonstrates a linkage to the Trust's strategic objectives including the leadership and delivery of clinical services,	Level nine award is the maximum that can be awarded locally.

		April 2018 remain in place.	teaching, training and research.	
10% bonus	Group Chief Medical Director and Executive Managing Director	Nominations and Remuneration Committee & Regional Medical Director	A separate cash payment of 10% of an employee's basic salary where a bonus payment has been agreed.	Payment is made at 10% of gross basic pay.

Accompanying notes:

1. In 2025/26 a 10% bonus payment has been introduced for the Group Chief Medical Director and Executive Managing Director. This is to attract the appropriate talent to senior roles.
2. With the exception of the end of the Local Clinical Impact Awards (formerly Clinical Excellence Awards) scheme and bonus scheme, there have been no additions or changes to the components of the remuneration package during 2025/26.
3. With the exception of the bonus scheme, there are no significant differences between the remuneration policy for senior managers and the general policy for employees' remuneration.

5 Annual report on remuneration

Service contracts

The table below summarises, for each senior manager (directors who are members of the Group Board of Directors) who has served during the year, the date of their service contract, the unexpired term and details of the notice period.

Name and title	Start date	End date	Unexpired term at: 31 Mar 2026 (months)	Notice period (months)
Group Executive Directors				
L Dwyer, Group Chief Executive	1 Nov 2025	Ongoing	N/A	6
J Segasby, Group Chief Delivery Officer	1 Nov 2025	Ongoing	N/A	6
J Segasby, Acting Group Chief Nurse	1 Nov 2025	14 Dec 2025	N/A	6
M Thorman, Group Chief Finance Officer	1 Nov 2025	Ongoing	N/A	6
M Thorman, Interim Executive Managing Director	13 Nov 2025	7 Dec 2025	N/A	6
M Arrowsmith, Executive Managing Director	19 Jan 2026	Ongoing	N/A	6
J Sherwin, Group Chief Medical Director	1 Dec 2025	Ongoing	N/A	6
B Brett, Acting Group Chief Medical Director (NNUH)	1 Nov 2025	30 Nov 2025	N/A	6
V Chitre, Acting Group Chief Medical Director (JPUH)	1 Nov 2025	30 Nov 2025	N/A	6
R Martin, Acting Group Chief Medical Director (QEH)	1 Nov 2025	30 Nov 2025	N/A	6
R Cocker, Interim Group Chief Nurse	15 Dec 2025	Ongoing	N/A	6
QEH Trust Executive Directors prior to Group				
A Webster, Trust Chief Executive Officer	1 Mar 2022	30 Nov 2025	N/A	N/A
S Illingworth, Chief Operating Officer	28 Aug 2023	31 July 2025	N/A	N/A
R Martin, Medical Director	1 Sep 2023	31 Oct 2025	N/A	N/A
P Street, Chief Nurse	21 Aug 2023	31 Oct 2025	N/A	N/A
L Hooper, Finance Director	7 Oct 2024	31 Jul 2025	N/A	N/A
S Kelk, Interim Director of Finance	1 Aug 2025	31 Oct 2025	N/A	N/A
C Bown, Interim Executive Managing Director	5 Jun 2025	31 Jan 2026	N/A	N/A
J Syson, Director of People	20 Mar 2023	31 Oct 2025	N/A	N/A

Notes:

1 Acting Group Chief Medical Director was shared by the three previous Trust Medical Directors.

Name and title	Start date	End date	Unexpired term at: 31 Mar 2026 (months)	Notice period (months)
Group Non-Executive Directors				
D Roberts, Interim Group Chair	1 Nov 2025	31 Oct 2026	6	3
W Van't Hoff, Group Non-Executive Director	10 Dec 2025	9 Dec 2027	20	3
S Collier, Group Non-Executive Director	10 Dec 2025	9 Dec 2028	32	3
P Baker, Group Non-Executive Director	10 Dec 2025	9 Dec 2028	32	3
J Bowman, Group Non-Executive Director	10 Dec 2025	9 Dec 2028	32	3
J Churchill, Group Non-Executive Director	10 Dec 2025	9 Dec 2028	32	3
N Gray, Group Non-Executive Director	22 Dec 2025	21 Dec 2028	32	3
S Javes, Group Non-Executive Director	22 Dec 2025	21 Dec 2027	20	3
QEH Trust Non-Executive Directors				
A Wood, Trust Chair	2 Dec 2024	30 Jun 2025	N/A	N/A
S Roberts, Trust Non-Executive Director	20 May 2019	31 May 2025	N/A	N/A
G Ward, Trust Non-Executive Director	31 Oct 2022	31 Dec 2025	N/A	N/A
C Fernandez, Trust Non-Executive Director	1 Jul 2020	31 Dec 2025	N/A	N/A
S Hayter, Trust Non-Executive Director	1 May 2021	31 Dec 2025	N/A	N/A
S Ali, Trust Non-Executive Director	22 Jul 2024	31 Dec 2025	N/A	N/A
W Van't Hoff, Trust Non-Executive Director	1 Feb 2024	30 Nov 2025	N/A	N/A
D Childerhouse, Trust Associate Non-Executive Director	1 Feb 2024	31 Oct 2025	N/A	N/A
G Evbota, Trust Associate Non-Executive Director	1 Feb 2024	31 Dec 2025	N/A	N/A
A Finegan, Trust Associate Non-Executive Director	1 Oct 2024	31 Dec 2025	N/A	N/A
J Selvarajah, Trust Associate Non-Executive Director	1 Feb 2024	31 Dec 2025	N/A	N/A

The contracts of employment of the group executive directors are for indefinite terms and are subject to six months' notice by either side. All Executive Directors are subject to periodic appraisal and are accountable to the Board of Directors for performance in those areas to which they provide executive leadership. The terms of appointment of the non-executive directors are typically for three-year terms and are subject to three months' notice by either side. There are no provisions within the contracts of employment regarding compensation for early termination for any directors.

The Trust's normal disciplinary policies apply to senior managers. The Trust's redundancy policy is consistent with NHS redundancy terms for all staff.

Nominations and remuneration committee

The Nominations and Remuneration Committee consists of the Chairman of the Trust, at least three other Non-Executive Directors and the Chief Executive. During 2025/26 the membership comprised the Chairman of the Trust (Chair of the Committee) and all of the other non-executive directors and the Chief Executive.

The Committee meets as required and at least once a year. In accordance with NHS England's Code of Governance for NHS Provider Trusts, the role and policy of the Committee is to monitor the level and structure of remuneration for senior managers, having considered comparative salary levels in other organisations and NHS Foundation Trusts in particular, and the NHS VSM Pay Framework.

Where an individual's remuneration is above the level of £150,000 per annum pro rata the Nominations and Remuneration Committee's policy and practice will be in line with the requirements issued by the Cabinet Office.

Disclosures required by the Health and Social Care Act

Prior to the formation of the NWUHG in November 2025, there were a total of eight Executive Directors in office during the period (filling six roles) and eleven Non-Executive Directors, including the Chair (filling eleven roles). Following the formation of the NWUHG in November 2025, there were a total of 10 Executive Directors in office during the period (filling six roles) and eight Non-Executive Directors, including the Chair (filling nine roles).

In 2024/25, 21 directors had been in office, being seven Executive Directors (filling seven roles) and fourteen Non-Executive Directors (filling 14 roles).

No significant awards were made to past directors during the 12 months ended 31 March 2026.

The new Very Senior Manager (VSM) pay framework applies for 2025/26. To comply with the framework the Trust has reviewed all staff in VSM roles and compared their remuneration to the thresholds published in the framework. There are two instances of departure from the framework where NHS England and Department of Health and Social Care (DHSC) approval is required.

Executive Managing Director - The remuneration for this post represents a departure from the NHS VSM pay framework, reflecting the scale and complexity of the role and the organisation's operational and improvement challenges. Approval remains outstanding by DHSC but has been supported and submitted by NHS England.

Group Chief Financial Officer - remuneration for this post represents a departure from the NHS VSM pay framework, reflecting the scale and complexity of the Group role, as well as its operational and improvement challenges. The post holder is formally designated as Deputy Group Chief Executive. Approval has been granted by DHSC and NHS England.

The Governor role is unpaid. When the Council of Governors was established, it was agreed that governors were entitled to claim travel expenses for attending meetings. In 2025/26 there were 28 governors (15 public governors, six staff governors and seven appointed governors).

Table of disclosures	2025/26	2024/25
Governors		
The total number of governors in office	28	29
The number of governors receiving expenses in the reporting period	13	12
The aggregate sum of expenses paid to governors in the reporting period	£5,809	£7,491
Directors		
The total number of directors in office	21	20
The number of directors receiving expenses in the reporting period	13	14
The aggregate sum of expenses paid to directors in the reporting period	£10,751	£21,046

Trust single total figure remuneration table

	12 months ended 31 March 2026					12 months ended 31 March 2025				
	Salary	All taxable benefits	Annual and long-term performance related bonuses	Pension related benefits	Total	Salary	All taxable benefits	Annual and long-term performance related bonuses	Pension related benefits	Total
	(bands of £5,000)	Rounded to the nearest £100	(bands of £5,000)	(bands of £2,500)	(bands of £5,000)	(bands of £5,000)	Rounded to the nearest £100	(bands of £5,000)	(bands of £2,500)	(bands of £5,000)
Name and title (Chair and Executive Directors)	**£'000**	**£**	**£'000**	**£'000**	**£'000**	**£'000**	**£**	**£'000**	**£'000**	**£'000**
A Webster, Chief Executive *(until Nov 2025)*	130-135	100	0	0	130-135	195-200	100	0	20.0-22.5	215-220
S Illingworth, Chief Operating Officer *(until Jul 2025)*	35-40	0	0	0	35-40	135-140	0	0	92-5-95.0	230-235
R Martin, Medical Director *(until 31 Oct 2025)*	125-130	100	0	40.0-42.5	165-170	210-215	0	0	0	210-215
P Street, Chief Nurse *(until 31 Oct 2025)*	75-80	0	0	32.5-35.0	110-115	130-135	0	0	25.0-27.5	255-260
L Hooper, Interim Director of Finance *(until 31 Jul 2025)*	55-60	100	0	0	55-60	80-85	0	0	0	80-85
J Syson, Director of People *(until 31 Oct 2025)*	75-80	0	0	25-27.5	100-105	130-135	0	0	10-12.5	140-145
C Bown, Interim Executive Managing Director *(until Jan 2026)*	120-125	100	15-20	0	140-145	0	0	0	0	0
M Arrowsmith, Executive Managing Director *(appointed Jan 2026)*	30-35	0	0	7.5-10.0	40-45	0	0	0	0	0
C Benham, Director of Finance *(resigned Nov 2024)*	0	0	0	0	0	105-110	0	0	0	105-110

- the highest paid director of the Trust in 2025/26 and 2024/25 was the Medical Director
- the full salaries of the Medical Director and the 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.
- the Medical Director, Chief Nurse and Director of People ceased to be executive voting directors on 31 October 2025 as their roles were removed following the consultation process for transition to the Group. The table above discloses their remuneration up to that date.
- included in the salary costs for the Chief Executive were payments for compensation for loss of office totalling £99k.
- Pippa Street received a payment in lieu of notice of £68k when she left the trust in February 2026.
- Sarah Kelk was acting finance director for the period 1 August 2025 until 31 October 2025 under secondment from another NHS body. For this period the Trust paid £36k for her services.

	12 months ended 31 March 2026					12 months ended 31 March 2025				
	Salary	All taxable benefits	Annual and long-term performance related bonuses	Pension related benefits	Total	Salary	All taxable benefits	Annual and long-term performance related bonuses	Pension related benefits	Total
	(bands of £5,000)	Rounded to the nearest £100	(bands of £5,000)	(bands of £2,500)	(bands of £5,000)	(bands of £5,000)	Rounded to the nearest £100	(bands of £5,000)	(bands of £2,500)	(bands of £5,000)
Name and title (Non-Executive Directors)	**£'000**	**£**	**£'000**	**£'000**	**£'000**	**£'000**	**£**	**£'000**	**£'000**	**£'000**
C Lawrence, Trust Chair	0	0	0	0	0	30-35	1,400	0	0	30-35
A Wood, Trust Chair	10-15	300	0	0	10-15	15-20	0	0	0	15-20
S Roberts, Trust Non-Executive Director	0-5	400	0	0	0-5	10-15	1,900	0	0	10-15
G Ward, Trust Non-Executive Director	15-20	0	0	0	15-20	10-15	0	0	0	10-15
C Fernandez, Trust Non-Executive Director	10-15	800	0	0	10-15	10-15	1,300	0	0	15-20
S Hayter, Trust Non-Executive Director	5-10	0	0	0	5-10	10-15	0	0	0	10-15
S Ali, Trust Non-Executive Director	5-10	2,000	0	0	10-15	5-10	1,400	0	0	10-15
W Van't Hoff, Trust Non-Executive Director	5-10	0	0	0	5-10	10-15	0	0	0	10-15
D Childerhouse, Trust Non-Executive Director	5-10	400	0	0	5-10	5-10	500	0	0	10-15
G Evbota, Trust Assc. Non-Executive Director	5-10	1,500	0	0	10-15	5-10	1,700	0	0	10-15
A Finegan, Trust Assc. Non-Executive Director	5-10	0	0	0	5-10	0-5	200	0	0	5-10
J Selvarajah, Trust Assc. Non-Executive Director	5-10	400	0	0	5-10	5-10	400	0	0	5-10
A Brown, Trust Non-Executive Director	0	0	0	0	0	10-15	0	0	0	10-15
D Dickinson, Trust Non-Executive Director	0	0	0	0	0	0-5	0	0	0	0-5

Definitions

Senior managers

The definition of ‘senior managers’ is those persons in senior positions having authority or responsibility for directing or controlling the major activities of the NHS Foundation Trust. The Chief Executive has confirmed that the senior managers within the Trust for the purposes of the Remuneration and Staff Report are Executive Directors (voting members) and Non-Executive Directors.

Salary

The total amount of salary, fees and allowances paid for services provided (inclusive of salary sacrifice) but excluding reimbursement of expenses and employers pension and national insurance contributions.

Expense payments

Taxable expenses and benefits in kind are expressed to the nearest £100. The values and bands used to disclose sums in this table are prescribed by the Cabinet Office through Employer Pension Notices and replicated in the HM Treasury Financial Reporting Manual. Expense Payments relate to reimbursement for travel, subsistence and where appropriate, relocation expenses. Figures presented are shown gross, before tax.

Pension related benefits

Pension related benefits disclosed arise from membership of the NHS Pensions defined benefit scheme. Pension-related benefits are pro-rated/time-apportioned for directors who are appointed or resign part-way through the year. The value of pension benefits accrued during the year is calculated as the real increase in pension multiplied by 20, less the contributions made by the individual. The real increase excludes increases due to inflation or any increase or decrease due to a transfer of pension rights. This value does not represent an amount that will be received by the individual.

The calculation applies a prescribed formula as set out within the Finance Act (2004) and is intended to convey to the reader of the accounts an estimation of the benefit that being a member of the pension scheme could provide. The pension benefit table provides further information on the pension benefits accruing to the individual. Where there has been only a small increase in pension and lump sum benefits between the current year compared to last year, this formula can sometimes generate a negative figure. Where this is the case, Department of Health guidance states that a “zero” should be substituted for any negative figures.

Factors determining the variation in the values recorded between individuals include but are not limited to:

- a change in role with a resulting change in pay and impact on pension benefits
- a change in the pension scheme itself
- changes in the contribution rates
- changes in the wider remuneration package of an individual

Benefits in kind

These relate to the benefit in kind associated with lease cars obtained through the Trust's Salary Sacrifice Lease Car Scheme.

Bonus

The Group is required by NHS England to disclose any payments that fall within the definition of "Performance Related Bonuses" and it has been determined by the Department of Health and Social Care that Clinical Impact Awards (CIA), formerly Clinical Excellence Awards (CEA), meet this definition. As such they have been disclosed as a "Bonus". Clinical Impact Awards are given to recognise and reward the exceptional contribution of NHS consultants, over and above that normally expected in a job, to the values and goals of the NHS and to patient care. Clinical Impact Awards are administered at a national level by the Advisory Committee on Clinical Excellence Awards, and at a local level by the Local Awards Committee. These payments were previously classified within Other Remuneration. There have been no new Clinical Impact Awards payable to the directors in 2025/26, however the individuals who held the role of Trust and Group medical director during the period were in receipt of existing clinical impact awards as part of their remuneration package.

A separate bonus payment of 10% has been paid to the Group Chief Medical Director.

Group remuneration split

				Total earnings	Pension related benefits	Earning less pension adjustment	NNUH contribution *(based on earnings less pension)*	JPUH contribution *(based on earnings less pension)*	QEHKL contribution *(based on earnings less pension)*
		Dates		Bands of £5,000	Bands of £2,500	Bands of £5,000	Bands of £5,000	Bands of £5,000	Bands of £5,000
Name	Position	Appointed	End	£'000	£'000	£'000	£'000	£'000	£'000
D Roberts	Interim Group Chair	1 Nov 2025	Ongoing	35-40	0	35-40	10-15	10-15	10-15
L Dwyer	Group Chief Executive Officer *(NNUH Chief Executive Officer until 31 Oct 2025)*	4 May 2025	Ongoing	295-300	57.5-60	235-240	75-80	75-80	75-80
M Thorman	Group Chief Financial Officer *(NNUH Interim Chief Financial Officer from 24 Mar 2025 to 31 Oct 2025)*	1 Nov 2025	Ongoing	150-155	42.5-45	105-110	35-40	35-40	35-40
J Segasby	Group Delivery Officer	1 Nov 2025	Ongoing	245-250	147.5-150	95-100	30-35	30-35	30-35
J Sherwin	Group Chief Medical Director	1 Dec 2025	Ongoing	135-140	62.5-65	75-80	25-30	25-30	25-30
B Brett	Acting Group Medical Director (NNUH)	1 Nov 2025	30 Nov 2025	35-40	12.5-15	20-25	5-10	5-10	5-10
V Chitre	Acting Group Medical Director (JPUH)	1 Nov 2025	30 Nov 2025	35-40	20-22.5	15-20	5-10	5-10	5-10
R Martin	Acting Group Medical Director (QEHKL) *(Previous QEHKL Medical Director)*	1 Nov 2025	30 Nov 2025	25-30	5-7.5	15-20	5-10	5-10	5-10
R Cocker	Interim Group Chief Nurse *(from 15 Dec 2025)*	15 Dec 2025	Ongoing	55-60	7.5-10	50-55	15-20	15-20	15-20
P Baker	Group Non-Executive Director	10 Dec 2025	Ongoing	0-5	0	0-5	0-5	0-5	0-5
J Bowman	Group Non-Executive Director	10 Dec 2025	Ongoing	5-10	0	5-10	0-5	0-5	0-5
J Churchill	Group Non-Executive Director	10 Dec 2025	Ongoing	5-10	0	5-10	0-5	0-5	0-5
S Collier	Group Non-Executive Director	10 Dec 2025	Ongoing	5-10	0	5-10	0-5	0-5	0-5
N Gray	Group Non-Executive Director	22 Dec 2025	Ongoing	0-5	0	10-15	0-5	0-5	0-5
S Javes	Group Non-Executive Director	22 Dec 2025	Ongoing	0-5	0	0-5	0-5	0-5	0-5
W Van't Hoff	Group Non-Executive Director	10 Dec 2025	Ongoing	5-10	0	5-10	0-5	0-5	0-5

Notes:

1. With the formation of the Norfolk and Waveney University Hospitals Group most directors had roles overlapping the three trusts. A schedule of their spilt is shown in the table above.
2. There are no pensionable benefits paid to Non-Executive Directors for the year 2025/26.
3. Taxable benefits cover the monetary value of benefits in kind, such as car mileage allowances where subject to income tax.
4. Pension-related benefits have been pro-rated/time-apportioned for directors who were appointed or resigned part-way through the year.
5. The value of pension benefits accrued during the year is calculated as the real increase in pension multiplied by 20, less the contributions made by the individual. The real increase excludes increases due to inflation or any increase or decrease due to a transfer of pension rights. This value does not represent an amount that will be received by the individual. It is a calculation that is intended to convey to the reader of the accounts an estimation of the benefit that being a member of the pension scheme could provide.
6. No additional benefits will become receivable by directors if they retire early.
7. The pension benefit table provides further information on the pension benefits accruing to the individual.
8. L Dwyer was appointed Chief Executive of all three Trusts on 6 May 2025. The three trusts formed part of the Group from 1 November 2025.
9. The appointed date relates to the earlier of the individual's appointment to the Trust, or their commencement of a group role. Where they have only held a group role, only the salary and pension elements post this date have been included.
10. J Segasby was the JPUH CEO until 10 May 2025 and subsequently the group delivery officer from 1 November 2025. Between 11 May 2025 and 1 November 2025 she had no voting rights and therefore is not considered a member of senior management during this period.

Trust pension entitlement table 2025/26

Name and title	Real increase in pension at age 60 (bands of £2,500) £'000	Real increase in pension lump sum at age 60 (bands of £2,500) £'000	Total accrued pension at age 60 at 31 March 2026 (bands of £5,000) £'000	Lump sum at age 60 related to accrued pensions at 31 March 2026 (bands of £5,000) £'000	Cash Equivalent Transfer Value at 1 April 2025 £'000	Real increase in Cash Equivalent Transfer Value	Cash Equivalent Transfer Value at 31 March 2026
A Webster, Chief Executive	N/A	N/A	N/A	-	2,179	-	N/A
P Street, Chief Nurse	0-2.5	0.2-5	70-75	180-185	116	18	166
S Illingworth, Chief Operating Officer	0-2.5	-	40-45	95-100	782	1	815
R Martin, Medical Director	2.5-5.0	2.5-5.0	70-75	175-180	1,579	52	1,719
M Arrowsmith, Executive Managing Director	0-2.5	-	55-60	155-160	1,241	9	1,328
J Syson, Director of People	0-2.5	0-2.5	35-40	80-85	598	20	658
C Bown, Interim Executive Managing Director	N/A	N/A	N/A	N/A	N/A	N/A	N/A
L Hooper, Interim Director of Finance	N/A	N/A	N/A	N/A	N/A	N/A	N/A

Notes:

1. The Interim Executive Managing Director and Interim Director of Finance did not receive any pension benefits for 2025/26
2. The Chief Executive left the NHS pension scheme on 30 November 2025
3. The CETV disclosure for P Street was excluded in the prior year

Group pensions entitlement table 2025/26

Name and title	Real increase in pension at age 60 (bands of £2,500) £'000	Real increase in pension lump sum at age 60 (bands of £2,500) £'000	Total accrued pension at age 60 at 31 March 2026 (bands of £5,000) £'000	Lump sum at age 60 related to accrued pensions at 31 March 2026 (bands of £5,000) £'000	Cash Equivalent Transfer Value at 1 April 2025 £'000	Real increase in Cash Equivalent Transfer Value £'000	Cash Equivalent Transfer Value at 31 March 2026 £'000
L Dwyer, Group Chief Executive	2.5-5	0	10-15	0-5	99	0	0
M Thorman, Group Chief Financial	5-7.5	2.5-5	85-90	225-230	1,816	109	1,988
J Segasby, Group Delivery Officer	5-7.5	15-17.5	35-40	110-115	763	159	946
T Bleakley, Interim Executive Managing Director of NNUH	2.5-5	0	15-20	0-5	193	25	272
S Gordon, Executive Managing Director of NNUH	N/A	N/A	N/A	N/A	N/A	N/A	N/A
J Sherwin, Group Chief Medical Director	2.5-5	5-7.5	60-65	150-155	1,225	71	1,487
B Brett, NNUH Medical Director	5-7.5	7.5-10	100-105	265-270	2,246	135	2,516
V Chitre, Acting Group Chief Medical Director (JPUH)	0-2.5	0-2.5	10-15	20-25	22	6	33
R Martin, Acting Group Chief Medical Director (QEH)	2.5-5	2.5-5	70-75	175-180	1,579	0	1,719
R Cocker, Interim Group Chief Nurse	2.5-5	0	70-75	180-185	1,555	42	1,645

Notes:

1. S Gordon chose not to be covered by the pension arrangements during the reporting year
2. L Dwyer - for the 2015 scheme a CETV as at 31 March 2026 is not available via a Greenbury request and therefore a “zero” value has been entered

3. For individuals which are shared between the three trusts which form part of the NWUHG, the full CETV is disclosed for those individuals within each set of accounts and it has not been apportioned between the trusts
4. Negative values are not disclosed in this table but are substituted with a “zero”
5. As non-executive members do not receive pensionable remuneration there will be no entries in respect of pensions for Non-Executive members
6. Cash equivalent transfer value (CETV) figures are calculated using the guidance on discount rates for calculating unfunded public service contribution rates that was extant on 31 March 2026. HM Treasury published updated guidance on 27 April 2023; this guidance was used in the calculation of 2025/26 CETV figures.

Trust pensions entitlement table 2024/25

Name and title	Real increase in pension at age 60 (bands of £2,500)	Real increase in pension lump sum at age 60 (bands of £2,500)	Total accrued pension at age 60 at 31 March 2025 (bands of £5,000)	Lump sum at age 60 related to accrued pensions at 31 March 2025 (bands of £5,000)	Cash Equivalent Transfer Value at 1 April 2024	Real increase in Cash Equivalent Transfer Value	Cash Equivalent Transfer Value at 31 March 2025
	£'000	£'000	£'000	£'000	£'000	£'000	£'000
A 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
P Street, Chief Nurse	5.0-7.5	10.0-12.5	65-70	175-180	N/A	N/A	N/A
S Illingworth, Chief Operating Officer	2.5-5.0	7.5-10.0	35-40	95-100	642	82	782
R Martin, Medical Director	-	-	65-70	170-175	1,634	-	1,579
J Syson, Director of People	0-2.5	-	30-35	75-80	542	2	598

Notes:

1. Cash equivalent transfer value (CETV) figures are calculated using the guidance on discount rates for calculating unfunded public service contribution rates that was extant on 31 March 2025 HM Treasury published updated guidance on 27 April 2023; this guidance was used in the calculation of 2024/25 CETV figures.
2. As non-executive members do not receive pensionable remuneration there will be no entries in respect of pensions for non-executive members.

Lump sum

No lump sum will be shown for senior managers who only have membership in the 2015 Scheme or 2008 Section (unless they chose to move their 1995 Section benefits to the 2008 Section under the Choice exercise).

Cash Equivalent Transfer Values

A Cash Equivalent Transfer Value (CETV) is the actuarially assessed capital value of the pension scheme benefits accrued by a member at a particular point in time. The benefits valued are the member's accrued benefits and any contingent spouse's (or other allowable beneficiary's) pension payable from the scheme. CETVs are calculated in accordance with SI 2008 No.1050 Occupational Pension Schemes (Transfer Values) Regulations 2008.

No CETV will be shown for pensioners and senior managers over Normal Pension Age (NPA). NPA is age 60 in the 1995 Section, age 65 in the 2008 Section or State Pension Age (SPA) or age 65, whichever is the later, in the 2015 Scheme.

Real increase in CETV

This reflects the increase in CETV that is funded by the employer. It does not include the contributions paid by the employee (including the value of any benefits transferred from another pension scheme or arrangement).

Compensation on early retirement or for loss of office

Included in the salary costs for the Chief Executive were payments for compensation for loss of office totalling £99K.

Payments to past directors

There were no payments made to former directors in 2025/26. There were also no performance bonuses to past directors during the last two financial years. Benefits in kind were in respect of use of leased vehicles by senior staff.

Fair pay disclosure

In line with HM Treasury requirements, reporting bodies are required to disclose the relationship between the remuneration of the highest-paid director in their organisation against the lower quartile, median and upper quartile remuneration of the organisation's workforce.

Total remuneration comprises basic salary and allowances, non-consolidated performance-related pay and all taxable benefits. It does not include any severance

payments, benefits in kind, employer pension contributions and the cash equivalent transfer value of pensions.

Some directors have been operating across the Norfolk and Norwich University Hospitals NHS Foundation Trust (NNUH), the Queen Elizabeth Hospital King's Lynn NHS Foundation Trust (QEH) and James Paget University Hospitals NHS Foundation Trust (JPUH) during part of 2025/26. In compiling this note, the earnings were apportioned across the three trusts.

The banded remuneration of the highest paid Director, calculated for comparison purposes on a pro-rate full-time basis at the QEH in the financial year 2025/26 was £215,000 to £220,000 (2024/25 £210,000 to £215,000). The relationship to the remuneration of the organisation's workforce is disclosed in the table below.

In 2025/26, 25 (2024/25 - 4) members of the workforce received remuneration in excess of the highest paid director.

When considering agency staff within the fair pay report the Trust has picked a sample of agency staff members to represent the full time equivalent of agency staff that have worked throughout the period.

Pay ratio information table

2025/26	25th percentile	Median	75th percentile
'All staff' remuneration based on annualised, full-time equivalent remuneration of all staff (including temporary and agency staff) (£)	26,598	31,049	44,439
salary component of 'all staff' remuneration based on annualised, full-time equivalent remuneration of all staff (including temporary and agency staff) (£)	26,598	31,049	44,439
'All staff' remuneration based on annualised, full-time equivalent remuneration of all staff (including temporary and agency staff):	8.18	7.01	4.89
mid-point of band of highest paid director (£)	217,500	217,500	217,500
2024/25	**25th percentile**	**Median**	**75th percentile**
'All staff' remuneration based on annualised, full-time equivalent remuneration of all staff (including temporary and agency staff) (£)	23,615	29,970	42,008
salary component of 'all staff' remuneration based on annualised, full-time equivalent remuneration of all staff (including temporary and agency staff) (£)	23,615	29,970	42,008
'All staff' remuneration based on annualised, full-time equivalent remuneration of all staff (including temporary and agency staff):	9.00	7.09	5.06
mid-point of band of highest paid director (£)	212,500	212,500	212,500

The median and lowest salary cost for the Trust is low compared to some other trusts. This is as a result 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 3.6% against 2025 as a result of the annual pay award.

Percentage change in remuneration of highest paid director

2025/26	% change from previous financial year in salary and allowances
Highest paid director (midpoint of band)	2.35
All employees (total for all employees on an annualised basis, excluding the highest paid director), divided by the FTE number of employees (also excluding the highest paid director)	5.2
2024/25	**% change from previous financial year in salary and allowances**
Highest paid director (midpoint of band)	13.3
All employees (total for all employees on an annualised basis, excluding the highest paid director), divided by the FTE number of employees (also excluding the highest paid director)	5.5

The table below shows the average earnings for employees of the Trust at 25%, 50% and 75%. This is compared to the highest paid director.

	2025/26	2024/25
Band of highest paid director's total remuneration (£'000)	215-220	210-215
Midpoint of band	217,500	212,500
25th percentile (£)	26,598	23,615
Median total (£)	31,049	29,970
75th percentile (£)	44,439	42,008
Remuneration ratio	7.01	7.09

Employee remuneration range

	2025/26	2024/25
Band of highest paid employee (£'000)	455-460	435-440
Band of lowest paid employee (£'000)	20-25	20-25

The highest paid director's remuneration was 7.17 times (2024/25: 7.09 times) the median remuneration of the workforce which was £31,049 (2024/25: £29,970).

Signed on behalf of the Board on 25 June 2026

Professor Lesley Dwyer
Group Chief Executive

Patient safety

Challenges and areas requiring improvement

The Trust recognises that it has faced a number of significant challenges during the period, including serious concerns relating to General Surgery, its position within the NHS National Oversight Framework, and its involvement in the independent maternity and neonatal investigation led by Baroness Amos. These issues highlighted shortcomings in aspects of quality, governance, oversight, culture and performance, and demonstrated the need for sustained improvement across a number of services. The Trust accepts that improvement is required and remains committed to learning from reviews, inspections and external scrutiny, while implementing the actions necessary to strengthen patient safety, quality of care, organisational learning and public confidence in its services.

Issues in General Surgery

The Trust acknowledges that General Surgery has been a significant area of concern and has been subject to external review and regulatory scrutiny during the reporting period. These reviews identified a number of serious issues requiring improvement, including weaknesses in clinical governance, escalation processes, decision-making, communication, teamwork and organisational learning. The findings highlighted shortcomings in the way concerns were identified, escalated and acted upon, and demonstrated the need for stronger leadership, oversight and accountability within surgical services.

The Trust accepts these findings and recognises the impact that these issues may have had on patients, families and staff. In response, a comprehensive programme of improvement has been implemented to strengthen governance arrangements, enhance clinical leadership, improve multidisciplinary working and ensure that learning is identified, shared and embedded effectively. The Trust remains committed to delivering sustained improvements in the quality, safety and effectiveness of General Surgery services and to restoring confidence among patients, staff and stakeholders.

Patient Safety Incident Response Framework (PSIRF)

The Patient Safety Incident Response Framework (PSIRF) sets out a strategic, system-wide approach to how the Trust responds to patient safety incidents. It strengthens a culture of continuous learning through four core aims: compassionate engagement with those affected, systems-based learning, proportionate responses and strengthened oversight to support effective, sustainable improvement.

By adopting a systems-based approach, PSIRF enables deeper understanding of contributory factors and supports targeted improvements to prevent recurrence. It

emphasises the quality and rigour of Patient Safety Incident Investigations (PSIIs), providing assurance to patients, families, carers and staff of the Trust's commitment to learning and transparency.

Since transitioning to PSIRF in September 2023, around 50 colleagues have completed NHS England-approved training. This has equipped learning response and engagement leads, and those in oversight roles, with the skills to apply systems thinking and engage compassionately with those affected.

Additional training in Swarm Huddle (SWARM) and After-Action Review methodologies has broadened investigation approaches, supporting a more comprehensive learning response toolkit and increasing capacity for timely, proportionate and high-quality reviews.

Regular multidisciplinary incident review huddles are now embedded across all divisions. These support effective triage, ensure alignment with the Trust's Patient Safety Incident Response Plan (PSIRP) and enable prompt identification of safety actions and compassionate engagement with patients, families and staff, including application of Duty of Candour.

Incidents requiring further scrutiny, including those with potential Trust-wide impact or complexity, are escalated to the Safety Incident Review Forum (SIRF). Here, they undergo multi-professional review to determine the most appropriate response and ensure effective sharing of learning.

Following the Health Service Safety Investigations Body national report on PSIRF implementation (October 2025), the Trust commenced a self-assessment in January 2026. This is reviewing governance infrastructure, assessing how PSIRF principles are embedded, identifying gaps and benchmarking progress.

Outcomes will inform strengthened governance processes and development of an annual audit cycle, ensuring continued compliance with PSIRF and delivery of high-quality responses to patient safety incidents.

The Trust's second PSIRF, published in July 2025, is based on local analysis and organisational insight. It sets out priorities for PSIIs:

- recognition and timely treatment of sepsis
- management of hospital-acquired thrombosis (HAT)
- detection of deterioration in maternity care

Additional monitoring priorities include postnatal readmissions related to feeding and escalation of deteriorating patients.

Incident reporting

A total of 10,768 patient safety incidents were reported in 2025/26 (9,645 excluding pressure ulcers and skin damage on admission). Of these, 22 were categorised as major (severe harm) or catastrophic (death).

Over the past three years, major and catastrophic incidents have reduced while overall reporting has increased. Data indicates reduced harm across multiple categories, reflecting increased maturity in incident management and classification following the introduction of incident huddles and enhanced engagement under PSIRF.

	Total reported patient safety incidents, excluding pressure ulcers on admission	Safety incidents categorised as major or catastrophic	Total incidents commissioned as PSII or NE
2025/26	9,645	22	15
2024/25	8,511	28	17
2023/24	7,494	31	31
2022/23	6,508	47	49
2021/22	7,549	29	54
2020/21	7,631	29	56

Several work programmes during 2024/25 delivered key improvements:

- enhancements to the Datix risk management system, including compassionate engagement and learning summary sections, integration of Clinical Audit and National Institute for Health and Care Excellence (NICE) guidelines and divisional risk register dashboards
- launch of the ‘Supporting Compassionate Engagement with Patients and Families’ training programme across the Integrated Care System, now transitioning to local delivery
- improved staff communication and support following incidents, aligned with the Professional Nursing/Midwifery Advocate workforce
- continued publication of the Patient Safety and Quality Improvement Newsletter
- expansion of ‘Lunchtime Learning’, a quarterly Trust-wide learning event
- delivery of a two-day externally facilitated training programme on SWARM, After-Action Review and debrief methodologies
- collaboration across the Group to align PSIRF training and develop shared approaches
- ongoing collaboration on a Group-wide patient safety newsletter and shared learning

Patient Safety and Quality Improvement teams continue to work jointly on priorities including falls, HAT, rib fracture management and aseptic pharmacy safety.

Targeted reviews included:

- a comprehensive review of pressure ulcer incidence and contributory factors
- analysis of stroke-related incidents, with strengthened learning shared through multiple channels
- ophthalmology process mapping to support service improvement
- the 'Go Decaf!' initiative in frailty wards, showing early benefits including potential reductions in falls risk and cost savings

'Falls Hot Debrief' transitioned from paper-based to Datix recording, enabling more timely learning. The Infection Prevention and Control team adopted SWARM methodology for post-infection reviews, with positive feedback and wider interest from other specialties.

Patient Safety Learning Event

During Patient Safety Week (15 to 19 September 2025), the Trust hosted a Patient Safety Learning Event on World Patient Safety Day (17 September). In collaboration with the Women and Children's division, the event focused on the theme 'Safe Care for Every Newborn and Child'.

Held in person and online, the event attracted over 80 attendees. Topics included Martha's Rule, safeguarding children and the Paediatric Virtual Ward. A key highlight was a personal account from a patient's mother, reinforcing the importance of listening to and learning from patients and families.

Patient Safety Incident Investigations (PSII)

In 2025/26, 15 PSIIs were commissioned across a range of incident types including diagnostic delays, surgical procedures, treatment delays, maternity care, pressure ulcers and deteriorating patients.

	Emergency Care and Medicine	Surgery	Women's and Children's	Total
Diagnostic incident including delay (and failure to act on test results)	5	0	0	5
Surgical/invasive procedure	0	1	1	2
Treatment delay	0	2	0	2

	Emergency Care and Medicine	Surgery	Women's and Children's	Total
Maternity/obstetric: mother and baby (this includes foetus, neonate and infant)	0	0	2	2
Pressure ulcer	1	0	0	1
Sub-optimal care of the deteriorating patient	1	0	0	1
Venous thromboembolism	1	0	0	1
Maternity/obstetric: baby only (this includes foetus, neonate and infant)	0	0	1	1
Total	8	3	4	15

Never Events

Two incidents met Never Event criteria in 2025/26: one wrong site surgery and one retained swab.

The wrong site surgery was graded as major harm as further surgery was required. The retained swab was graded as a near miss major, as it was removed promptly.

Both incidents were commissioned as PSIIs. The patient affected by the wrong site surgery is receiving full support through a dedicated engagement lead.

Duty of Candour

The Trust remains committed to meeting its statutory Duty of Candour obligations under Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The process is initiated as soon as reasonably practicable following a notifiable safety incident.

Compliance in 2025/26 was:

- Phase One: 100%
- Phase Two: 96%
- Phase Three: 100%

Three Phase Two breaches were identified. Contributory factors included local operational issues, temporary uncertainty regarding document access following an intranet transition and a need for strengthened divisional oversight. Actions included reinforcing template accessibility and incorporating monitoring into divisional huddles. One breach reflected the need to facilitate a face-to-face discussion not possible in Phase One.

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	30	30	30	100%
Quarter two	26	26	26	100%
Quarter three	33	33	33	100%
Quarter four	27	27	27	100%
Overall compliance	**116**	**116**	**116**	**100%**

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	16	16	16	100%
Quarter two	22	22	2	100%
Quarter three	26	26	25	96%
Quarter four	21	21	19	90%
Overall compliance	**85**	**85**	**82**	**96%**

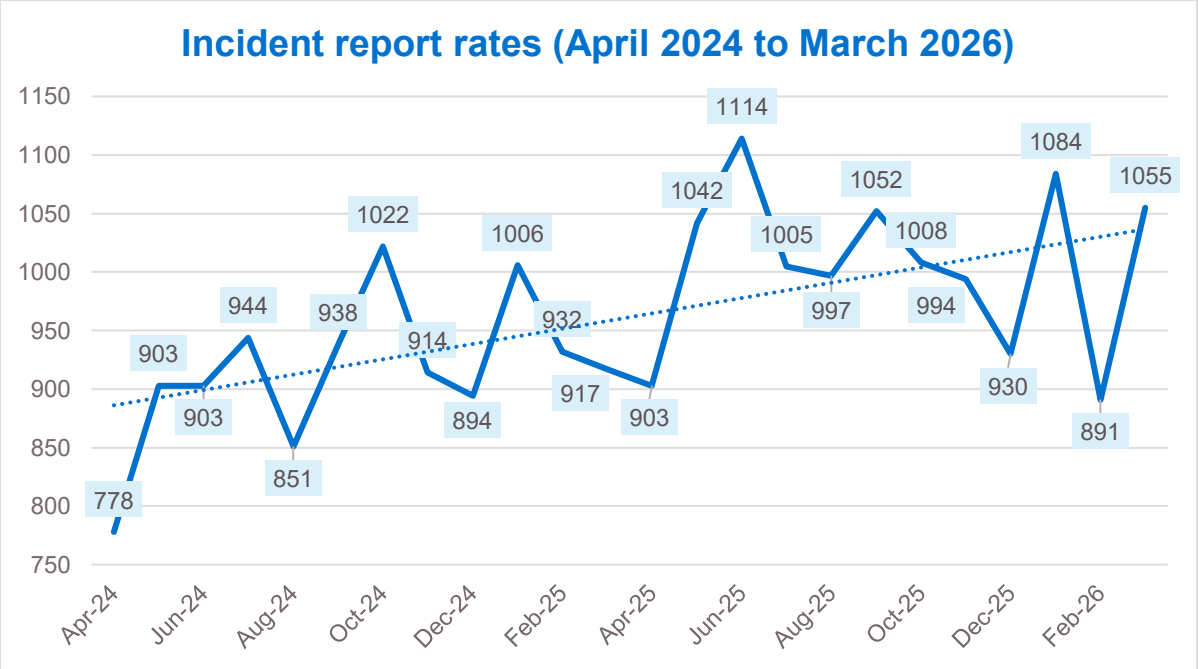
Phase Three compliance

	Phase Three required	Phase Three completed	Phase Three count (completed within 10 working days)	Phase Three % (completed within 10 working days)
Quarter one	3	3	3	100%
Quarter two	3	3	3	100%
Quarter three	1	1	1	100%
Quarter four	1	1	1	100%
Overall compliance	**8**	**8**	**8**	**100%**

Learn from Patient Safety Events (LFPSE)

LFPSE is a national NHS system replacing the National Reporting and Learning System. It provides a central platform for recording, reviewing and analysing patient safety events.

The QEH integrated LFPSE into Datix in April 2024, strengthening data analysis, trend identification and organisational learning. Concerns about increased reporting burden have not materialised locally, with reporting rates continuing to rise.



Work to improve Datix awareness has focused on clarifying its purpose, simplifying reporting, strengthening feedback and promoting a just culture. Initiatives included training videos, induction content, staff engagement sessions, promotional materials, reinstated feedback loops and simplification of incident classification.

LFPSE dashboards now enable benchmarking against other organisations. Version six of the taxonomy introduces improved classification, reporting of external incidents and direct recording of PSIIs and Never Events, removing future reliance on Strategic Executive Information System (StEIS). Adoption is planned for 2026/27.

Patient Reported Outcome Measures (PROMs)

PROMs assess health outcomes from the patient perspective following surgery, currently focusing on hip and knee replacements.

Based on finalised data for April 2023 to March 2024 (published February 2025), participation rates were:

Participation rate: Hernia	Participation rate: Hip	Participation rate: Knee	Participation rate: Vein
N/A	73%	85%	N/A

Routine collection for varicose vein and groin hernia procedures ceased in October 2017 following national consultation.

Total scanned: Hernia	N/A
Total scanned: Hip	16
Total scanned: Knee	22
Total scanned: Vein	N/A

Patient and carer experience

Patient experience reflects every stage of an individual's journey through the Trust. Every member of staff plays a vital role in delivering high-quality, person-centred care, regardless of role or setting. At the Queen Elizabeth Hospital NHS Foundation Trust (the QEH), we remain committed to engaging patients, families, carers and the wider public, ensuring their voices inform continuous and sustainable service improvement. Over the past year, progress has been made in enhancing patient and family experience through meaningful engagement and learning from feedback.

This report outlines patient experience and engagement activity during 2025/26 and highlights key opportunities for learning and improvement. The function operates under the leadership of the Chief Nurse, with Trust-wide multidisciplinary collaboration.

The Patient Experience and Engagement team is central to delivering consistently high-quality, person-centred care. This includes supporting staff to provide not only excellent clinical care but care delivered with respect, empathy and compassion. Quality is determined by patient satisfaction, clinical outcomes, staff feedback and sustainable infrastructure.

Patient experience is embedded within the Trust strategy, with a focus on safe, compassionate and effective care and patient involvement in care pathway development. The team has contributed significantly to Strategic Objective 1: Holistic and Person-Centred Care and Experience.

Engagement activities during the year delivered several developments, including collaboration with care charities to develop a carer handbook, increased engagement with veterans and their families, and work with local communities and schools to support young carers and promote Carers Identity Passports.

Governance and engagement

In 2025/26, the Trust strengthened partnerships with community groups supporting people with disabilities, sensory impairments, carers and the Armed Forces community.

The Associate Director of Patient Experience and Engagement and Patient Experience and Engagement Lead supported the Trust in achieving Gold reaccreditation as a Veteran Aware organisation.

The Patient Panel and Readers Panel continued to ensure the patient voice is represented across Trust forums. Membership is established through volunteer pathways, with representation embedded across governance structures. The Patient Panel is led by a Chair and Vice Chair.

Supported groups include Learning Disability and Autism, Patient Feedback Forum, Mental Health, Care of the Elderly, End of Life Care, Carers Forum, Sensory Impairment and Disabilities, Spiritual Wellness, Patient Panel and Readers Panel.

The Patient Panel Chair and Vice Chair provide a regular Chair's Assurance Report to the Patient Experience and Safety Forum, ensuring feedback is reviewed, escalated and acted upon.

Eight core workstreams drive the Patient Experience Programme, with objectives informed by triangulated feedback from patients, carers and families. Progress is monitored through the Quality, Safety and Effectiveness Management Group.

Listening to our patients

Engagement activity has increased significantly, strengthening patient and public involvement and ensuring services are shaped by those who use them. Work continues to widen participation and improve inclusion of underrepresented groups.

Patient engagement has contributed to the New Hospital Programme (NHP), including redevelopment plans. Patient Panel members have actively scrutinised proposals and provided feedback.

Participation across Trust workstreams has increased, supporting co-production and embedding patient perspectives in decision making. Work has also progressed to improve the accessibility and readability of patient information.

Feedback from national and local surveys has informed improvements. Children's survey feedback led to redevelopment of the Children's Department to create a more accessible and age-appropriate environment.

Parental feedback identified concerns about being heard. In response, Martha's Rule has been introduced within the children's department, supported by staff training and awareness initiatives.

Let's Get Moving

This workstream promotes patient mobility to reduce deconditioning, which can negatively affect outcomes, wellbeing and length of stay.

The programme is being relaunched in 2025/26 with increased staff engagement and embedding across clinical areas. A mobility dashboard supports daily monitoring and ward champions encourage patient mobilisation.

Optimising nutrition and hydration

This workstream focuses on improving nutrition and hydration as key components of patient safety and recovery. The Nutrition and Hydration Group leads this work, supported by Patient Panel input.

A dashboard has been introduced to identify trends and support data-driven improvements. Patient feedback regarding limited healthy snack options has led to a review of snack provision and expansion of healthier and caffeine-free options.

Quality and timely discharge

Discharge remains a key priority, supported by transformation programmes and digital solutions such as Patient Observation Management System (POMS) and OPTICA Discharge Planning.

Significant improvements include reduced patients without criteria to reside, fewer failed discharges and fewer complaints. Initiatives such as criteria-led discharge, Golden Patients and Home Before Lunch have improved patient flow.

The discharge lounge continues to receive positive feedback. While communication has improved, further work on post-discharge support is planned for 2026/27.

Education and training

Education has been strengthened to align with patient experience data and organisational priorities. Programmes have been updated using patient feedback, supporting a responsive and relevant curriculum.

Innovations include in situ simulation in Same Day Emergency Care and the launch of the THRIVE - Transforming Healthcare, Reflection, Innovation, Values, Excellence - Leadership Programme.

The Trust achieved Teaching Hospital status, supported by programme accreditation and partnership with Anglia Ruskin University. The Nursing Associate Apprentice Programme commenced in September 2025.

Plans are in place to deliver the Compassionate Engagement Programme locally to improve accessibility and impact.

Volunteers matter

Volunteer engagement has increased, supported by improved recruitment, onboarding and training. Enhanced data management has strengthened oversight and planning.

New training and clearer guidance have improved volunteer confidence and retention. Staff are supported to integrate volunteers effectively into teams.

The Infant Feeding Peer Support Volunteer role demonstrates the value of volunteers in improving patient experience.

Learning disability and autism

Progress has been made in improving care for patients with learning disabilities and autism. Key areas include workforce training, pathway development and patient experience.

Implementation of the Oliver McGowan Mandatory Training is ongoing, with improved compliance monitoring. Oversight of admissions and reasonable adjustments has strengthened.

Collaboration with partner trusts has supported pathway development and consistency. Work continues on transition pathways for young people.

Learning from lives and deaths – people with a learning disability and autistic people (LeDeR) reviews is embedded, including initiatives such as visual pain scales in maternity services.

Environment and accessibility

The Environment and Accessibility workstream has focused on improving patient experience, site efficiency and quality assurance.

Patient feedback informs improvements, including changes to facilities, signage and parking.

Examples include repositioned facilities for accessibility, improved wayfinding and increased Blue Badge parking.

Chaplaincy

The Chaplaincy continues to provide pastoral and spiritual care through bedside visits, events and bereavement support. Activity levels remain high, with support provided to patients, staff and visitors.

Statistics for chaplaincy	2025/26	2024/25	2023/24
Patients visited	2,555	2,294	1,974
End-of-life encounters	1,877	1,074	678
Baby funerals	34	36	4
Naming and blessings of babies	15	20	16
Private funerals	13	9	8
Staff support	130	79	5

Voluntary services

Volunteer services have expanded, with increased staff engagement and improved recruitment. Partnerships with community organisations have strengthened delivery and inclusion.

Achievements include expansion of the patient buggy service and new volunteer roles. Volunteer satisfaction remains high.

Carers

Support for unpaid carers has increased, with over 100 carers identified and supported. The Carers Identity Passport has been promoted.

A Carers Directory has been introduced and partnership working strengthened. Events such as Carers Week and Young Carers Action Day have raised awareness.

A joint Carers Policy has been developed with partner trusts and staff training delivered to improve understanding of carers' needs.

Armed forces and reaccreditation

Progress has continued in supporting the Armed Forces community. Partnerships with charities have strengthened referral pathways.

The Trust retained the Defence Employer Recognition Scheme Gold Award and increased staff engagement through training and awareness initiatives.

A new prompt supports identification of Armed Forces patients and a dedicated intranet page provides guidance and resources.

External engagement events

The Patient Experience team participated in external events including carers, community and veterans' engagement activities. These supported awareness, networking and promotion of Trust services.

Patient stories at Board

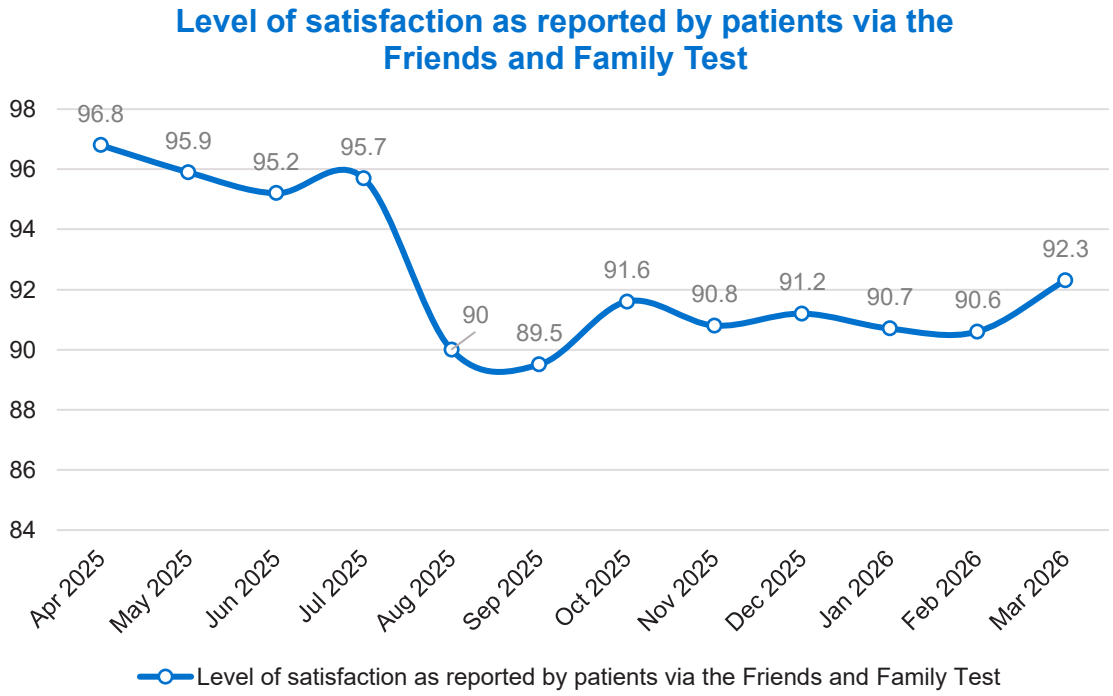
Patient stories continued to be shared at Trust Board meetings until the transition to the Group structure in November, providing valuable insight into patient experience and informing improvement.

Stories presented during this period highlighted the experiences of a young carer, the value of volunteering, challenges in communication and interpretation, and positive end-of-life care. These accounts have informed service improvements.

Friends and Family Test (FFT)

A new provider was implemented in 2025, following a collaborative procurement. Temporary manual processes were used during transition, with full implementation achieved in August 2025.

Staff training has been delivered, with positive feedback on usability. Feedback is collected through multiple accessible channels.



National patient surveys

The Trust participates in national surveys including inpatient, maternity, children and cancer. Results are reviewed and used to drive improvement, with oversight through governance structures.

Adult Inpatient Survey results showed areas for improvement including discharge communication and personal care, with strengths in cleanliness and accessibility.

The Maternity Survey showed overall improvement, with strong performance in communication and support.

The Cancer Survey identified areas for improvement including inclusivity, waiting times and treatment information.

The Children and Young People Survey highlighted strengths in staff communication and trust, with actions in place to address identified gaps.

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

Pictured above: *A new patient experience initiative is being trialled at The Queen Elizabeth Hospital designed to provide additional wellbeing support to people during their hospital stay.*

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

The Trust is committed to learning from complaints and driving continuous improvement across all services. All complaints are managed in accordance with the Trust's Complaints Procedure and national NHS complaints regulations. The aim is to work collaboratively with complainants to achieve timely, clear and constructive resolution through open explanation and discussion.

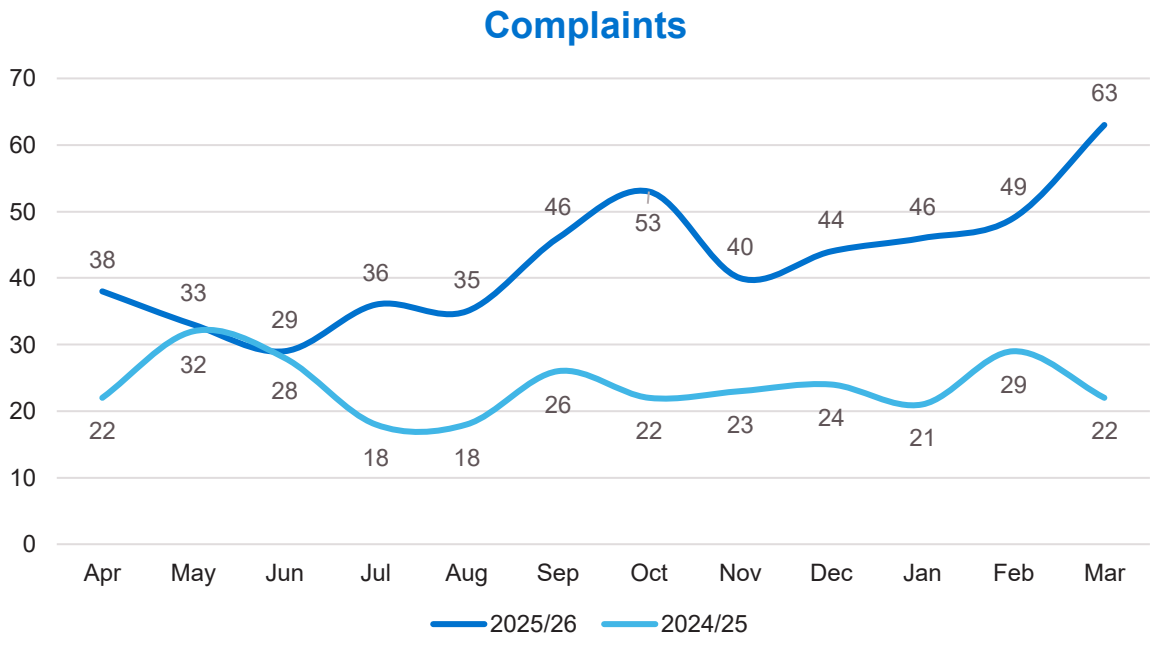
For individuals who do not wish to pursue a formal complaint but would like to raise a concern or seek support, PALS is available. PALS works to resolve concerns promptly by liaising with relevant staff, reducing anxiety for patients and families and helping to prevent escalation into formal complaints.

Formal complaints

The Complaints team ensures all formal complaints are fully investigated and that a written response is provided within 30-working days. In 2025/26, the Trust received 512 formal complaints, an increase of 227 (80%) compared with 285 in 2024/25. A similar increase was also seen in PALS concerns.

During 2025/26, 53 cases were reopened where service users felt concerns had not been fully addressed in the initial response. These were reinvestigated and further responses provided or face-to-face meetings arranged.

The chart below shows monthly complaint activity in 2025/26 compared with 2024/25.



	Q1 – 2025/26	Q2 – 2025/26	Q3 – 2025/26	Q4 – 2025/26	Total 2025/26
Clinical Support and Cancer Services	7	8	4	5	24
Emergency Care and Medicine	48	45	63	65	221
Surgery	27	40	47	66	180
Women's and Children's	16	19	17	16	68
Other	2	5	6	6	19
Total	**100**	**117**	**137**	**158**	**512**

Written response rate

The Service Level Agreement (SLA) for responding to complaints is 30-working days.

The table below shows performance against this standard by division. Although extensions are permitted under policy, these are still recorded as breaches against the 30-day standard.

Compliance with 30-working day SLA (2025/26)

	Q1 – 2025/26	Q2 – 2025/26	Q3 – 2025/26	Q4 – 2025/26	Total 2025/26
Clinical Support and Cancer Services	50%	100%	100%	75%	81%
Emergency Care and Medicine	86%	84%	60%	59%	72%
Surgery	74%	70%	84%	62%	72%
Women's and Children's	81%	93%	79%	75%	82%
Other	100%	93%	79%	75%	82%

Top themes from complaints (2025/26)

Some complaints included more than one theme.

Complaints	Number
Clinical treatment	317
Communication	263
Values and behaviours (staff)	115
Patient care	107
Appointments	76
Admission / discharge	56
Waiting times	34
Access to treatment or drugs	26
Prescribing	22
Trust admin, policies and procedures	22

During Quarter 3, the Complaints team transitioned to new management with a strengthened focus on improving complaint handling. The aim is to deliver high-quality responses within 30-working days or fewer. While the Complaints team leads coordination, accountability remains with operational divisions. Learning from

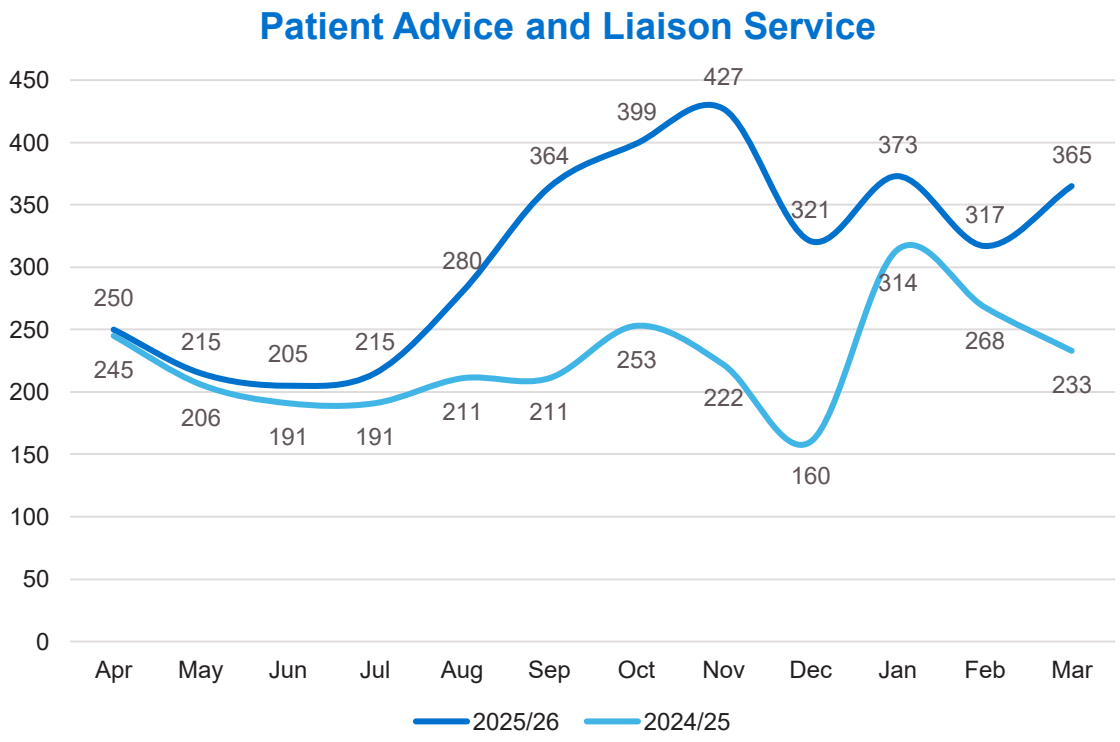
complaints continues to inform service improvement and enhance patient experience.

All complaint responses undergo a structured review process. On completion of investigation, findings and outcomes are reviewed by the Divisional Leadership Team, Complaints team, Chief Nurse and Executive Managing Director. This provides senior oversight and assurance that concerns are addressed thoroughly.

Patient Advice and Liaison Service (PALS)

In 2025/26, 3,731 PALS concerns were recorded, an increase of 1,041 (39%) compared with 2,690 in 2024/25. All divisions saw increased activity during Quarter 2, reflecting the trend in formal complaints.

The chart below shows monthly activity in 2025/26 compared with 2024/25.



The table below shows PALS activity by division.

	Q1 – 2025/26	Q2 – 2025/26	Q3 – 2025/26	Q4 – 2025/26	Total 2025/26
Clinical Support and Cancer Services	41	62	80	60	243
Emergency Care and Medicine	194	303	384	301	1,182

Surgery	215	289	367	405	1,276
Women's and Children's	64	56	85	94	299
Other	156	149	231	195	731
Total	**670**	**859**	**1,147**	**1,055**	**3,731**

Top themes for PALS concerns

- patient care
- appointments (delays and cancellations)
- communication
- test results
- lost property
- discharge arrangements
- access to medical records
- values and behaviours
- parking permits
- Trust administration, policies and procedures

Compliments

The PALS team records all compliments received, including verbal feedback, emails, cards and gifts. In 2025/26, 1,253 compliments were recorded compared with 1,470 in 2024/25, a reduction of 15%.

	Q1 – 2025/26	Q2 – 2025/26	Q3 – 2025/26	Q4 – 2025/26	Total 2025/26
Clinical Support and Cancer Services	15	17	9	6	47
Emergency Care and Medicine	138	157	162	80	537
Surgery	86	83	130	55	354
Women's and Children's	48	53	67	38	206
Other	37	29	24	24	109
Total	**319**	**339**	**392**	**203**	**1,253**

Parliamentary and Health Service Ombudsman (PHSO)

Where complaints cannot be resolved locally, individuals may escalate concerns to the Parliamentary and Health Service Ombudsman (PHSO) for independent review.

In 2025/26, the PHSO contacted the QEH regarding five complaints, a reduction of 65% from 14 in 2024/25.

Current case status:

- 12 cases under assessment
- two cases under formal investigation
- eight cases under preliminary review
- two cases nearing closure

Five cases were closed during the year, three following formal investigation.

Planned improvements for 2025/26

Over the next 12 months, priorities include:

- increasing early engagement with divisions in Quarter 1 to identify risks and support timely responses
- achieving 90% compliance with the 30-working day complaint response standard
- expanding use of Local Resolution Meetings to support earlier resolution
- reviewing and strengthening internal processes and procedures
- updating documentation to reflect continuous improvement activity
- ensuring all PALS and Complaints staff are trained across both functions to improve resilience
- improving how learning from complaints is captured, embedded and audited against Trust KPIs
- strengthening collaboration between Patient Experience and Patient Safety teams to ensure learning is shared and drives wider organisational improvement

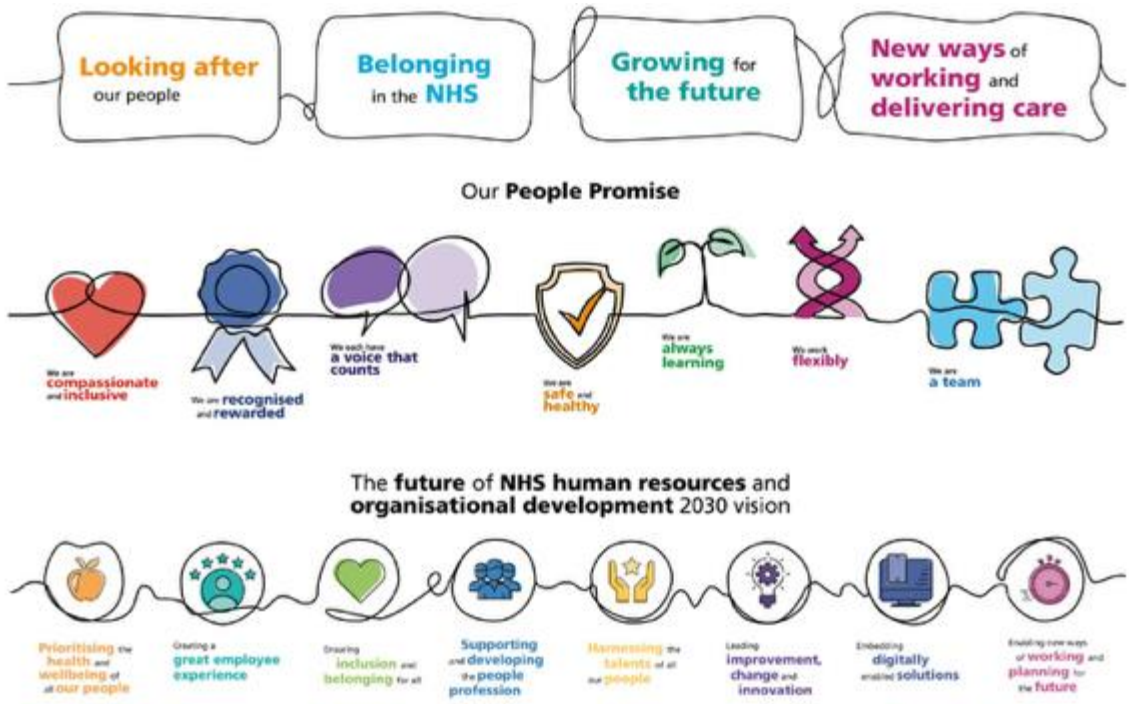
Staff report

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 Queen Elizabeth Hospital King's Lynn NHS Foundation Trust (the QEH) People Plan has been enacted during 2025/26. Aligned with the delivery of the Trust's strategic objectives, the People Plan has underpinned improvements across the workforce and employee experience.

Over the past year, we have completed a detailed diagnosis of how leaders, managers and staff experience HR in practice, using this insight to design clearer and more consistent People Services. This work identified what was working well, where experiences were uneven and what needed to change to better support day-to-day decision-making and people management. With a clear direction now established, we have begun implementing the new approach by simplifying access to support, improving response times and reshaping core processes to better reflect how work is undertaken. Alongside this, we are establishing the foundations for longer-term change in how workforce information is used, responsibilities are shared and decisions are made. These changes are not always visible but are significant in building trust and confidence in our People Services and creating a more integrated experience for staff. These steps mark the transition from design to delivery and lay the groundwork for sustained improvements in staff experience and how the organisation plans, develops and supports its workforce.

We have continued to strengthen our talent pipelines within the community, evolving our work experience, outreach and employability initiatives. Our collaboration with schools and colleges has strengthened, and we continue to fulfil our important role as an anchor institution in King's Lynn and West Norfolk through partnerships with higher and further education providers. Our Teaching Hospital status has been confirmed.

Throughout the reporting year, we have continued to identify ways to improve the management of employee relations cases. Working with the Freedom to Speak Up (FTSU) team and our recognised trade unions, we have developed our approach to informal resolution and improved the achievement of transparent, proportionate and consistent outcomes.

We have also seen improvements in the training experience of our medical students and junior doctors, informed by insights and feedback from General Medical Council (GMC) survey results.

Our staff survey has achieved its highest level of response, reflecting the expectations of our workforce and their desire to create a caring, inclusive and supportive workplace culture where every individual can contribute to excellence.

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	
	2025	2024	2025	2024	2025	2024
Medical and dental	505	482	44	49	548	531
Ambulance staff	0	0	0	0	0	0
Administration and estates	990	1,059	72	73	1,062	1,133
Healthcare assistants and other support staff	791	759	61	93	851	852
Nursing, midwifery and health visiting staff	1,108	1,100	45	67	1,152	1,167
Nursing, midwifery and health visiting learners	6	5	0	0	6	5
Allied health professionals	208	205	12	11	220	217
Scientific, therapeutic and technical staff	77	70	4	9	82	80
Healthcare science staff	23	25	1	2	24	27
Social care staff	0	0	0	0	0	0
Total average numbers	**3,708**	**3,706**	**237**	**305**	**3,946**	**4,012**

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

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

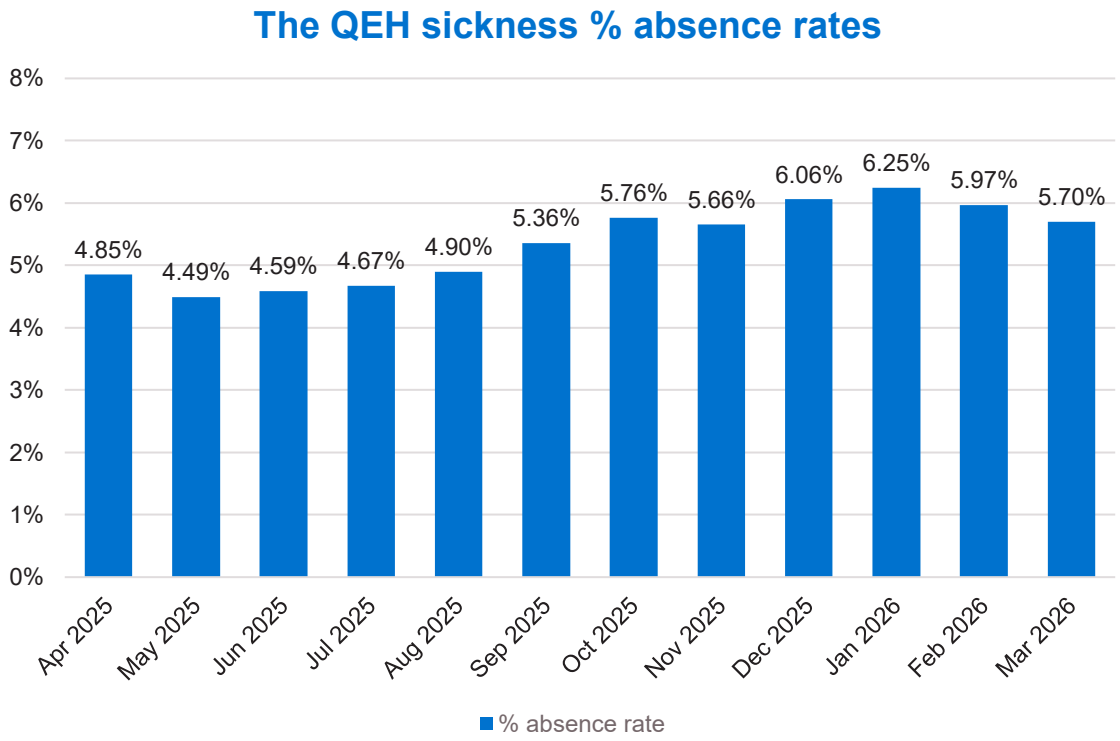
Category	Female	Male	Total
Executives	5	2	7
Non-executives	0	0	0
Senior managers	15	9	24
Other	3,180	1,053	4,233
Total	**3,200**	**1,064**	**4,264**

Staff sickness

Our sickness rate averaged 5.35% across the reporting year, compared with a Trust target of 4.5%, and closed at 5.7% in March 2026.

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

- promoting our Employee Assistance Programme (EAP), resulting in a 10-percentage point increase in self-service support during the year
- reviewing our Occupational Health offering, with improvements to access, triage and wellbeing-focused services to be implemented from April 2026
- evaluating the effectiveness of current attendance management processes and identifying improvements to better support staff at key moments, while strengthening approaches to short-term and long-term absence



We continue to support divisions in proactively encouraging attendance at work. Improvements to return-to-work practices enable managers, HR and Occupational Health colleagues to tailor wellbeing support and better understand short, medium and long-term absences. Staff on long-term sick leave have plans in place to support a successful return to work.

Workplace health, reducing sickness and improving attendance remain key Trust objectives. We have seen a reduction in cases of stress, anxiety and depression, indicating the positive impact of support services such as:

- appointing a specialist in post-traumatic stress disorder to support emotional wellbeing and trauma-related issues
- providing staff with direct access to Mental Health First Aiders (MHFA)
- strengthening the Occupational Health service through additional staffing
- increasing the number of MHFAs across the Trust
- recruiting and training mediators to support informal resolution of employee relations cases, thereby reducing associated workplace stress

Steps taken to safeguard staff physical health include:

- offering COVID-19 vaccinations to patients and staff
- offering flu vaccinations to all staff
- enhancing and extending the ‘No Excuse for Abuse’ campaign, reinforcing expected behaviours towards staff and supporting them to raise concerns

Staff turnover

The retention of skilled and experienced staff remains a key element of the Trust's People Strategy. We continue to focus on improving staff experience and retaining and developing our workforce. The NHS Staff Survey provides valuable insight to inform these improvements.

Staff annualised turnover for permanent staff reduced from 12.26% in March 2025 to 9.54% in March 2026.

Pictured above: *NHS stars celebrated at our annual awards where more than 300 guests heard heartwarming stories about the finalists and winners..*

Staff communications and engagement

Support for our staff is overseen by the Culture, Organisational Development and Equality, Diversity and Inclusion Forum alongside our staff networks. This continues to be delivered under the following headings: financial health, physical health and emotional health.

Financial health

Financial health is a key pillar of our employee wellbeing programme. By providing support, we continue to normalise conversations around financial wellbeing at work, promote internal support systems, signpost to external support services and understand the specific challenges facing our staff.

We currently support the financial health of our staff by offering:

- **Stream (formerly Wagestream),** which allows staff to access a percentage of their earnings, helping to prevent them from going into an overdraft
- **Cavell,** which provides financial wellbeing support to nurses, midwives, nursing associates and maternity support workers
- **Vita Health Group Employee Assistance Programme services,** which offers staff at the QEH confidential financial wellbeing support as part of its wider employee assistance programme. This includes access to advice on debt management, budgeting and financial planning, as well as signposting to external financial support services. Support is available 24/7 and is designed to help staff manage financial stress and improve overall wellbeing
- **crisis loans of up to £1,500,** which staff can apply for should an urgent need arise
- **NHS discounts,** which are publicised to staff on a dedicated intranet page

Physical health

Support in this area, both at home and at work, remains a key part of our strategy. Evidence shows that when staff are happier and healthier in the workplace, there is a positive impact on patient care.

We currently support the physical health of our staff by offering:

- **extended catering provision,** with the Midnight Café serving hot food until 2am, ensuring equitable access for night staff
- **enhanced changing facilities,** upgraded to improve accessibility and inclusivity

Emotional health

We currently support the emotional health of our staff by offering:

- **a staff psychology service,** which is a dedicated service for the QEH staff
- **Mental Health First Aiders,** available across the Trust to offer peer support and signposting
- **Wellbeing Passports,** which are portable records outlining 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 300 attendees and was live streamed to over 1,300 additional viewers. Entertainment was provided by special guest speaker Nicolas Hamilton, who was the first disabled driver to compete in the British Touring Car Championship and brother of Formula 1 racing driver Lewis Hamilton, as well as Lavender Hill Mob Theatre Company and the Marham Military Wives Choir.

Over 650 nominations were received, each reflecting the passion and commitment of our staff, volunteers and teams. Awards were presented in 13 categories by the then 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
- 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

- **Long Service Awards,** recognising continuous NHS service at 15, 20, 25, 30, 35 and 40 years. In 2025, we celebrated 7,240 years of combined service, with a cumulative total of 34,205 years recognised since 2020

- **volunteer recognition,** presented at a dedicated event hosted by the Executive Managing Director
- **Living our Values Awards,** presented monthly based on over 240 nominations in 2025/26, 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 Director-led 'Thank You' events
- **staff recognition boards,** displayed at hospital entrances
- **Ppeer thank-you cards,** available for staff to recognise colleagues informally

NHS Staff Survey 2025

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 2025/26, the response rate at the QEH was 53%, up from 47% the previous year and above the NHS Acute Trust average. Scores across all indicators declined; however, all indicators remain below the benchmark average for acute and community trusts.

Indicators	2025/26		2024/25		2023/24	
('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	7.3	6.9	7.2	7.0	7.2
We are recognised and rewarded	5.5	5.9	5.6	5.9	5.6	6.0
We each have a voice that counts	6.1	6.6	6.2	6.7	6.4	6.7
We are safe and healthy	5.8	6.1	5.9	6.1	5.9	6.1
We are always learning	5.0	5.6	5.2	5.6	5.3	5.6

We work flexibly	5.8	6.2	5.7	6.2	6.1	6.2
We are a team	6.3	6.7	6.5	6.7	6.5	6.8
Staff engagement	6.2	6.7	6.4	6.8	6.7	6.9
Morale	5.4	5.8	5.6	5.9	5.8	5.9

Areas of focus in 2025/26

Key focus areas based on the 2025 NHS Staff Survey findings included:

- organisational trust and confidence, particularly in leadership and care standards
- speaking up culture and psychological safety
- leadership and management effectiveness
- staff voice and engagement
- workforce wellbeing

These reflect a continued gap between positive team-level experience and lower confidence at organisational level.

Future priorities

The 2025 survey identifies the need for a more structured and coordinated approach to leadership and culture improvement, with priorities focused on:

- strengthening leadership culture and management capability
- improving staff engagement and organisational listening
- addressing organisational confidence and trust
- improving psychological safety and speaking up culture

Our planned response will include:

- establishing a dedicated NHS Staff Survey Working Group to lead development and delivery of the 2025/26 Action Plan
- developing a structured NHS Staff Survey Action Plan by June 2026, aligned to identified workforce culture priorities
- aligning with group-level leadership and culture programmes, including the NHS Management and Leadership Development Framework, Vanderbilt Culture Model and 18,000 Voices staff engagement programme
- implementing the Vanderbilt Culture Model to support leadership behaviour and psychological safety
- delivering the 18,000 Voices programme to strengthen organisational listening and staff engagement
- ongoing governance and oversight through the People Management Group, including monitoring progress against workforce, engagement and culture metrics

Investing in staff development

The Trust remains committed to developing and supporting its workforce through a comprehensive range of learning and career development opportunities. These initiatives are designed to enhance capability, promote progression and ensure the attraction and retention of a skilled and compassionate workforce.

We continue to support early career development through school and college work experience placements and an expanding apprenticeship offer. These programmes provide entry routes into the Trust and enable existing staff to broaden their skills and progress their careers.

In 2025/26, over 800 work experience placements were supported and more than 50 new apprentices were enrolled. Our T-Level programme continues to expand, developed in close partnership with 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.

Leadership and management development

The continuation of the Management Fundamentals Programme in 2025/26 included the establishment of the Management Fundamentals Network to enable peer support, shared learning and collaborative problem-solving across the Trust. Evaluation of the programme towards the end of the year has informed joint work with the Norfolk and Norwich University Hospitals NHS Foundation Trust (NNUH) and the James Paget University Hospitals NHS Foundation Trust (JPUH) to review leadership provision and begin the design and development of a tailored leadership programme. This programme will equip leaders with the skills, behaviours and mindset required to lead a complex and evolving organisation. It will strengthen leadership effectiveness, promote consistency in leadership standards and behaviours, support cultural and quality improvement and build sustainable internal leadership capability.

The launch of the Anglia Ruskin University satellite site in September 2025 represents a significant step in delivering locally accessible, high-quality nurse education.

Key features include:

- local delivery of Adult, Child and Nursing Associate programmes
- up to 30 students per cohort, increasing workforce supply
- integration of academic study, simulation and clinical placements
- strengthened pathways into healthcare careers for the local community

In September 2025, eight candidates joined the Nursing Associate Apprenticeship programme, with 12 candidates due to join the BSc Nurse Degree Apprentice (top-

up) in June 2026. Engagement events have been held to promote the direct entry pathway BSc (Hons) Nursing (Adult or Child), commencing in September 2026.

As a Teaching Hospital, this development is critical to building a sustainable workforce pipeline.

Embedding our values

Our Values Refresh Programme has enabled colleagues to reflect on how our values influence everyday practice and the experiences of patients and staff. It supports our aim to build an inclusive and supportive culture where everyone can perform at their best. Feedback from colleagues, alongside staff survey results, has been reviewed to identify opportunities to strengthen and better align this work with our wider leadership, management, staff experience and culture initiatives.

Recognitions and achievements

Achieving Teaching Hospital status

2025 marks a defining milestone in the organisation's journey, with the successful achievement of Teaching Hospital status following a rigorous quality assurance process.

This designation recognises the organisation's long-standing commitment to education, research and workforce development, and reflects the strength of its partnerships across healthcare and higher education.

This achievement is the culmination of sustained investment in education infrastructure, faculty development and high-quality learning environments across all professions.

Continued excellence in preceptorship and professional development

The Preceptorship Academy continues to demonstrate excellence, maintaining its Royal College of Nursing accreditation. This reflects a sustained commitment to supporting newly registered practitioners through a high-quality blended programme that promotes confidence, competence and professional belonging, with 98 participants enrolled in 2025.

Embedding compassionate, person-centred care

Our Royal College of Nursing accredited patient experience programmes continue to play a pivotal role in shaping organisational culture, ensuring care is consistently compassionate, personalised and responsive:

- **caring with kindness,** empowering staff to enhance patient experience
- **Bereavement Training Programme,** strengthening compassionate end-of-life care
- **frailty is everyone's business,** improving recognition and response to frailty

- **compassionate engagement,** strategies to support compassionate engagement

These programmes are integral to delivering high-quality care and align strongly with the values of a Teaching Hospital.

Enhancing clinical education: simulation innovation and expansion

Simulation continues to be a cornerstone of education, supporting safe, high-quality care and experiential learning.

In 2025, simulation capability was enhanced through:

- introduction of SimBaby through charitable investment
- expansion into neonatal and paediatric simulation
- realistic, high-fidelity training for life-saving interventions
- strengthened multidisciplinary team training and patient safety capability

On 19 March 2026, a Paediatric Emergency Simulation Day was delivered for core trainees, facilitated by the Education Faculty, Simulation Lead and Medication Education team.

Launch of in situ mobile simulation

Simulation was delivered directly within the Acute Medical Unit (AMU) and Same Day Emergency Care (SDEC), enabling real-time learning in clinical environments, identification of safety risks and strengthening of teamwork and communication.

Leadership and development: THRIVE for Clinical Leaders (October 2025)

The THRIVE – which stands for Transforming Healthcare, Reflection, Innovation, Values, Excellence – Leadership Programme supports early clinical leaders across professions, with 12 participants from nursing, midwifery and allied health professions. The programme focuses on compassionate leadership, improvement and systems thinking.

National recognition

At the Nursing Times Workforce Awards in November 2025, the THRIVE Graduate Programme won Preceptorship Programme of the Year. The programme was also presented at NHS England regional webinars and showcased at the EPIIC (East of England Policy, Innovation and Implementation Centre) Conference at the University of Essex.

Pictured above: *QEH THRIVE Programme wins prestigious 2025 Nursing Times Workforce Award recognising the innovation, compassion and dedication behind the programme's development, and highlights the outstanding work of the Trust's Education Faculty and its partners.*

Equality, Diversity and Inclusion

At the QEH, we remain firmly committed to promoting Equality, Diversity and Inclusion (EDI) across every aspect of our organisation. Our ambition is to foster a culture in which 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 emphasises the importance of creating a culture of belonging, trust and fairness. This includes celebrating difference, actively challenging discrimination and supporting staff wellbeing. These principles are also reflected in our Trust values of Kindness, Wellness and Fairness, which guide our decision-making and day-to-day interactions.

A key part of this work is ensuring fairness and inclusion for all, regardless of sex, race, religion or belief, gender identity, gender reassignment, disability, sexual orientation, marital status, pregnancy or maternity. Strategic leadership for this agenda is provided by our Culture and Engagement Business Partner, supported by our active staff networks and dedicated Director-level sponsors.

Staff networks

REACH (Race, Ethnicity and Cultural Heritage) Network

The REACH Network continued to grow and thrive in 2025/26, supporting staff from over 105 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
- **Diwali,** a Trust-wide event bringing staff together to celebrate culture and community, featuring traditional dance, authentic food and opportunities to learn about its significance
- **Black History Month – *'Standing Firm in Power and Pride'*,** celebrating the resilience, strength and achievements of Black communities and recognising the contributions of leaders, activists and pioneers, including educational content and a flag-raising ceremony
- **South Asian Heritage Month,** where staff shared personal stories to foster empathy and cultural understanding

PRIDE Network

The PRIDE Network supports LGBTQIA+ colleagues and allies, providing a space for discussion, advocacy and visibility. In 2025/26, the network hosted several awareness-raising events and initiatives, including:

- **a Transgender Remembrance Service,** held in partnership with the Spirituality and Belief Network, providing 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 2025/26, the QEH was awarded the Veterans Gold Award under the Defence Employer Recognition Scheme, reflecting our commitment to the Armed Forces Covenant.

Key achievements 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 2025/26, the network:

- **worked closely with Estates and Facilities** teams to inform accessibility planning
- **led awareness events** for Neurodiversity Week, Men's Health Month, World Mental Health Day and Disability Pride Month, including sharing staff stories of empowerment
- **partnered with AccessAble** to further enhance the accessibility of the QEH facilities

Spirituality and Belief Network

Initially established 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 2025/26, 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

Our EDI calendar has been introduced to ensure that dates important to our staff and patients are recognised.

During 2025/26, we arranged a spotlight event each month to celebrate diversity and encourage conversations that enhance understanding of our workforce. These events included Holi, Ramadan, Black History Month, Pride, Armed Forces Day, World Mental Health Day and Neurodiversity Week, among others.

Other achievements during 2025/26

- re-engagement of the ‘No Excuse for Abuse’ campaign across the Trust to protect staff from violence, abuse, harassment or aggression
- continued delivery of the QEH EDI Action Plan aligned to the Trust strategy and the NHS EDI improvement plan
- ongoing monitoring of Workforce Race Equality Standard (WRES) and Workforce Disability Equality Standard (WDES) data, with actions in place to drive improvement
- collaboration with medical and nursing staff to support the onboarding and induction of junior doctors and student nurses
- delivery of the EDI Culture and Engagement element within the QEH THRIVE Programme, an initiative funded by NICHE focusing on workforce development, sustainable transformation and system collaboration, which has received national recognition including an award from Nursing Times
- delivery of EDI and culture training across multiple teams to build knowledge and capability
- support for onboarding international doctors

Forward plan for 2026/27

Key priorities for the QEH include:

- progressing implementation of a ‘Just Culture’ aligned with organisational practices and people policies

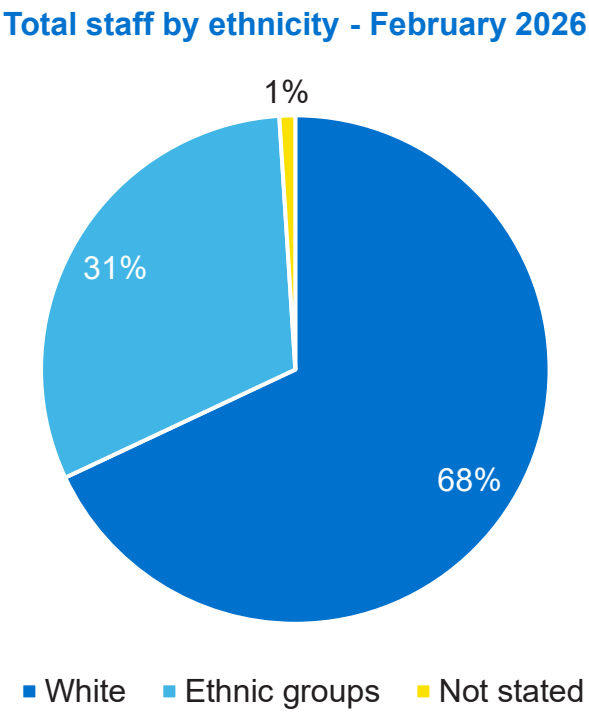
- strengthening the staff network framework to increase allyship and engagement across the Trust and community
- collaborating across Norfolk and Waveney to improve staff experience and address inequalities
- continuing to develop the QEH culture toolkit to engage, coach and support staff
- Reviewing and updating ongoing campaigns as required

Diversity data reporting

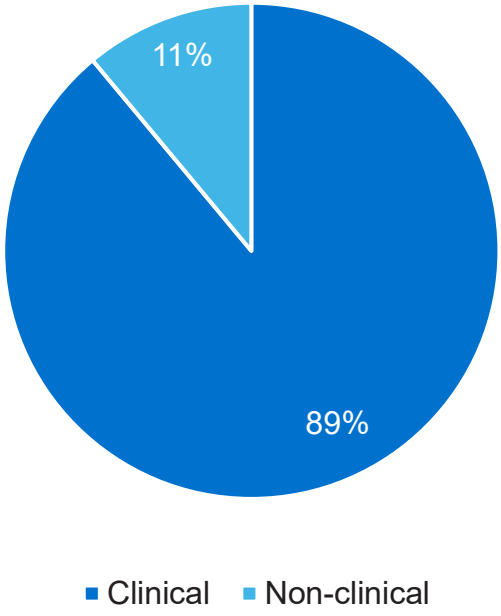
The Trust collects diversity data through the WRES and WDES, in line with NHS guidelines.

These metrics monitor progress against indicators of workforce equality, including representation at Board level. Data is drawn from the Electronic Staff Record (ESR) for workforce metrics and the National Staff Survey for staff experience indicators.

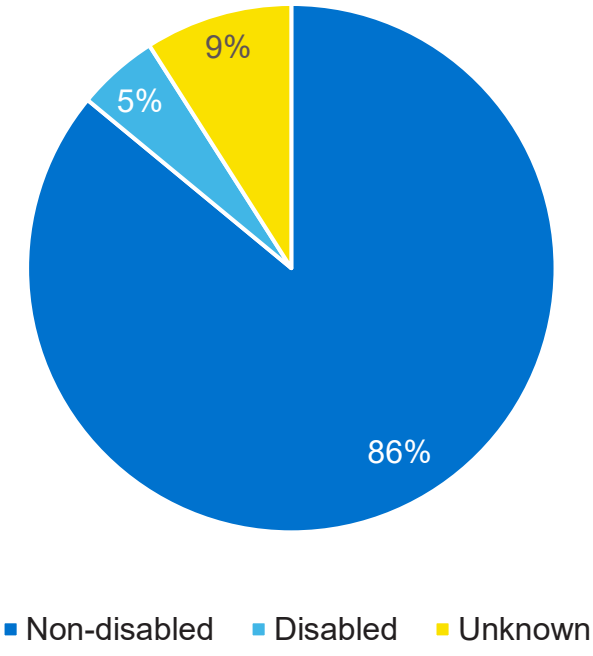
This information is used to develop and publish action plans, with year-on-year comparisons enabling the Trust to demonstrate progress in improving equality outcomes.



Breakdown of staff from an ethnic background - February 2026



Total staff by disability - February 2026



Raising concerns

At the Trust, we believe that a culture in which people feel safe to speak up is fundamental to delivering high-quality, compassionate care. Staff are often the first to

identify opportunities for improvement, whether relating to patient safety, service quality or ways of working. We actively encourage all staff to raise concerns and are committed to ensuring that these are heard, respected and acted upon.

Freedom to Speak Up (FTSU)

Our FTSU service provides a confidential and, where preferred, anonymous route for staff to raise concerns independently of their management structure. The service is impartial, accessible and available to all.

In 2025/26, 134 staff members raised concerns through the service. Each contact is acknowledged, with support and feedback provided throughout. Themes are regularly reviewed and used to inform improvements across the organisation.

The service is led by a full-time FTSU Guardian, with executive oversight provided at senior level. A network of FTSU Champions supports visibility and accessibility across divisions. Regular updates are provided to the People and Culture Management Group and Hospital Management Group, with awareness maintained through ongoing communications.

Whistleblowing

Whistleblowing is a vital safeguard for patients, staff and the public. Staff who raise concerns in good faith are protected under the Public Interest Disclosure Act 1998. The Trust is committed to ensuring that no individual suffers detriment as a result of speaking up.

A dedicated phoneline is available for both FTSU and whistleblowing concerns, allowing anonymous reporting where preferred.

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

Volunteers continue to provide valuable support in roles including patient buggy driving, ward support, telephone reminders and front desk reception.

In collaboration with the Norfolk and Norwich University Hospitals NHS Foundation Trust (NNUH) and Helpforce, a project was launched to support attendance at diagnostic radiology appointments. A dedicated co-ordinator established the service, recruiting and training volunteers and supporting expansion to the James Paget University Hospitals NHS Foundation Trust (JPUH). Following completion of the initial funding period, the service has been embedded into routine practice.

Volunteers contact patients three days before appointments, contributing to reduced non-attendance rates across diagnostic radiology specialties, as demonstrated by Helpforce analysis.

Volunteer feedback has been highly positive. One individual progressed from volunteering to employment at NNUH, demonstrating the wider impact of the programme.

Engagement with partners, including job centres, has increased volunteer recruitment and diversity. A breastfeeding peer support initiative has also been introduced, with volunteers receiving accredited training to support new mothers.

Volunteer support on inpatient wards has expanded, with 12 wards now benefiting from dedicated volunteers. Tailored roles have been developed to reflect specialist skills and lived experience.

Volunteer experience remains a priority. Annual recognition events are established, and improvements in staff understanding of volunteer roles have led to increased satisfaction, with 80% of volunteers reporting feeling extremely supported and 96% recommending the QEH as a place to volunteer.

Zero tolerance to sexual harassment and abuse

As part of a national NHS commitment to address inappropriate and harmful sexual behaviour, the QEH launched its Workplace Sexual Safety campaign in 2025, aligned with the NHS Sexual Safety Charter. This reinforces our zero-tolerance approach and builds on the No Excuse for Abuse campaign.

Following the Worker Protection (Amendment of the Equality Act 2010) Act in October 2024, the QEH has implemented a comprehensive programme to strengthen prevention, reporting and response. This reflects a proactive approach aligned with new legal duties.

The campaign promotes a culture of respect, safety and dignity for staff, patients and visitors. It includes a Sexual Safety Toolkit, mandatory annual training and clear, trauma-informed reporting pathways. Staff can report concerns anonymously or directly and are encouraged to seek support through FTSU Guardians, HR or leadership teams.

Sexual harassment and abuse are unacceptable and will not be tolerated. This work strengthens compliance with the Equality Act and reinforces the shared responsibility

to create a respectful and inclusive environment, supporting lasting cultural change across the QEH.

Pictured above: *Celebrating our apprentices. Pictured (top left): Francesca Hubbard - named Apprentice of the Year - Degree Level 6 to 7 at the Norfolk Apprenticeship Awards 2026, (top right): Ian Coventry, (bottom left): Amy Durrant and (bottom right): Alice Jeffery*

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

Estates

This has been another significant year for the Operational and Capital Estates team, delivering a £63m capital programme of which £29m was allocated for continued delivery of the Reinforced Autoclaved Aerated Concrete (RAAC) programme, and £10m for enabling works to support the future delivery of the New Hospital Programme (NHP).

Alongside managing immediate estate risks, the team has continued to align investment and infrastructure improvements with both the Trust's Green Plan and the longer-term requirements of the new hospital.

During 2025/26, the following was achieved:

- maintaining safety and operational continuity in response to roof and wall panel risks, in line with structural survey findings
- progressing the RAAC programme, including installation of failsafe steel supports and use of decant wards to enable works
- addressing £5m of backlog maintenance through a risk-based and monitored programme
- delivering estate modernisation works, including refurbishment of key patient and public areas and improvements to site infrastructure
- enhancing fire safety compliance, including continued L1 installation and a successful audit in partnership with Norfolk Fire and Rescue Service
- upgrading critical infrastructure, including ventilation systems, water systems, medical gas resilience and lift refurbishment
- completing a new modular Sterile Services Department, which will form part of the retained estate for the future hospital
- supporting clinical service reconfiguration, including enabling relocation of maternity services to the King's Lynn Health Hub
- undertaking enabling works aligned to the NHP, including early site preparation and infrastructure improvements

In addition, the Estates team has supported delivery of sustainability priorities through infrastructure improvements, including energy efficiency works and enabling projects that will support longer-term decarbonisation.

Looking ahead

During 2026/27, the Estates team will:

- continue delivery of the RAAC programme, including works across clinical and non-clinical areas
- support further enabling works linked to the NHP

- deliver backlog maintenance informed by the latest Six Facet Survey
- progress fire safety improvements across the site
- support service developments and relocations, including use of the King's Lynn Health Hub

Facilities

The Facilities team plays a vital role in supporting the delivery of safe, high-quality care by maintaining a clean, secure and well-functioning environment for patients, visitors and staff. Services include catering, domestic services, portering, security, waste, postal and linen services.

During 2025/26, Facilities teams continued to deliver essential services despite sustained operational pressures, including significant estate disruption associated with RAAC works. Service performance and continuity have been maintained throughout.

Key achievements during 2025/26 include:

- 146,257 portering jobs completed, supporting patient flow across the site
- processing approximately 150,000 items of laundry per month, supporting infection prevention and control
- delivery of over 480,000 patient meals and 96,000 staff and visitor meals
- maintaining a 5-star Environmental Health rating
- sustaining high cleaning standards, supported by on-site laundering of cleaning materials

Facilities teams have also contributed to the Trust's sustainability objectives, particularly in waste management, recycling and sustainable catering practices. These contributions form part of the wider Green Plan delivery described in the Sustainability section.

Looking ahead

In 2026/27, the Facilities team will continue to focus on:

- service resilience and value for money
- workforce development and leadership capability
- supporting delivery of the Trust's sustainability ambitions, including waste reduction and improved recycling
- identifying efficiencies and income opportunities

Health and Safety

The Health and Safety team advises on staff safety, supports risk assessment and incident investigation and monitors compliance across the Trust.

The Health and Safety Forum continued to meet monthly, chaired by the Deputy Director of Estates and Facilities, reporting to the Hospital Board for assurance.

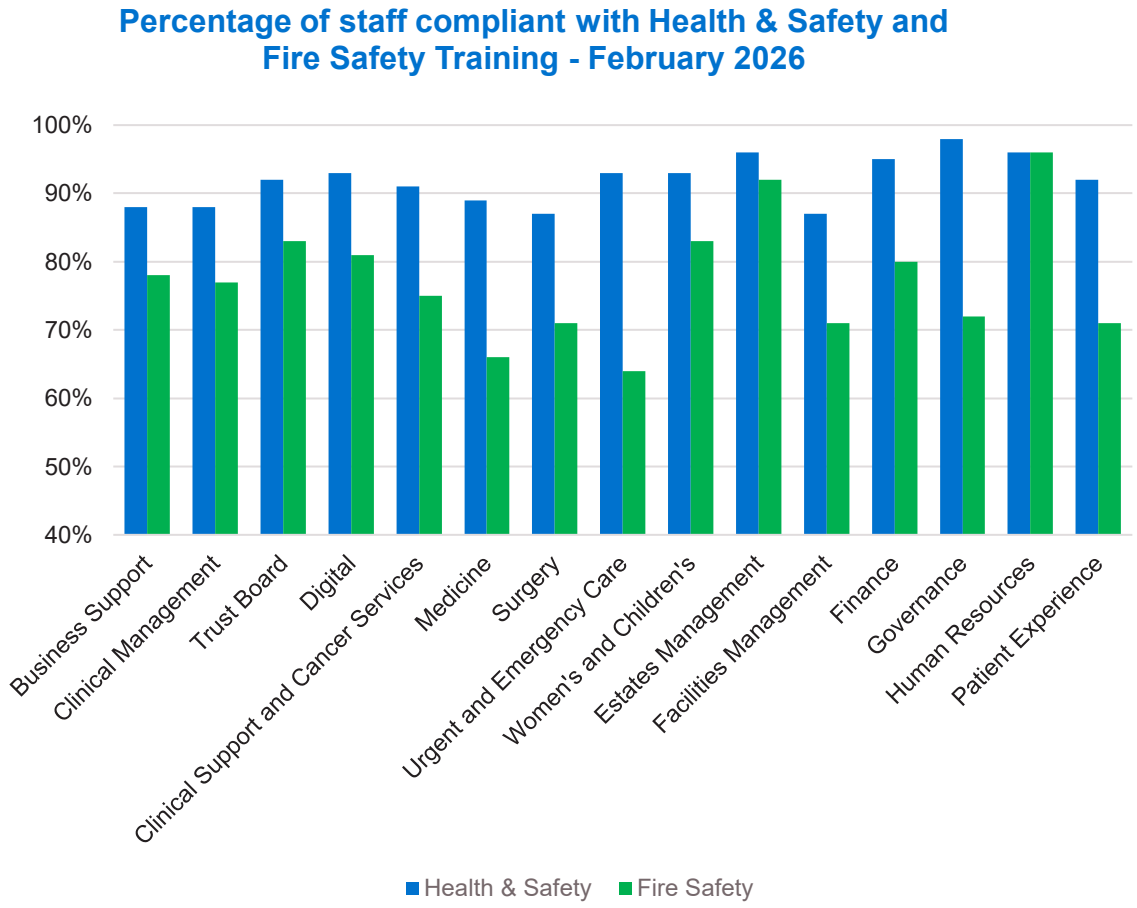
Key activities during the year included:

- continued provision of FFP3 face fit testing, with integration into Electronic Staff Record (ESR) as a mandatory requirement in key areas
- support for risk assessments across tasks, individuals and the built environment
- completion of walk-round inspections and development of action plans
- ongoing development of the control of substances hazardous to health (COSHH) electronic management system
- monitoring and investigation of incidents reported via Datix, including RIDDOR (Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 2013) reporting
- completion of Premises Assurance Model (PAM), Patient-Led Assessments of the Care Environment (PLACE) and Estates Return Information Collection (ERIC) returns
- development of a Trust-wide network of health and safety leads
- management of water safety in collaboration with Estates and Infection Prevention and Control (IPC) teams
- contribution to key governance groups and forums
- management of the Estates and Facilities risk register with executive reporting
- support for capital and operational estate changes, including decant moves

Training

Health and Safety training is delivered through the ESR system, covering mandatory topics including risk assessment, aggression management, COSHH, waste and sharps awareness. A local information pack is also available via the intranet.

Health and safety training compliance stands at 92% across the Trust.



Incidents

The most frequently reported incident categories are:

- slips, trips and falls
- needle-stick and sharps injuries
- environmental incidents
- other accidents
- exposure to hazardous substances, electricity or infection

A total of 403 staff safety incidents were reported in 2025/26, compared with 394 in 2024/25.

RIDDOR incidents

19 staff injuries were reported to the Health and Safety executive, compared with 13 in the previous year. All reportable incidents and those rated moderate or above are fully investigated.

Looking ahead

During 2026/27, the team will:

- lead PAM, ERIC and PLACE submissions
- support effective utilisation of estate space
- assist departments with risk assessments and action plans
- coordinate water testing for Pseudomonas in augmented care areas
- support RAAC and NHP delivery
- maintain oversight of risk management processes
- update the COSHH database
- review contractor induction processes annually

Fire Safety

The Trust continues to meet its obligations under the Regulatory Reform (Fire Safety) Order 2005. The Deputy Director of Estates and Facilities works closely with the local fire inspector to ensure compliance.

A new Fire Safety Officer was appointed in February 2026.

Key achievements include:

- continued L1 fire alarm upgrade programme
- review and update of fire risk assessments
- Trust-wide fire safety visits and inspections
- improvements to fire safety documentation and logbooks
- ongoing liaison with the Fire Service
- updates to evacuation plans, signage and fire safety guidance
- support to capital projects on fire safety matters
- delivery of updated fire safety training with positive staff feedback

Fire Safety Training

Fire safety training has been redesigned to improve engagement and align with NHS standards. Compliance has increased to 77%, up from 73%.

Fire Incidents

A total of 118 fire-related incidents were recorded, compared with 75 in 2024/25. There were two minor fires, neither requiring Fire Service attendance. Accidental false alarms remain the majority of incidents.

The Fire Service attended once and also conducted familiarisation visits and a positive audit in January 2026.

Fire Safety Action Plan 2026/27

Area of Focus	Person Responsible	Target Completion Date
Continue to equip the Fire Safety Officer with skills and knowledge to support them in their role.	H&S Manager and Fire Safety Officer	March 2027
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.	Capital Project Manager and Fire Safety Officer	March 2027
Ongoing progress that is seeing numbers of delegates attending the range of Fire Safety training is increasing.	Fire Safety Officer	March 2027
Continuing to work closely with the fire service and support with fire team familiarisation visits to the trust during the year	Fire Safety Officer, Health & Safety Officer	March 2027
Update the fire risk assessments across the site and communicate these to the department leads, and the fire service if requested	Fire Risk Assessor	March 2027

Net Zero

Climate change continues to rise in prominence across the NHS. The NHS Carbon Management Strategy, Saving Carbon, Improving Health, sets out an ambition to exceed government targets and become the leading public sector organisation on climate action.

The QEH is committed to reducing its environmental impact and delivering sustainable healthcare. The Trust recognises its role in contributing to the NHS ambition of becoming the world's first net zero health service by 2040.

Progress during 2025/26 includes:

- expansion of recycling infrastructure
- introduction of Green Champions across the Trust
- delivery of sustainability training through external partnerships
- improved waste segregation in the main kitchen

- ongoing improvements to waste compound compliance

Looking ahead

This work will be progressed through Estates and Facilities programme, including:

- installation of Light Eliminating Diode (LED) lighting across 90% of the Trust
- continued expansion of recycling
- growth of the Green Champions network
- implementation of food waste recycling systems to significantly reduce waste
- improved control of heating and ventilation systems to reduce carbon emissions

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
8	7.18

Percentage of time spent on facility time

Percentage of time	Number of employees
0%	0
1-50%	7
51-99%	1
100%	0

Percentage of pay bill spent on facility time

Total cost of facility time	£39,102.27
Total pay bill	£184,540,517.10
Percentage of the total pay bill spent on facility time, calculated as:	0.02%

(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:	0.87%

(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 2025/26 can be found on the Gender Pay Gap Service website at https://gender-pay-gap.service.gov.uk/employers/15272/reporting-year-2025/gender-pay-gap-report

Expenditure on Consultancy

The Trust has spent £0.1m on consultancy in 2025/26, which has decreased significantly from £1.48m in 2024/25. 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 2026, for more than £245 per day	Number of engagements
Number of existing arrangements as of 31 March 2026	8
Of which:	
Number that have existed for less than one year at the time of reporting	5
Number that have existed for between one and two years at the time of reporting	2
Number that have existed for between three and four years at the time of reporting	1
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 2026 earning £245 per day or greater	
Number of off-payroll workers engaged during the year ended 31 March 2026	8
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	8
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 2025 and 31 March 2026	
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 2025/26	Total value of agreements in 2025/65	Number of payments agreed 2024/25	Total value of agreements in 2024/25	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	+	28	348	35	213	STA0750
Exit payments following employment tribunals or court orders	+	-	-	-	-	STA0760
Non-contractual payments requiring HMT approval (special severance payments)	+	1	99	-	-	STA0770
Total	**+**	**29**	**447**	**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 compulsory redundancies (£'000)	Number of other departures agreed	Cost 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	-	-	18	83	18	83	-	-
£10,001 to £25,000	2	22	8	122	10	144	-	-
£25,001 to £50,000	3	119	-	-	3	119		
£50,001 to £100,000	-	-	3	242	3	242	1	99
£100,001 to £150,000	-	-	-	-	-	-	-	-
£150,001 to £200,000	-	-	-	-	-	-	-	-
Greater than £200,000	-	-	-	-	-	-	-	-
Total	5	141	29	447	34	588	1	99

Statement of Compliance with the Code of Governance for NHS Provider Trusts

The Board of Directors of The Queen Elizabeth Hospital King's Lynn NHS Foundation Trust has applied the principles of the NHS England Code of Governance for NHS Provider Trusts on a "comply or explain" basis.

The Board considers that the Trust applied the principles of the Code of Governance for NHS Provider Trusts during 2025/26. Where the transition to the Group model affected the timing, operation, or embedding of governance arrangements, this is explained in the relevant sections of this report.

During 2025/26, the Trust transitioned to a formal group operating model alongside Norfolk and Norwich University Hospitals NHS Foundation Trust and James Paget University Hospitals NHS Foundation Trust, forming the Norfolk and Waveney University Hospitals Group. The principles of the Code of Governance have been embedded within the Group Governance Framework, the Provider Collaboration Agreement, and the Terms of Reference for the General Purpose Joint Committee, known as the Group Board. The Board is satisfied that these collaborative arrangements preserve the statutory independence of the Trust while supporting effective corporate governance, accountability, Board effectiveness, and Non-Executive Director scrutiny expected of an NHS Foundation Trust.

The Board's assessment is also informed by the Trust's regulatory and improvement context during the year, including Care Quality Commission conditions, NHS England Enforcement Undertakings, National Provider Improvement Programme support, and the significant internal control issues disclosed in the Annual Governance Statement. These matters are described in the relevant sections of this Annual Report and Accounts and were considered by the Board in assessing governance effectiveness, internal control, risk management, and the fair, balanced, and understandable nature of this report.

In accordance with the Code, the required disclosures set out in Schedule A are integrated throughout the Accountability Report and wider Annual Report and Accounts.

Furthermore, the Directors consider the 2025/26 Annual Report and Accounts, taken as a whole, to be fair, balanced, and understandable, providing the information necessary for patients, staff, Governors, members, regulators, and stakeholders to assess the Trust's performance, business model, governance, and strategy.

Schedule A: Table of supporting explanation for required disclosures

- **A2.1 / A2.8 (System Working and Stakeholders):** The Board of Directors' assessment of its contribution to system objectives, partnerships, and

stakeholder engagement is detailed in the *Strategic Commitment to our Partners* and the *Overview of Performance* sections

- **A2.3 (Culture):** The Board's alignment of policy, practice, and behaviour with the Trust's vision is detailed in the *Staff Survey* and *People Promise* sections
- **B2.6 / B2.13 (Board Composition and Attendance):** The identification of independent Non-Executive Directors and the attendance records for the Board and its committees are located in the *Directors' Report*
- **C5.15 (Governors):** The Cycle of Business for the Council of Governors defines how Governors are engaged. The draft Annual Operating Plan was shared with Governors during development to canvass opinions on the forward plan and strategy
- **D2.4 (Audit Committee):** Significant issues considered by the Audit Committee, alongside assessments of external auditor independence and the absence of non-audit services provided by the external auditor, are detailed in the *Audit Committee* section
- **D2.6 (Responsibilities):** The Directors' explanation of their responsibility for preparing the Annual Report, and their statement that it is fair, balanced, and understandable, is located in the *Statement of Accounting Officer's Responsibilities*
- **D2.8 / D2.9 (Internal Controls and Going Concern):** The Board's review of risk management, internal control systems, and the appropriateness of the going concern basis of accounting are detailed in the *Annual Governance Statement*

Pictured above: *Cancer patients at the QEH are now receiving treatment in a brighter, more comfortable and compassionate environment following a £255,000 refurbishment of the Cancer Care and Treatment Centre.*

The Board of Directors

The Board of Directors is a unitary board, with all Executive and Non-Executive Directors sharing joint responsibility for every decision of the Board and sharing the same liabilities. During 2025/26, the Trust transitioned into a formal collaborative model alongside two other acute trusts to establish the Norfolk and Waveney University Hospitals Group (NWUHG). Under this collaborative Group model, all statutory Directors hold office concurrently on the Boards of all three NHS Foundation Trusts. The composition of the Board of Directors is set out in the Trust's Constitution and ensures that the number of voting Non-Executive Directors always exceeds the number of voting Executive Directors, guaranteeing a majority of independent oversight.

The role of the Board of Directors

The Board of Directors has a dual role of leadership and control. It has collective responsibility for setting the strategic direction of the organisation, overseeing the delivery of its strategy, and monitoring the overall performance of the Trust. The Board governs the organisation in accordance with statutory obligations and the NHS Provider Code of Governance, ensuring accountability, transparency, and adherence to sound principles of corporate governance.

Responsibilities of the Board of Directors

The Board of Directors is responsible for all aspects of the operation and performance of the Trust, including ensuring that safe and effective healthcare services are delivered. The Board must ensure the Trust meets its statutory duties and complies with the provisions of its NHS provider licence and Constitution.

Following the implementation of the Group governance architecture in 2025/26, the Board delegates specific Joint Functions to the General Purpose Joint Committee (the Group Board) to ensure unified strategic leadership. However, the sovereign Board of Directors retains absolute authority over its Mandatory Reserved Functions. These non-delegable responsibilities include the approval of the Annual Report and Accounts, making amendments to the Trust's Constitution, approving significant transactions, and applying for mergers or acquisitions.

The Chair, the Vice Chair and the Senior Independent Director

The Chair is appointed by the Council of Governors and leads both the Board of Directors and the Council of Governors, ensuring strategic alignment, clarity of roles, and effective communication between the two bodies.

The Trust Constitution makes provision for the appointment of a Senior Independent Director (SID). Following consultation with the Lead Governors, Sally Collier was

appointed as the Senior Independent Director (SID) for each of the three trusts in the Group. The SID provides a sounding board for the Chair and serves as a trusted intermediary for other Directors and Governors to address issues where it is inappropriate or impossible for the Chair to do so.

Delegation and committees of the Board of Directors

The Board of Directors has agreed a Scheme of Reservation and Delegation which defines the decisions reserved strictly to the sovereign Board and those delegated to the General Purpose Joint Committee (Group Board), Board-level committees, and executive management.

Under the Group governance structure, statutory committees operate as Committees in Common. This includes the Group Audit Committees in Common and the Group Nomination and Remuneration Committees in Common, which remain directly accountable to their respective statutory Trust Boards while reporting into the Group Board.

Non-statutory committees are established as sub-committees of the Group Board, including the Group Risk Assurance Committee and the Group Research and Education Committee. Operational accountability is formally separated from Board governance by a strict "G-line", with day-to-day risk control, financial management, and service provision delegated to the Executive-led Hospital Management Group at the site level.

The Audit Committee and audit

The Group Audit Committees in Common provide independent, objective assurance to the trust Boards regarding the system of governance, risk management, internal control, financial oversight, and audit arrangements. Membership consists exclusively of independent Non-Executive Directors, with at least one member possessing recent and relevant financial expertise.

The Committee assesses the independence, objectivity, and effectiveness of the external audit process, and oversees the provision of any non-audit services by the external auditor. In discharging its responsibilities, the Committee draws upon the work of Internal Audit, External Audit, and Local Counter Fraud Services, and meets privately with both the Internal and External Auditors at least once per year without executive management present to ensure unrestricted dialogue.

Nomination and Remuneration Committee (Executive appointments)

The Group Nomination and Remuneration Committees in Common are responsible for the appointment, succession planning, and remuneration of the Group Chief

Executive and all voting Executive Directors. The appointment of the Group Chief Executive is subject to the formal approval of the Council of Governors.

The Committee determines the Group's remuneration policy for executive roles, having due regard to the NHS England Very Senior Manager (VSM) Pay Framework, national benchmarking information, and all other relevant statutory regulations. The Committee ensures that executive remuneration is linked to performance by conducting annual reviews and setting appropriate terms and conditions of office.

Evaluating the Board's performance

The Board of Directors employs multiple methodologies to continuously evaluate and improve its performance, ensuring it possesses the necessary skills, capacity, and experience to lead the organisation. Performance evaluation mechanisms include annual self-assessments of the Board, regular committee effectiveness reviews, and the formal appraisal of the Chair, Non-Executive Directors, and Executive Directors. These annual appraisals link individual contributions to the strategic objectives of the Trust and identify opportunities for learning and development.

Furthermore, in accordance with the Code of Governance for NHS Provider Trusts, the Board is strongly encouraged to undertake an externally facilitated developmental review of its leadership and governance using the Well-Led framework every three to five years to ensure independent validation of its effectiveness.

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.

The role of the Council of Governors

The Council of Governors is chaired by the Chair of the Group. The Chair acts as the link between the Council of Governors and the Trust Board of Directors, ensuring that feedback from the Council is communicated to the Trust Board.

The Council of Governors is responsible for representing the interests of Foundation Trust members and partner organisations in the governance of the Trust.

The Council of Governors:

- appoints the Chair and Non-Executive Directors to the Trust Board of Directors
- determines the remuneration and terms and conditions of the Chair and Non-Executive Directors
- approves the appointment of the Chief Executive
- appoints and oversees the Auditor
- formally receives the Trust's audited Annual Report and Accounts at a public meeting
- influences decisions relating to service development, strategic planning and clinical strategy

Statutory duties for Governors:

- to hold the Trust Non-Executive Directors individually and collectively to account for the performance of the Trust Board
- to communicate with their member constituencies and the public, and to relay feedback to the Council of Governors and the Trust Board of Directors
- to contribute to the development of the Foundation Trust's forward plans

Governors:

- vote to approve:
    - constitutional changes
    - mergers, acquisitions, dissolution, or separation
    - increases by more than 5% of the Foundation Trust's non-NHS income

Advice and training for Governors:

Foundation Trusts are required to ensure their Governors have the skills and knowledge needed to carry out their roles. The Trust provides induction training and mentoring opportunities for new Governors.

The composition of the Council of Governors

Public Governors (16):

- Theresa Banks – West Norfolk
- Bob King – West Norfolk

- Andrew Riley – West Norfolk
- Sara Shaw – West Norfolk
- vacancy – West Norfolk
- vacancy – West Norfolk
- vacancy – West Norfolk
- vacancy – West Norfolk
- vacancy – West Norfolk
- Mark Dyer – Cambridgeshire/Fenland
- vacancy – Cambridgeshire/Fenland
- vacancy – Cambridgeshire/Fenland
- Antonia Hardcastle – Breckland, North Norfolk and Rest of England
- vacancy – Breckland, North Norfolk and Rest of England
- Chris Brewis – South East Lincolnshire
- vacancy – South East Lincolnshire

Staff Governors (6):

- Ruth Overton – Staff Clinical
- vacancy – Staff Clinical
- vacancy – Staff Clinical
- Leanne Kendrick – Staff Non-Clinical
- Alasdair Willett – Staff Non-Clinical
- vacancy - Staff Non-Clinical

Appointed Governors (7):

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

Lead Governor's Statement

As Lead Governor, I am pleased to present this statement on behalf of the Council of Governors for The Queen Elizabeth Hospital King's Lynn NHS Foundation Trust (the QEH).

Over the past year, the Trust has continued to operate in a highly challenging environment, with sustained pressure on services, workforce demands and increasing patient needs. In this context, the dedication, professionalism and compassion shown by staff across the organisation has been outstanding. On behalf of the governors, I extend our sincere thanks to all colleagues for their continued commitment to delivering high-quality care.

The Council of Governors plays a vital role in representing the interests of members, patients, staff and the wider public. Throughout the year, we have continued to engage with our communities, ensuring that their voices help to shape the Trust's priorities and services. This included listening to feedback, supporting public engagement initiatives and maintaining strong links with partner organisations. Particularly important as the Trust has moved into the Norfolk and Waveney University Hospitals Group.

The governors have statutory responsibility to hold the Non-Executive Directors, individually and collectively, to account for the performance of the Board. The Council of Governors has undertaken this duty through regular meetings, committee work, and constructive challenge, focusing on areas such as quality of care, patient safety, financial sustainability, and workforce wellbeing. We were proud to present our work on the formation of the Youth Council at the NHS Providers Governors Perspectives Conference. Governors have also contributed to the appointment of the Chair and Non-Executive Directors, ensuring strong and effective leadership at Board level.

There is much to applaud with the Trust gaining Teaching Hospital status, the approval of the Strategic Outline Business Case for the new Hospital and the strong commitment to its local community. We recognise that the Trust continues to face significant challenges, including meeting demand, improving access to services and maintaining financial balance. Governors have sought assurance that clear plans are in place to address these issues and are encouraged by the progress being made.

Safeguarding, equality, diversity and inclusion remain central to the Trust's values of Kindness, Wellness, Fairness. The Council of Governors supports the ongoing work to ensure that services are accessible, inclusive and responsive to the diverse needs of the population it serves.

Looking ahead, the Council of Governors remains committed to working collaboratively with the Executive Managing Director and Trust Board and our partners to support the Trust in delivering safe, effective, and compassionate care. Governors will continue to strengthen engagement with members and the public, ensuring that public perspective remains at the heart of decision-making.

I would like to thank my fellow governors for their time, insight, and dedication and I look forward to continuing our work together in the year ahead.

Dr Antonia Hardcastle

Lead Governor

Council of Governors Report 2025/26

The Trust was scheduled to hold elections across all constituencies and staff classes in January 2026, in line with the normal election cycle, with new Governors due to commence their terms on 1 February 2026. Elections were not held during 2025/26 but are scheduled to take place in May/June 2026.

Foundation Trust members may nominate themselves for election as Governors and vote in elections to the Council of Governors. Election rules are defined in the Trust's Constitution and align with the Model Election Rules 2014. The standard term of office for a Governor is three years, or the remainder of a term where a vacancy arises.

At the conclusion of their terms on 31 January 2026, four public Governors stood down. The Trust records its thanks to Esmé Corner, Pru Fox, Barbara Turner and Betty Lewis for their significant contributions.

Meetings of the Council of Governors

Dates, venues, papers and minutes for meetings held in public are available on the QEH website under 'About Us' and 'Council of Governors'. The Council met three times during 2025/26 and held one informal meeting.

Governors participated in a range of Trust activities, including the Dementia Fair, health and wellbeing events, patient awareness initiatives and staff awards. They also visited the Central Sterile Services Department, Frailty Same Day Emergency Care and a local further education college. The Council maintained a strong interest in the progress of Martha's Rule and received regular updates. Governors also participated in monthly Quality Assurance Visits.

Lead Governor

Dr Antonia Hardcastle serves as Lead Governor. The Lead Governors of the QEH, Norfolk and the Norwich University Hospitals NHS Foundation Trust (NNUH) and the James Paget University Hospitals NHS Foundation Trust (JPUH) contributed to the recruitment of the Interim Group Chair and Non-Executive Directors for the Norfolk and Waveney University Hospitals Group.

Deputy Lead Governor

The Deputy Lead Governor position was held by Alan Maltby until 31 January 2026, when the term of office concluded.

Council of Governors Groups

The Council of Governors cannot delegate its statutory powers but established three subgroups to support specific areas of work and make recommendations. These groups met twice during the year and were closed in Quarter 2. Future arrangements will be determined during 2026/27.

Membership, Communications and Engagement Group

This group supported engagement with members and the public, assisting Governors in fulfilling their statutory duties. Activities included membership recruitment and engagement initiatives. A Freshers Fair at the College of West Anglia in King's Lynn and Wisbech in September supported recruitment. The membership database is updated quarterly. The group closed on 16 July 2025.

Patient Experience Group

This group monitored service quality and contributed to the Trust's quality improvement programme, including safety, effectiveness and patient experience. It engaged with senior clinical staff and drew on multiple information sources including the QEH Patient Experience team, Patient Participation Groups, Quality Assurance Visits, PLACE assessments and feedback. The group noted the withdrawal of funding for West Norfolk Carers in May 2025. It supported initiatives including same day hip operations, care for people with learning disabilities and autism, nutrition and hygiene improvements, medical examiners and mortuary services. Governors also supported funding for refurbishment of The Roxburgh Children's Centre garden. The group closed on 2 July 2025.

Strategy and Business Planning Group

This group contributed to the Trust's strategic direction and planning, seeking assurance from Executive and Non-Executive Directors and making recommendations to the Council. It closed on 16 July 2025.

Nominations and Remuneration Committee

This committee makes recommendations regarding the appointment, reappointment, remuneration and terms and conditions of office for the Trust Chair and Non-Executive Directors.

The committee met six times and considered extensions to the Interim Vice Chair and two Non-Executive Director contracts to 31 October 2025, as well as appointments of Group Non-Executive Directors. It reviewed and contributed to the role description and person specification for the Group Chair position.

The Committee in Common recommended final versions of the Group Chair and Group Non-Executive Director role descriptions and remuneration packages. Extraordinary Council of Governors meetings were convened as required to approve appointments.

Constitution Working Group

This group reviews and recommends amendments to the Trust's Constitution. It did not meet during 2025/26 pending completion of the Group Model Constitution.

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 2025/26

The table detailing Governor attendance, including the Annual Members' Meeting, is presented in the full report.

Governors declare interests and sign the Trust's Code of Conduct. The Register of Interests is reviewed at least twice annually and is available via the QEH website or on request from the Foundation Trust Office.

Constituency	Governor name, month appointed and term of office	Governors' Council meetings attended	Strategy & Business planning	Patient Experience	Membership, engagement and culture	Nomination and remuneration
West Norfolk	Theresa Banks February 2025 1st term	1/3		✓		
West Norfolk	Bob King February 2025 1st term	2/3	✓			
West Norfolk	Andrew Riley February 2025 1st term	3/3			✓	
West Norfolk	Sara Shaw February 2025 2nd term	2/3	✓			
West Norfolk	Vacant					
West Norfolk	Vacant					
West Norfolk	Vacant					
West Norfolk	Vacant					
West Norfolk	Vacant					
Cambridgeshire / Fenland	Mark Dyer February 2025 1st term	3/3			✓	

Cambridgeshire / Fenland	Vacant					
Cambridgeshire / Fenland	Vacant					
Breckland, North Norfolk, and the rest of England	Antonia Hardcastle (Lead Governor) February 2025 2nd term	3/3			✓	✓
Breckland, North Norfolk, and the rest of England	Vacant					
South East Lincolnshire	Chris Brewis February 2025 2nd term	2/3		✓		
South East Lincolnshire	Vacant					
Staff Clinical	Ruth Overton February 2025 1st term	3/3				
Staff Clinical	Vacant					
Staff Clinical	Vacant					
Staff Non-Clinical	Leanne Kendrick February 2025 2nd term	3/3			✓	✓
Staff Non-Clinical	Alasdair Willett February 2025 1st term	2/3	✓			
Staff Non-Clinical	Vacant					

Appointed Governor	Governor name and month appointed	Governors' Council meetings attended	Strategy & Business planning	Patient Experience	Membership, engagement and culture	Nomination and remuneration
Borough Council of King's Lynn and West Norfolk	Alexandra Kemp December 2023	3/3			✓	
Breckland District Council	Peter Wilkinson June 2019	3/3				
College of West Anglia	Rachel Boast June 2023	2/5		✓		
Freebridge Community Housing	Matthew Brown September 2024	0/3	✓			
Norfolk County Council	Lesley Bambridge August 2021	3/3		✓		
University of East Anglia	Sue Madden November 2019	1/3			✓	✓
Vacant						

Governors no longer serving at 31 March 2026

Constituency / Staff Class / Appointed	Name	Leaving date
West Norfolk	Esmé Corner	31 January 2026
West Norfolk	Prudence Fox	31 January 2026
West Norfolk	Mike Press	31 January 2026
West Norfolk	Barbara Turner	31 January 2026

Breckland, North Norfolk and Rest of England	David Chittenden	31 January 2026
Cambridgeshire and Fenland	Betty Lewis	31 January 2026
South East Lincolnshire	Alan Maltby	31 January 2026
Staff Clinical	Risa Birbal	31 January 2026
Staff Clinical	Karen Wilson	31 January 2026
Staff Non-clinical	Sheena Johnson-Banks	31 January 2026
West Norfolk Carers	Jane Evans	19 May 2026

Foundation Trust and public membership

Membership is open to patients, the public, NHS staff and individuals aged 16 and over, including those living outside the local area with an interest in the Trust.

Members receive the monthly the QEH Modernising our Hospital e-newsletter and updates on key developments. They are invited to attend the Annual Members' Meeting, healthcare events and focus groups. Members may vote in Governor elections or stand for election. Engagement levels vary and may include volunteering and fundraising.

The four public constituencies are:

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

Staff and volunteer membership

Staff receive communications issued to members and are part of the QEH.

To apply for membership:

- apply online using this link: https://www.qehkl.nhs.uk/about-us/foundation-trust-membership
- email FT.membership@qehkl.nhs.uk or call 01553 613142
- write to **The Foundation Trust Office**, The Queen Elizabeth Hospital King's Lynn, Gayton Road, King's Lynn, PE30 4ET

Public membership

Public membership totalled 3,347 as at March 2026.

Gender	At 31 March 2026	At 31 March 2025
Male (including trans men)	1,183	1,183
Female (including trans women)	2,152	2,112
Not stated	9	21
Non-binary and other (not listed)	2	3

Constituency	At 31 March 2026	At 31 March 2025
Breckland, North Norfolk and Rest of England	493	487
Cambridgeshire and Fenland	333	316
South East Lincolnshire	206	204
West Norfolk	2,315	2,313

Age	At 31 March 2026	At 31 March 2025
16-21	253	225
22-29	594	659
30-39	319	251
40-49	247	251
50-59	352	344
60-74	673	697
75+	787	768
Not stated	122	125

Ethnicity	At 31 March 2026	At 31 March 2025
White	3,001	2,977
Mixed	23	23
Asian or Asian British	54	55
Black or Black British	27	25
Other	7	8
Not stated	231	231

	At 31 March 2026	At 31 March 2026
Total	3,347	3,320

Staff membership stands at 4,319, giving a total Foundation Trust membership of 7,666.

NHS System Oversight Framework

NHS England's NHS Oversight Framework 2025/26 is the principal mechanism for assessing health systems and NHS providers. It promotes transparency, drives improvement, and helps identify potential support or intervention needs.

Under this framework, NHS organisations are allocated to one of five segments. Segmentation indicates an organisation's level of delivery and whether improvement support is required, ranging from consistently high performing across all domains (Segment 1) to significantly off track across a range of areas (Segment 4). An organisation assessed as Segment 4 that is also determined to have a low capability to improve without mandated intensive support is allocated to Segment 5.

NHS England's oversight response to an organisation is based on the following components:

- performance metrics: the segment is derived from scored metrics across five performance domains: access to services, effectiveness and experience of care, patient safety, people and workforce, and finance and productivity
- financial override: a strict segmentation override is applied where any provider reporting a financial deficit cannot be allocated to a segment better than Segment 3, regardless of their performance in other domains
- contextual metrics: consideration of supplementary metrics which are not scored, such as those relating to improving health and reducing inequalities
- capability assessments: an evaluation of the organisation's leadership, strategy, and governance. While this assessment no longer dictates the quantitative segment score, it directly informs the type of improvement support or regulatory intervention NHS England will apply

The framework presents this performance data transparently in quarterly league tables, ensuring that patients and stakeholders can clearly see how organisations are performing relative to their peers. Trust Boards are expected to use this intelligence to benchmark their position, understand areas for focus, and drive continuous improvement.

During 2025/26, The Queen Elizabeth Hospital King's Lynn NHS Foundation Trust moved from Segment 3 to Segment 4 of the NHS Oversight Framework, reflecting deterioration across quality, access, productivity, finance, and governance indicators. The Trust was rated 133 out of 134 within the National Oversight Framework and received support through the National Provider Improvement Programme, supported by an NHS England Improvement Director.

The Trust continued to operate under four active section 31 conditions of the Health and Social Care Act 2008. These related to Urgent and Emergency Care, Diagnostic and Screening Services, and Maternity and Midwifery Services. Evidence to support

closure of the section 31 conditions has been submitted to the Care Quality Commission and formal feedback is awaited.

Following an unannounced Care Quality Commission inspection of Surgical Care Services in March 2026, the Trust was subject to two section 29A (S.29) notices. These related to surgical ward access and to the assessment and management of risks to the health and safety of service users receiving care or treatment, including safety of premises. Immediate actions were taken and the formal inspection report is awaited.

The Trust also received an Information Commissioner's Office Enforcement Notice on 23 March 2026 relating to the backlog of responses to Freedom of Information Act requests and the Trust's ability to respond within the required statutory timeframes. Immediate actions were taken, including short-term additional capacity and longer-term substantive recruitment. An action plan and lessons learned report were shared with the Information Commissioner by the required deadline of 26 April 2026.

During the year, the Trust was subject to NHS England Enforcement Undertakings. These included requirements relating to provider licence conditions, SHMI and HSMR review and improvement planning including clinical coding, the Royal College of Surgeons review and its recommendations, financial governance and the medium-term financial plan, staff survey improvement planning, patient experience self-assessment and improvement planning, programme governance, and engagement with the Integrated Care Board and NHS England regional team.

The Trust's Annual Governance Statement describes the significant internal control issues identified during 2025/26 and the actions being taken in response. These include General Surgery service quality and escalation controls, Freedom of Information Act compliance, data quality, clinical coding and mortality reporting controls, and financial resilience, liquidity management and associated control discipline.

CQC

The Trust has legacy outstanding CQC 'must' and should' which it is focusing on closing via the Evidence Assurance Group:

Should

- the Trust must ensure patient records are stored securely
- the Trust must ensure that staff receive an annual appraisal

Must

- the service should ensure people can access the service when they need it (medicine)

- the service should ensure mandatory and safeguarding training amongst medical staff is completed in line with trust targets (medicine)
- the service should ensure all medical staff complete appropriate levels of safeguarding training for adults and children (UEC)

The Trust has legacy S.31 notices. Two relate to Radiology, one relates to Maternity and Midwifery and one relates to UEC. Evidence for closure of all section 31's has been submitted to CQC. Formal feedback is awaited

The Trust is subject to two S.29A notices in relation to Surgical Services following an unannounced CQC inspection in March 2026. The first relates to surgical ward access and ensuring that appropriate controls are in place and the second relates to assessment of risks to the health and safety of service users receiving care or treatment and safety of premises. Immediate actions have been taken and the formal inspection report is awaited.

ICO

- the Trust received an Information Commissioners Enforcement Notice on 23 March 2026
- the Enforcement Notice relates to the Trust's backlog of responses to Freedom Information requests and ability to respond within the required statutory timeframes
- the Trust has taken immediate actions including a short-term increase in capacity alongside longer-term substantive recruitment
- an action plan and lessons learnt report has been shared with the Information Commissioner by the required deadline of 26 April 2026

Legal Undertakings

- licensee conditions
- SHMI and HSMR review and plan including clinical coding
- Royal College of Surgeons – 21 recommendations
- financial governance - MTFP
- staff survey plan
- patient experience self-assessment and improvement plan
- programme governance
- ICB and regional engagement

Statement of Chief Executive's responsibilities

NHS England has given Accounts Directions which require the Queen Elizabeth Hospital King's Lynn NHS Foundation Trust (the QEH) 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 QEH 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

Annual Governance Statement

Scope of responsibility

As Accounting Officer, I have responsibility for maintaining a sound system of internal control that supports the achievement of the Queen Elizabeth Hospital King's Lynn NHS Foundation Trust's (the QEH) 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 QEH is administered prudently and economically and that resources are applied efficiently and effectively. I also acknowledge my responsibilities as set out in the NHS Foundation Trust Accounting Officer Memorandum.

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 2026 and up to the date of approval of the annual report and accounts.

The management system of risk and internal control maintains the policies, procedures, standards, and review mechanisms required to support the lawful and effective achievement of the Board's strategic aims and intended outcomes to the requisite standards. In doing so, it links the Board's vision to measurable objectives, oversight, and corrective action.

Capacity to handle risk

The Trust remains an independent, statutory organisation with a Board of Directors. During 2025/26, the QEH, Norfolk and Norwich University Hospitals NHS Foundation Trust (NNUH), and James Paget University Hospitals NHS Foundation Trust (JPUH) moved progressively to work within a formal Group model through the Norfolk and Waveney University Hospitals Group (NWUHG). As established and defined through a Provider Collaboration Agreement, the Trust's Board of Directors retains a number of Reserved Functions while a General Purpose Joint Committee (the Group Board) exercises a range of Joint Functions on behalf of the three trusts. Executive and Non-Executive Directors are members of the Group Board and of the Boards of each of the foundation trusts.

Leadership of risk management during 2025/26 was exercised through the Trust Board and, within management, through the Executive Managing Director, the Hospital Management Group, and its specialist management groups for quality, people and culture, and finance and performance. The Board's Audit Committee (from November 2025 constituted as a Group Audit Committees in Common) scrutinised the adequacy and effectiveness of the Trust's risk management and internal control arrangements.

Operational responsibility for risk management rested with divisions and corporate departments, each of which was required to identify, assess, manage, and escalate risks in line with the risk management framework. Executive Directors were responsible for risks within their portfolios and for ensuring that mitigations were operating effectively before escalation through local governance routes to the corporate risk register and, where necessary, to Group structures. Staff were supported through mandatory training, policy guidance, patient safety learning, use of the Three Lines of Defence model, and investment in a just and learning culture. During the year, this included Patient Safety Incident Response Framework training, Trust-wide patient safety learning events, and strengthened learning and benchmarking through the Learn from Patient Safety Events service and improved safety reporting.

The risk and control framework

During 2025/26, the Trust transitioned to a new, enhanced risk management approach, including a revised approach to risk scoring which takes more explicit account of the effectiveness of control measures. The risk management framework and approach is set out in a Group Risk Management Policy which was approved by the Board of Directors in September 2025.

The Risk Management Policy underpins the Trust's and the Group's focus on risk-based assurance. It defines roles, responsibilities, and reporting lines in relation to risk management and describes the organisation's approach to risk identification, analysis, evaluation, treatment, and review.

At an operational level, responsibility for risk management rests with the Trust's Executive Managing Director and their senior leadership team. Risks are reviewed on a monthly basis by the Hospital Management Group in accordance with agreed risk thresholds. The Trust's 'Red-rated' risks are received and reviewed each month by the Group's Executive Risk Assurance Group (ERAG), which in turn reports to the monthly Group-Board level Group Risk Assurance Committee (GRAC).

The Group Board Assurance Framework (BAF) Report, which identifies principal risks to the achievement of the Group's strategic objectives, is also reviewed monthly by ERAG and GRAC. It is received by the Group Board three times a year. Each BAF Report risk has a clearly identified Group Executive as the risk lead and sets out the controls in place to manage the risk and the sources of assurance on the

effectiveness of the controls. The BAF Report also identifies any gaps in control or assurance and the actions being taken to address those and reduce the risk score in line with its trajectory.

By March 2026, the Group BAF Report had been populated with 14 principal risks relating to quality standards variation; maternity services improvement; access, flow and productivity; financial sustainability; workforce capacity and engagement; digital capability and data readiness; Electronic Patient Record implementation and dependent change; cyber security and information governance; estate and infrastructure; transformation capacity and programme discipline; new hospitals programme; corporate governance; public and stakeholder confidence; and research, innovation and education. The BAF Report recorded assurance strength, current and target risk scores, mapped controls, first, second and third line assurances, and identified gaps in control or assurance with action plans and due dates.

Work in 2026/27 will focus on embedding a Group Board approved risk appetite statement fully within the BAF and associated escalation arrangements.

Quality arrangements formed a central part of the risk and control framework. Group Aim A1 defined Quality as patient safety, patient experience, and clinical effectiveness. Associated principal risks included variation in quality standards, maternity services improvement, Electronic Patient Record dependent change, and new hospital programme transformation risk. The new hospital programme risk was particularly relevant to the QEH because the materially Reinforced Autoclaved Aerated Concrete (RAAC)-affected estate created a direct dependency between estate safety, service continuity, clinical environment and workforce resilience. Controls and review routes recorded in the March 2026 Group BAF Report included trust-level Quality Management Groups, Hospital Management Groups, monthly Executive Performance Reviews, management escalation through ERAG, Board-level scrutiny through GRAC, and external review through NHS England oversight, Care Quality Commission inspection, and accreditation visits. The assurance position was active but not yet complete: the controls provided structured routes for oversight, escalation, and intervention, but were not yet sufficient to demonstrate that all quality variation, regulatory compliance, surgical care, maternity improvement, and estate-dependent transformation risks had been reduced to target. Identified gaps included the need for a Group-wide quality framework, a Group-wide quality improvement programme, more consistent real-time quality data, and enhanced Board-level oversight of quality and outcomes. These actions will continue during 2026/27, with progress monitored through trust management structures, ERAG, GRAC and the Group Board.

Group Aim A4 and Principal Risk 4 established the strategic framework for financial sustainability and value. The March 2026 BAF recorded limited assurance over financial sustainability, with key controls including the Board-approved Medium-term Plan, Cost Improvement Programme (CIP) development, bank and agency controls,

and capital planning. Assurance sources included monthly Executive Performance Reviews, escalation through ERAG and GRAC, monthly reporting to NHS England, internal audit opinion, and external audit value for money findings once completed. The controls were operating and provided a defined route for oversight, grip, and escalation, but were not yet fully effective in reducing the financial sustainability risk to target. Gaps remained in relation to finalisation and delivery of 2026/27 CIP programmes, recurrent deficit reduction, liquidity resilience, and the need for deeper assurance over delivery trajectories, run-rate improvement, and the recurrent effect of savings.

Access, flow, and productivity remained a material operational risk during 2025/26, including urgent and emergency care pressures, elective waiting list management, diagnostic capacity, cancer and long-wait pathways, and the Trust's low relative position within the NHS Oversight Framework. Controls included integrated performance reporting, daily and weekly Patient Tracking List review, elective and diagnostic validation, cancer and long-wait oversight, specialty recovery planning, Executive Performance Reviews, and escalation through HMG, ERAG, GRAC and Board reporting. Assurance was available over the existence and operation of these controls, but controls had not yet delivered the required level of sustained recovery across all relevant standards. Further assurance will be sought through the planned 2026/27 Group-wide Internal Audit review of Waiting List Management and through continued scrutiny of recovery trajectories, clinical harm review processes, diagnostic and cancer pathway controls, and data quality controls.

During 2025/26, the Group identified digital capability and data readiness as a principal risk because insufficient digital maturity, data quality assurance, and analytics capability could inhibit modern clinical practice, transformation, and confident decision-making. Risks to data security were managed through digital and cyber controls including Data Protection and Security Toolkit improvement planning, cyber action plans, layered technical controls, user education, internal audit coverage, Cyber Assessment Framework work, and business case development for cyber and infrastructure investment. Cyber security and information governance were treated as a major principal risk, with further work required on resources, infrastructure refresh, governance alignment, and compliance capability across the Group.

The Trust's principal risks to compliance with the NHS provider licence section 4 on governance during the year related to the effectiveness and completeness of the evolving Group governance arrangements, clarity of responsibilities between the Trust Board, the Group Board, Committees in Common, and executive management structures, the sufficiency of Non-Executive Director scrutiny within the new model, the evidential standards required for lawful and informed decision-making, and the need to complete and embed the aligned governance instrument set. These matters were reflected in Group Principal Risk relating to corporate governance.

The Trust's review of governance effectiveness also drew explicitly on the Care Quality Commission and NHS England Well-Led Framework. This informed consideration of Board leadership, culture, strategy, risk management, information quality, learning, accountability, and the effectiveness of the developing Group governance and operating model. The Trust's Well-Led arrangements were reviewed alongside NHS England oversight, CQC intelligence, internal audit, external audit, Board and committee reporting, and the work undertaken to complete and embed the Group governance instrument set.

Risk management was embedded in the activity of the organisation through integrated performance reporting, incident reporting, escalation processes, finance and performance review, quality review mechanisms, workforce planning, management group oversight, committee scrutiny, and use of the BAF Report. Equality, diversity, human rights, and wider regulatory obligations were addressed through the Trust's established policies, operational controls, and decision-making processes.

Public stakeholders remained engaged through the continuing constitutional role of the Trust's Council of Governors, patient and public involvement arrangements, patient feedback and complaints systems, and the Group's stated intention to strengthen stakeholder engagement and confidence through transparent communication and visible leadership. Group Aim A6 explicitly required proactive public and stakeholder engagement to build and maintain confidence in Group services.

The Trust continued to ensure that short, medium, and long-term workforce strategies and staffing systems were in place to support safe, sustainable, and effective staffing. In accordance with Developing Workforce Safeguards, the Board's approach to staffing assurance drew on evidence-based tools, professional judgement, and patient safety, quality, finance, workforce, and outcome indicators. The Group Aims and BAF Report identified workforce capacity, capability, retention, safe staffing, wellbeing, engagement, inclusion, and workforce pipeline as central priorities. The March 2026 BAF recorded controls including Trust-level workforce plans, establishment control, acuity-based rostering, temporary staffing controls, sickness absence plans, and staff survey improvement planning, while also identifying gaps in relation to shortage specialties, sickness rates, staff engagement, and service resilience. Where staffing indicators were outside tolerance, actions were overseen through the People and Culture Management Group, Hospital Management Group, Executive Performance Reviews and Group assurance routes.

The People and Culture Management Group oversees safe staffing and red-flag processes. One-to-one maternity care was maintained throughout the year. Highest sickness absence rates were addressed through Group-supported interventions, strengthened management support, and monitoring of absence, retention, engagement, and workforce controls through local and Group reporting routes.

The Trust is not fully compliant with the registration requirements of the Care Quality Commission. The Trust operates under four active section 31 conditions relating to Urgent and Emergency Care, Diagnostic Services, and Maternity Services, and is rated Requires Improvement overall. The relevant improvement actions were managed through formal quality, maternity, urgent and emergency care, diagnostic and regulatory improvement plans, supported by executive review, quality and performance reporting, NHS England oversight, and escalation through trust and Group governance routes where risks remained outside tolerance.

Further regulatory concerns were raised following an unannounced Surgical Care inspection in March 2026. These concerns were managed through immediate executive review, formal regulatory response arrangements, and alignment with the wider General Surgery improvement work described below. The Trust was assessed within segment 4 of the NHS Oversight Framework, entered the National Provider Improvement Programme in March 2026, and was subject to NHS England Enforcement Undertakings issued during the year. The related actions and evidence requirements were tracked through the Trust's management groups, Executive Performance Reviews, Group assurance routes, and direct regulatory oversight.

The principal RAAC estate risk is that the materially RAAC-affected estate could compromise patient and staff safety, service continuity and operational resilience. Controls included structural inspections, propping, monitoring, estates risk assessment, risk-register escalation, business continuity planning, capital planning, and reporting through local and Group governance routes. Assurance was taken from the continuing operation of the mitigation regime, professional estates advice, programme reporting, and oversight of the New Hospital Programme. The residual risk remained significant because mitigation depends on continued monitoring, effective maintenance of temporary measures, clarity over the New Hospital Programme timetable, and delivery of enabling work. During 2026/27, assurance will focus on the continuing safety of the mitigated estate, escalation of any deterioration, and the delivery confidence, timeline, cost, and operational continuity assumptions within the New Hospital Programme. General Surgery risks, financial sustainability pressures, and paediatric audiology fragility were managed through local and Group oversight.

The 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.

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.

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

The 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.

Review of economy, efficiency, and effectiveness of the use of resources

The Trust's arrangements for reviewing the economy, efficiency, and effectiveness of the use of resources included oversight by the Board of Directors, the Audit Committee, executive finance and performance review processes, internal audit, external audit, and the Group and local assurance structures. The Board monitored delivery of the financial plan, cost improvement requirements, workforce controls, capital expenditure, and value for money considerations within a period of continuing financial pressure and transformation demand.

Information governance

At Group level, information governance and cyber security were recognised as a principal risk. Controls included Data Protection and Security Toolkit improvement planning, cyber action planning, technical controls, annual audit, internal audit coverage, and strategic work to align information governance and cyber security governance across the Group. This wider context informed the Trust's own information governance control environment during the year.

An Information Commissioner's Office Enforcement Notice was issued on 23 March 2026 relating to non-compliance with the statutory timeframe for responding to Freedom of Information Act requests. This related to Freedom of Information Act handling rather than personal data breach. The Notice required all requests outstanding at the date of the Notice to be addressed within six months and required the Trust to devise and publish an action plan to achieve ongoing compliance. The Trust took immediate corrective action, including a lessons learned exercise, backlog assessment, allocation of outstanding requests, and development of a shared action plan, which was provided to the Information Commissioner's Office in April 2026. Progress against the action plan and the six-month clearance requirement will be monitored through 2026/27 and escalated where response times remain outside statutory requirements.

No major personal data incidents requiring Data Security Incident Reporting Tool escalation occurred in 2025/26. Local remediation and controls were managed through Datix and Caldicott processes.

Data quality and governance

The Trust maintained arrangements to provide the Board with confidence that appropriate controls were in place to ensure the accuracy of performance and operational data.

During 2025/26, the Group identified digital capability and data readiness as a principal risk because insufficient digital maturity, data quality assurance, and analytics capability could inhibit modern clinical practice, transformation, and confident decision-making. The BAF Report recorded the need for a costed digital roadmap, improved data analytics capability, and a Group-wide business intelligence, analytics, and data quality function.

The Trust employs rigorous validation controls for elective waiting times, including the daily validation of non-RTT patients by failsafe officers to ensure accurate clinical prioritisation.

The local Finance and Performance Management Group oversees elective validation. During 2025/26, the Trust's governance framework identified and managed a severe clinical coding backlog of approximately 12,000 non-elective episodes, which had materially distorted statutory mortality metrics (HSMR and SHMI). Through targeted intervention, this coding backlog was cleared by March 2026. The associated control response included strengthened oversight of coding recovery, reconciliation of coded and uncoded activity, review of mortality reporting impact, and escalation through management and regulatory oversight routes.

Under NHS England Enforcement Undertakings, the Trust is mandated to further assure mortality coding and data quality processes, with corrective audits required by March 2027. During 2026/27, assurance will focus on whether the strengthened controls remain durable after backlog clearance, whether mortality indicators accurately reflect coded activity and case mix, and whether data quality issues are identified, escalated, and corrected promptly.

A Group-wide Internal Audit review of Waiting List Management is planned for 2026/27 and will provide further assurance over elective pathway controls and data quality.

Review of effectiveness

As Accounting Officer, I have responsibility for reviewing the effectiveness of the system of internal control. My review of the effectiveness of the system of internal control is informed by the work of the internal auditors, clinical audit and the executive managers and clinical leads within the Trust who have responsibility for the development and maintenance of the internal control framework. I have drawn on performance information available to me. My review is also informed by comments made by the external auditors in their management letter and other reports.

I have been advised on the implications of the result of my review of the effectiveness of the system of internal control by the Board and the Audit Committee and a plan to address weaknesses and ensure continuous improvement of the system is in place.

The process applied in maintaining and reviewing the effectiveness of the system of internal control during 2025/26 included review by the Trust Board and Audit Committee, supported by internal audit, external audit, clinical audit, integrated performance reporting, and management review through the Trust's established executive and management group structure.

Where functions had been lawfully delegated for joint exercise, relevant matters were also scrutinised through the Group governance framework, including Board-level scrutiny through GRAC and management escalation through the Group Executive and ERAG.

The Head of Internal Audit opinion for 2025/26 has concluded that there are weaknesses in the framework of governance, risk management and internal control such that it could become inadequate and ineffective.

The review identified material areas requiring continued management action, most notably financial resilience, liquidity management, delivery of the Cost Improvement Programme, regulatory compliance, service quality, maternity improvement, Surgical Care concerns, clinical coding and mortality reporting controls, and the RAAC-affected estate. These matters were recorded through the Trust's and Group's risk and assurance arrangements and were subject to enhanced scrutiny through executive review, Board reporting, NHS England oversight, Enforcement Undertakings, National Provider Improvement Programme support, and Group-level governance.

The effectiveness review also drew on development of the Group Governance Framework itself. The March 2026 Board Assurance Framework recorded an assurance rating of 'reasonable' for Principal Risk 14, corporate governance, while also identifying that elements of the Group governance structure remained to be fully implemented and embedded, that the risk management framework remained in development, and that Non-Executive Director vacancies remained to be filled. Planned actions included establishment of remaining Board committees, finalisation and embedding of Constitutions, Standing Orders and Standing Financial Instructions, further population, and review of the BAF Report, and agreement of a revised Group risk appetite statement.

In February 2025, NHS England completed a leadership and governance review of the proposed Group model. This resulted in an Amber rating, meaning that the Group could proceed as planned with moderate support and monitoring. A follow-up review, conducted by the NHS England team in November 2025, formed part of the evidence base for the review of effectiveness. It recognised timely progress in development of the governance framework and operating model, while also

identifying a continuing need to keep the sufficiency of non-executive scrutiny under review, to evaluate the governance and operating model as it embedded, and to maintain focus on benefits realisation and governance effectiveness.

The review of effectiveness was further informed by completion of the statutory governance instrument set recorded in April 2026, with legal review confirming that the Provider Collaboration Agreement, Constitutions, Standing Orders, Standing Financial Instructions, and Scheme of Reservation and Delegation together formed a coherent and lawful governance framework for the Group model.

The review of effectiveness also took account of the way in which these risks were identified, escalated, and managed through the Trust's management groups, executive oversight processes, Board reporting arrangements, NHS England Enforcement Undertakings, support through the National Provider Improvement Programme, and the initiation of a Group-wide review of quality and safety assurance arrangements due to report in August 2026.

The Audit Committee has reviewed the overall framework for internal control and has recommended this statement to the Board of Directors.

Significant internal control issues

The Trust has identified the following significant internal control issues for disclosure in 2025/26.

General Surgery service quality and escalation controls

In October 2025, a Royal College of Surgeons review of General Surgery commissioned by the Trust identified significant areas for improvement, including recognition of deterioration, timely return to theatre, surgical decision-making and escalation, handovers, consultant accountability, team culture, and governance. The review identified weaknesses in teamwork and learning systems, such that problems were not recognised or addressed sufficiently early. While the review did not identify evidence of widespread harm and mortality outcomes were within expected ranges, a number of cases were judged to have involved care below the expected standard. Further regulatory concerns were raised following an unannounced Surgical Care inspection in March 2026, reinforcing the need for demonstrable grip, clear leadership, reliable escalation, and sustained evidence of improvement.

In response, the Group mandated new leadership, oversight, and service arrangements as part of a move towards a shared service with Norfolk and Norwich University Hospitals NHS Foundation Trust from December 2025. This included stronger clinical leadership, mandatory Norfolk and Norwich consultant oversight of emergency surgery, revised expectations for escalation and handover, and work to align standards, pathways, and expectations across both hospitals. A wider Group-supported review of QEH quality and safety assurance arrangements was initiated

and is due to report in August 2026. The resulting action plan will be monitored through the Hospital Management Group, Executive Performance Reviews, ERAG, GRAC and Board reporting during 2026/27, with overdue actions escalated where recovery is not on track.

Freedom of Information Act compliance

In March 2026, the Trust received an Enforcement Notice from the Information Commissioner's Office relating to non-compliance with the statutory timeframe for responding to Freedom of Information Act requests. The Notice required the Trust to address all outstanding requests as at the date of the Notice within six months and to devise and publish an action plan to achieve ongoing compliance. The Trust took immediate steps in response, including a lessons learned exercise, backlog assessment, allocation of outstanding requests, and development of an action plan, which was shared with the Information Commissioner's Office in April 2026. During 2026/27, progress will be monitored against the six-month clearance requirement and ongoing compliance trajectory, with escalation where statutory timeframes are not being met.

Data quality, clinical coding and mortality reporting controls

During the year, the Trust identified a severe backlog in non-elective clinical coding, which materially distorted statutory mortality indicators. Immediate corrective action was taken, and the backlog was cleared by March 2026. Further mandated assurance work remains in train to confirm the durability of strengthened controls. Under NHS England Enforcement Undertakings, corrective audits are required by March 2027. During 2026/27, the Trust will monitor whether mortality indicators accurately reflect coded activity and case mix, whether coding timeliness is sustained, and whether data quality issues are identified, escalated, and corrected promptly.

Financial resilience, liquidity management and associated control discipline

Extreme financial pressure and short-term liquidity constraints required enhanced oversight, escalation, and recovery controls during the year. This issue remains disclosed because the significant control concern related to in-year liquidity resilience, recurrent financial sustainability, and control discipline, not solely to the final year-end outturn. Actions taken included strengthened executive and Board oversight, enhanced expenditure control, cash and liquidity monitoring, CIP oversight, bank and agency controls, and financial recovery reporting through local and Group governance routes.

These issues were identified and escalated through the Trust's control and risk reporting systems during the year, including Board reporting, regulatory escalation, NHS England oversight, Audit Committee review, and Group-level scrutiny. Actions

taken and in progress include strengthened executive and Board oversight, mandated General Surgery service arrangements with Norfolk and Norwich University Hospitals NHS Foundation Trust, delivery under NHS England Enforcement Undertakings, corrective action in response to the Information Commissioner's Office Enforcement Notice, corrective data quality assurance work, and the Group-wide review of quality and safety assurance arrangements due in August 2026.

Conclusion

Overall, the Board's conclusion on the system of internal control is informed by the Head of Internal Audit opinion, external audit findings, management review, and the evidence set out in this statement. The Board recognises that controls were present and active across the principal risk areas described above, but that assurance was limited in relation to financial sustainability and not yet fully mature in relation to quality variation, regulatory compliance, General Surgery and wider Surgical Care concerns, maternity improvement, elective access, clinical coding and mortality reporting controls, and the RAAC-affected estate. This is reflected in the significant internal control issues identified above and in the Head of Internal Audit opinion for 2025/26 which has concluded that there are weaknesses in the framework of governance, risk management and internal control such that it could become inadequate and ineffective.

Professor Lesley Dwyer
Group Chief Executive
The Queen Elizabeth Hospital King's Lynn NHS Foundation Trust
25 June 2026

Financial Report

Annual Accounts for the year ended 31 March 2026

The accounts for the year ended 31 March 2026 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.

Professor Lesley Dwyer,
Group Chief Executive

25 June 2026

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 2026 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 2026 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 2026 as being relevant to NHS Foundation Trusts and included in the Department of Health and Social Care Group Accounting Manual 2025/26; 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.
- Reading the Trust's accounting policies.

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 and a fraud risk around the capitalisation of expenditure to reduce expenditure during the period to meet their adjusted performance target.

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 at the end of the reporting period.
- 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.
- Testing an increased sample of capital expenditure incurred by the Trust to ensure it is correctly capitalised.
- Assessing whether the judgements made in making accounting estimates are indicative of a potential bias.

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: 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 2025/26.

Accounting Officer's responsibilities

As explained more fully in the statement set out on page 179, 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 – Governance

There are significant areas that indicate weaknesses around the Trust's Governance during the year. An adverse internal audit opinion, the Trust's Segment 4 rating within the National Oversight Framework, and ongoing operational performance challenges highlight continued difficulties in delivering sustainable improvements. In particular, deteriorating staff survey results and findings from a Royal College of Surgeons review point to underlying cultural, workforce and leadership challenges which are impacting operational delivery and the consistency of service quality.

While the Trust has begun to take corrective action with targeted responses to workforce and service issues, and with them being enrolled in the National Provider Improvement Programme going forwards we would conclude that there is a significant weakness around the Trust's governance arrangements for the period.

Recommendation:

The Trust should prioritise strengthening its governance arrangements to ensure that the improvements made to risk management and financial governance are embedded and operating effectively in practice. This should include full and proactive engagement with the National Provider Improvement Programme and internal audit going forward to respond to their findings and improve the overall governance arrangements of the Trust

Significant Weakness - Improving economy, efficiency and effectiveness

We have identified a number of factors that indicate a significant weakness around improving economy, efficiency and effectiveness. The Trust has been unable to deliver the activity planned and agreed with the ICB. In addition, while progress has been made in reducing the clinical coding backlog this remains at year end. Regulatory concerns have been raised further highlight these pressures with the Care Quality Commission's warning notice in May 2026 and the issuance of a new NHS England undertakings notice in March 2026 point to ongoing weaknesses. As a result, while the Trust has demonstrated an ability to deliver financial efficiencies in the current year, this has been alongside operational underperformance and adverse regulatory findings. We therefore consider is appropriate to raise a significant weakness around the Trusts arrangements for Improving economy, efficiency and effectiveness during the year.

Recommendation:

The Trust should work closely with its regulators, including NHS England and the Care Quality Commission, to ensure that the findings from recent reviews and regulatory actions are fully embedded and translated into sustainable service improvements. The Trust should follow their CQC Improvement Programme Plan ensuring that the actions have defined milestones, accountable leads, and regular Board oversight, ensuring that operational performance is aligned with agreed system activity plans.

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 179, 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 2026 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 2026 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

KPMG LLP

20 Station Road

Cambridge

CB1 2JD

26 June 2026

Statement of Comprehensive Income

	Note	2025/26 £'000	2024/25 £'000
Operating income from patient care activities	3	347,553	298,617
Other operating income	4	20,994	26,806
Operating expenses	5	(393,076)	(405,212)
		(24,529)	**(79,789)**
Finance income	10	994	909
Finance expenses	10.1	(69)	(6)
PDC dividends payable		(4,512)	(4,155)
Net finance costs		**(3,587)**	**(3,252)**
Other gains / losses	11	57	(39)
Surplus / (deficit) for the year		**(28,059)**	**(83,080)**
Other comprehensive income			
Will not be reclassified to income and expenditure:			
Revaluations	24	2,307	2,321
Total comprehensive income / (expense) for the period		**(25,752)**	**(80,759)**
Adjusted financial performance (control total basis):			
Surplus / (deficit) for the period per SOCI		(28,059)	(83,080)
Remove net impairments not scoring to the departmental expenditure limit		29,683	47,206
Remove net impact of DHSC centrally procured inventory		-	14
Remove I&E impact of capital grants and donations		28	(2,618)
Adjusted financial performance (deficit)/surplus		**1,652**	**(38,478)**

All income and expenditure is derived from continuing operations

The accompanying notes form part of these financial statements

Statement of Financial Position

	Note	31 March 2026 £'000	31 March 2025 £'000
Non-current assets			
Intangible assets	12	16,057	10,948
Property, plant and equipment	13	160,617	145,337
Right of use assets	14	4,156	231
Receivables	17	514	391
Total non-current assets		**181,344**	**156,907**
Current assets			
Inventories	16	3,308	3,247
Receivables	17	8,751	8,662
Cash and cash equivalents	18	32,049	21,974
Total current assets		**44,108**	**33,883**
Current liabilities			
Trade and other payables	19	(57,409)	(50,228)
Borrowings	19.2	(187)	(168)
Provisions	20	(217)	(195)
Other liabilities	19.1	(1,491)	(1,807)
Total current liabilities		**(59,304)**	**(52,398)**
Total assets less current liabilities		**166,148**	**138,392**
Non-current liabilities			
Trade and other payables	19	(259)	(909)
Borrowings	19.2	(3,999)	(66)
Provisions	20	(186)	(204)
Total non-current liabilities		**(4,444)**	**(1,179)**
Total assets employed		**161,704**	**137,213**
Financed by			
Public dividend capital		440,760	390,517
Revaluation reserve	24	5,446	3,139
Income and expenditure reserve		(284,502)	(256,443)
Total taxpayers' equity		**161,704**	**137,213**

The accompanying notes form part of these accounts.

The financial statements on 191 to 246 were approved by the Board on 25 June 2026 and signed on its behalf by:

Professor Lesley Dwyer
Group Chief Executive

25 June 2026

Statement of Changes in Taxpayers' Equity for the year ended 31 March 2026

	Public dividend capital	Revaluation reserve	Income and expenditure reserve	Total
	£'000	£'000	£'000	£'000
Taxpayers' equity at 1 April 2025 - brought forward	**390,517**	**3,139**	**(256,443)**	**137,213**
Surplus / (deficit) for the year	-	-	(28,059)	(28,059)
Revaluations	-	2,307	-	2,307
Public dividend capital received	53,298	-	-	53,298
Public dividend capital repaid	(3,055)	-	-	(3,055)
Taxpayers' equity at 31 March 2026	**440,760**	**5,446**	**(284,502)**	**161,704**

Statement of Changes in Taxpayers' Equity for the year ended 31 March 2025

	Public dividend capital	Revaluation reserve	Income and expenditure reserve	Total
	£'000	£'000	£'000	£'000
Taxpayers' equity at 1 April 2024	**315,107**	**818**	**(173,363)**	**142,562**
Surplus / (deficit) for the year	-	-	(83,080)	(83,080)
Revaluation	-	2,321	-	2,321
Public dividend capital received	75,410	-	-	75,410
Taxpayers' equity at 31 March 2025	**390,517**	**3,139**	**(256,443)**	**137,213**

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 on 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. A charge, reflecting the cost of capital utilised by the Trust, is payable to the Department of Health 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 asset valuations are charged to the revaluation reserve to the extent that a 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

	Note	2025/26 £'000	2024/25 £'000
Cash flows from operating activities			
Operating surplus / (deficit)		(24,529)	(79,789)
Non-cash income and expense:			
Depreciation and amortisation	5	12,918	11,811
Net impairments	7	29,732	47,206
Income recognised in respect of capital donations	13.6	(1,098)	(3,371)
(Increase) / decrease in receivables and other assets		(245)	420
(Increase) / decrease in inventories		(61)	390
Increase / (decrease) in payables and other liabilities		2,605	14,332
Increase / (decrease) in provisions		(3)	36
Other movements in operating cash flows		-	-
Net cash flows from / (used in) operating activities		**19,319**	**(8,965)**
Cash flows from investing activities			
Interest received		994	910
Purchase of intangible assets		(5,191)	-
Purchase of PPE and investment property		(50,586)	(69,129)
Sales of PPE and investment property		56	-
Net cash flows used in investing activities		**(54,727)**	**(68,219)**
Cash flows from financing activities			
Public dividend capital received		53,298	75,410
Public dividend capital repaid		(3,055)	-
Capital element of lease rental payments		(234)	(453)
Interest paid on lease liability repayments		(62)	(11)
PDC dividend (paid) / refunded		(4,479)	(4,188)
Cash flows from (used in) other financing activities		15	1
Net cash flows from / (used in) financing activities		**45,483**	**70,759**
Increase / (decrease) in cash and cash equivalents		**10,075**	**(6,425)**
Cash and cash equivalents at 1 April 2025		**21,974**	**28,399**
Cash and cash equivalents at 31 March 2026		**32,049**	**21,974**

The accompanying notes form part of these financial statements

Notes to the accounts

Note 1 Accounting policies and other information

Note 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 2025/26 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.

Note 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.

Note 1.3 Critical judgements and estimates in applying accounting policies

The following are the judgements and estimations that management have made in applying the Trust's accounting policies and that have a material 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 desk-top valuation was undertaken for 2025/26 by professional Chartered Surveyors Montagu Evans as at 31 March 2026. A full site valuation was done for 2024/25.

The hospital roof is affected by issues with failing roof planks which will require substantial expenditure over the next one to six 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 six 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 £29.7m (31 March 2025 £47.2m) 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 1.6% 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.

Note 1.4 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.

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 the Best Practice Tariff (BPT) scheme. Delivery under the scheme is part of how care is provided to patients. As such 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 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.

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.

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.

Note 1.5 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.

Note 1.6 Expenditure on employee benefits

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.

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 employers, 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 and when 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.

Note 1.7 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.

Note 1.8.1 Recognition

Property, plant and equipment is capitalised where:

- It is held for use in delivering services or for administrative purposes
- It is probably that future economic benefits will flow to, or service potential 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 cost of more than £250, where the assets are functionally interdependent, had broadly simultaneous purchase dates, are anticipated to have similar disposal dates and are under single managerial control;

Or:

- Assets which are capital in nature, but which are individually valued at less than £5,000 but more than £250, may be capitalised as collective or 'grouped' assets where they are acquired as part of the initial setting up of a new building.

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 lives.

Note 1.8.2 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.

Note 1.8.3 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 (ie 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 modem equivalent asset basis

Current values in existing use is defined as market value except where a building is so specialised in nature no active market exists from which to draw satisfactory transactional evidence. In this case a valuer will adopt a depreciated replacement cost (DRC) model on a modern equivalent asset (MEA) basis. A DRC model estimates current value in existing use 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. 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 2026 and 31 March 2025.

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.

Note 1.8.4 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.

Note 1.8.5 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'.

Note 1.8.6 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 expenditure 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 were appointed as the valuer to the Trust in 2021. Montagu Evans conducted a desktop valuation of the land and buildings at 31 March 2026 and a full valuation at 31 March 2025. The valuation has resulted in an impairment of £29.7m being recognised in the accounts at 31 March 2026.

Note 1.8.7 Derecognition

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 useful life is adjusted. The asset is de-recognised when scrapping or demolition occurs.

Note 1.8.8 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.

Note 1.8.9 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	6	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 1-6 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 6 years with remedial work being undertaken as necessary.

Note 1.9 Intangible assets

Note 1.9.1 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.

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.

Note 1.9.2 Measurement

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 is defined as market value except where a building is so specialised in nature no active market exists from which to draw satisfactory transactional evidence. In this case a valuer will adopt a depreciated replacement cost (DRC) model on a modern equivalent asset (MEA) basis. A DRC model estimates current value in existing use 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. 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. Assets held at depreciated replacement cost have been valued on an alternative site basis where this would meet the location requirements.

Properties in the course of construction for service or administration purposes are carried at cost, less any impairment loss. Cost includes professional fees and, where capitalised in accordance with IAS 23, borrowings costs. Assets are revalued and depreciation commences when the assets 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.

Note 1.9.3 Impairment

Where indicators of impairment exist, the recoverable amount is assessed as the higher of its fair value and the cost to replace the service capacity. Where this is lower than the carrying value an impairment is recognised in expenditure. The recoverable amount of intangible assets under construction is assessed annually, irrespective of indicators of impairment.

Intangible assets are amortised over their expected useful lives in a manner consistent with the consumption of economic or service delivery benefits.

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

Note 1.10 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.

Note 1.11 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 3 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.

Cash, bank and overdraft balances are recorded at current values.

Note 1.12 Financial assets and financial liabilities

Note 1.12.1 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 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, ie, when receipt or delivery of the goods or services is made.

Note 1.12.2 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.

Note 1.12.3 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.

Note 1.12.4 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 1) and subsequently at an amount equal to lifetime expected credit losses if the credit risk assessed for the financial asset significantly increases (stage 2).

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.

Note 1.12.5 Derecognition

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.

Note 1.13 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.

Note 1.13.1 The Trust as lessee

Recognition and initial 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 4.81% applied to new leases commencing in 2025 and 5.32% to new leases commencing in 2026.

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.

Note 1.13.2 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.

Note 1.14 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 from 31 March 2026:

		Nominal rate	Prior year rate
Short-term	Up to 5 years	3.64%	4.26%
Medium-term	After 5 years up to 10 years	4.22%	4.03%
Long-term	After 10 years up to 40 years	5.32%	4.72%
Very long-term	Exceeding 40 years	5.07%	4.40%

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 1	2.5%	2.6%
Year 2	2.0%	2.3%
Into perpetuity	2.0%	2.0%

Early retirement provisions and injury benefit provisions both use the HM Treasury's post-employment benefits discount rate of 2.95% in real terms (prior year: 2.40%).

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 21 but is not recognised in the Trust's accounts.

Non-clinical risk pooling

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.

Note 1.15 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 27 where an inflow of economic benefits is probable.

Contingent liabilities are not recognised, but are disclosed in Note 27.

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.

Note 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 organisation. 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 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.

Note 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.

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.

Note 1.18 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.

Note 1.19 Third party assets

Assets belonging to third parties in which the Trust has no beneficial interest (such as money held on behalf of patients) are not recognised in the accounts. However, they are disclosed in a separate note to the accounts in accordance with the requirements of HM Treasury's FreM.

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, which are reported at the point the loss crystallises.

Note 1.20 Early adoption of standards, amendments and interpretations

No new accounting standards or revisions to existing standards have been early adopted in 2025/26.

Note 1.21 Standards, amendments and interpretations in issue but not yet effective or adopted

The DHSC GAM did not require the following IFRS Standard to be applied in 2025/26:

IFRS 18 Presentation and Disclosure in Financial Statements - The Standard has been adopted by the UK Endorsement Board to be effective for accounting periods beginning on or after 1 January 2027. The Standard has not yet been adopted by the FReM and early adoption is not permitted. The expected impact of applying the standard in future periods has not yet been assessed.

The following future changes to adaptations and interpretations of IAS 16 for the public sector are also not yet adopted:

Changes to valuation of property, plant and equipment (PPE) assets - The DHSC GAM for 2026/27 and associated consultation response document confirms future changes which will affect the financial statements.

From 2026/27 NHS bodies' valuation methodology will be a mandated quinquennial revaluation frequency (or rolling programme) supplemented by annual indexation in the intervening years. The requirement in IAS 16 to revalue an asset when its fair value differs materially from its carrying value is being withdrawn for the public sector. Given the variation in PPE valuations in any given year, and future changes in indices, it is not possible to quantify the impact of applying these changes in future periods.

Note 2 Operating segments

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 £347.5m (2024/25 £298.6m) and are reported within the single healthcare segment.

Note 3 Operating income from patient care activities

Note 3.1 Income from patient care activities (by nature)

	2025/26 £'000	2024/25 £'000
Acute services		
Income from commissioners under API contracts - variable element[*]	74,190	67,083
Income from commissioners under API contracts - fixed element[†]	221,066	149,328
High-cost drugs income from commissioners	19,321	18,814
Other NHS clinical income	17,869	49,370
Private patient income	205	82
National pay award central funding[‡]	-	765
Additional pension contribution central funding[§]	13,822	12,979
Other clinical income	1,080	196
Total income from activities	**347,553**	**298,617**

[*] Aligned payment and incentive contracts are the main form of contracting between NHS providers and their commissioners. More information can be found in the 2025/26 NHS Payment Scheme documentation at https://www.england.nhs.uk/pay-syst/nhs-payment-scheme/

[†]Non-recurrent deficit support funding of £22.5m is included within API contracts fixed element.

[‡] Increases to the employer contribution rates for NHS pensions since 1 April 2019 have been funded by NHS England. NHS providers continue to pay at the former rate of 14.38% with the additional amount being paid over by NHS England on providers' behalf. The full cost of employer contributions (23.7%) and related NHS England funding (9.4%) have been recognised in these accounts.

[§] Additional funding was made available directly to providers by NHS England in 2024/25 for implementing the backdated element of pay awards where government offers were finalised after the end of the 2023/24 financial year. NHS Payment Scheme prices and API contracts are updated for the weighted uplift in in-year pay costs when awards are finalised.

Note 3.2 Income from patient care activities (by source)

	2025/26 £'000	2024/25 £'000
Income from patient care activities received from:		
NHS England	26,340	25,147
Integrated care boards	318,151	270,619
Other NHS providers	1,777	2,573
Non-NHS: private patients	205	82
Non-NHS: overseas patients (chargeable to patient)	73	-
Injury cost recovery scheme	499	196
Non NHS: other	508	-
Total current assets	**347,553**	**298,617**

Note 3.3 Overseas visitors (relating to patients charged directly by the provider)

	2025/26 £'000	2024/25 £'000
Cash payments received in-year	-	47
Amounts written off in-year	-	293

Note 4 Other operating income

	2025/26			2024/25		
	Contract income	Non-contract income	Total	Contract income	Non-contract income	Total
	£'000	£'000	£'000	£'000	£'000	£'000
Research and development	1,244	-	**1,244**	640	-	**640**
Education and training	12,118	728	**12,846**	11,337	882	**12,219**
Non-patient care services to other bodies	2,254	-	**2,254**	3,819	-	**3,819**
Receipt of capital grants and donations and peppercorn leases	-	1,098	**1,098**	-	3,371	**3,371**
Other income**	3,552	-	**3,552**	6,757	-	**6,757**
Total other operating income	**19,168**	**1,826**	**20,994**	**22,553**	**4,253**	**26,806**

Note 5 Operating expenses

	2024/25	2023/24
	£'000	£'000
Purchase of healthcare from NHS and DHSC bodies	11,619	11,237
Purchase of healthcare from non-NHS and non-DHSC bodies	9,362	5,878
Staff and executive directors' costs	249,867	248,215
Remuneration of non-executive directors	120	193
Supplies and services – clinical (excluding drug costs)	18,587	20,798
Supplies and services – general	4,163	4,046
Drug costs (drugs inventory consumed and purchase of non-inventory drugs)	28,933	28,675
Consultancy costs	92	1,488
Establishment	1,832	1,767
Premises	10,881	10,322
Transport (including patient travel)	1,038	970
Depreciation on property, plant and equipment	12,836	11,729
Amortisation on intangible assets	82	82
Net impairments	29,732	47,206
Movement in credit loss allowance: contract receivables / contract assets	257	99
Increase/(decrease) in other provisions	(7)	-
Change in provisions discount rate(s)	(6)	(9)
Fees payable to the external auditor for statutory audit	244	213
Internal audit costs	88	164
Clinical negligence	6,987	6,123
Legal fees	813	342
Insurance (as a policy holder)	339	319
Education and training	1,431	1,493
Expenditure on short term leases	50	25
Redundancy	109	-
Car parking and security	67	29
Losses, ex gratia and special payments	14	114
Other services e.g. external payroll	3,546	3,694
Other	-	-
Total	**393,076**	**405,212**

Note 5.1 Limitation on auditor's liability

The limitation on auditor's liability for external audit work is £1m (2024/25: £1m)

Note 6 Reconciliation of liabilities arising from financing activities

	31 March 2026 Lease liabilities	31 March 2025 Lease liabilities
	£'000	£'000
Carrying value at 1 April:	235	413
Financing cash flows - payments and receipts of principal	(234)	(451)
Financing cash flows - payments of interest	(62)	(11)
Additions:	4,186	284
Non-cash movements	**4,125**	**235**

Note 7 Impairment of assets

	2025/26	2024/25
	£'000	£'000
Net impairments charged to operating surplus / deficit resulting from:		
Loss or damage from normal operations	49	-
Other	29,683	47,206
Total net impairments charged to operating surplus / deficit	29,732	47,206
Impairments charged to the revaluation reserve	-	-
Total net impairments	**29,732**	**47,206**

Note 8 Employee benefits

	2025/26 £'000	2024/25 £'000
Salaries and wages	189,236	190,105
Social security costs	24,585	19,506
Apprenticeship levy	728	882
Employer's contributions to NHS pensions	34,954	32,800
Pension cost - other	460	31
Termination benefits	491	-
Temporary staff (including agency)	4,489	8,915
Total gross staff costs	**254,943**	**252,239**
Recoveries in respect of seconded staff	-	-
Total staff costs	**254,943**	**252,239**
Of which		
Costs capitalised as part of assets	4,967	4,024

Note 8.1 Retirements due to ill health

During 2025/26 there were 7 early retirements from the trust agreed on the grounds of ill health (none in the year ended 31 March 2025). The estimated additional pension liabilities of these ill-health retirements is £77k (£0 in 2024/25).

These estimated costs are calculated on an average basis and will be borne by the NHS Pension Scheme.

Note 9 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 2026, is based on valuation data as at 31 March 2023, updated to 31 March 2026 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.

The latest assessment of the liabilities of the scheme is contained in the Statement by the Actuary, which forms part of the annual NHS Pension Scheme Annual Report and Accounts. These accounts can be viewed on the NHS Pensions website and are published annually. Copies can also be obtained from The Stationery Office.

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 (considering recent demographic experience), and to recommend the contribution rate payable by 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 1 April 2024 at 23.7% of pensionable pay. 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.

The 2024 actuarial valuation is currently being prepared and will be published before new contribution rates are implemented from April 2027.

Note 10 Finance income

Finance income represents interest received on assets and investments in the period.

	2025/26	2024/25
	£'000	£'000
Interest on bank accounts	994	909
Total finance income	**994**	**909**

Note 10.1 Finance expenditure

Finance expenditure represents interest and other charges involved in the borrowing of money or asset financing.

	2025/26	2024/25
	£'000	£'000
Interest expense:		
Interest on right of use assets	69	6
Total interest expense	**69**	**6**
Unwinding of discount on provisions	7	6
Other finance costs	-	-
Total finance costs	**76**	**6**

Note 10.2 The late payment of commercial debts (interest) Act 1998

	2025/26	2024/25
	£'000	£'000
Total liability accruing in year under this legislation as a result of late payments	-	-
Amounts included within interest payable arising from claims made under this legislation	-	-
Compensation paid to cover debt recovery costs under this legislation	-	-

Note 11 Other gains / (losses)

	2025/26	2024/25
	£'000	£'000
Gains on disposal of assets	57	-
Losses on disposal of assets	-	(39)
Total other gains / (losses)	**57**	**(39)**

Note 12 Intangible assets

Note 12.1 Intangible assets 2025/26

	Software licenses	Intangible assets under construction	Total
	£'000	£'000	£'000
Cost at 1 April 2025	**1,454**	**10,563**	**12,017**
Additions	10	5,181	5,191
Cost at 31 March 2026	**1,464**	**15,744**	**17,208**
Amortisation at 1 April 2025	**1,069**	**-**	**1,069**
Provided during the year	82	-	82
Amortisation at 31 March 2026	**1,151**	**-**	**1,151**
Net book value at 31 March 2026	**313**	**15,744**	**16,057**
Net book value at 1 April 2025	**385**	**10,563**	**10,948**

Note 12.2 Intangible assets 2024/25

	Software assets	Intangible assets under construction	Total
	£'000	£'000	£'000
Cost at 1 April 2024	**1,454**	**-**	**1,454**
Additions / reclassifications from PPE	-	10,563	10,563
Cost at 31 March 2025	**1,454**	**10,563**	**12,017**
Amortisation at 1 April 2024	**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**

Note 13 Property, plant and equipment
Note 13.1 Property, plant and equipment 2025/26

	Land	Buildings	Assets under construction	Plant and machinery	Transport equipment	Information technology	Total
	£'000	£'000	£'000	£'000	£'000	£'000	£'000
Valuation / gross cost at 1 April 2025 – brought forward	**4,169**	**126,971**	**17,216**	**60,599**	**106**	**31,278**	**240,339**
Additions	-	-	54,712	582	-	-	**55,294**
Impairments	-	(8,977)	(20,755)	-	-	-	**(29,732)**
Revaluations	38	2,269	-	-	-	-	**2,307**
Reclassifications	-	21,743	(25,654)	2,626	30	1,255	**-**
Transfers to / from assets held for sale	-	-	-	-	-	-	**-**
Disposals / derecognition	-	(6,719)	-	(9,239)	-	(2,848)	**(18,806)**
Valuation / gross cost at 31 March 2026	**4,207**	**135,287**	**25,519**	**54,568**	**136**	**29,685**	**249,402**
Accumulated depreciation at 1 April 2025 – brought forward	**-**	**36,911**	**-**	**37,789**	**105**	**20,197**	**95,002**
Provided during the year	-	5,945	-	4,328	5	2,311	**12,589**
Disposals / derecognition	-	(6,719)	-	(9,239)	-	(2,848)	**(18,806)**
Accumulated depreciation at 31 March 2026	**-**	**36,137**	**-**	**32,878**	**110**	**19,660**	**88,785**
Net book value at 31 March 2026	**4,207**	**99,150**	**25,519**	**21,690**	**26**	**10,025**	**160,617**
Net book value at 1 April 2025	**4,169**	**90,060**	**17,216**	**22,810**	**1**	**11,081**	**145,337**

Note 13.2 Property, plant and equipment 2024/25

	Land	Buildings excluding dwellings	Assets under construction	Plant and machinery	Transport equipment	Information technology	Total
	£'000	£'000	£'000	£'000	£'000	£'000	£'000
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**
Impairments	-	(25,878)	(21,328)	-	-	-	**(47,206)**
Revaluations	-	2,321	-	-	-	-	**2,321**
Reclassifications	-	44,614	(47,381)	1,929	-	838	**-**
Reclassification to intangible assets	-	-	(10,563)	-	-	-	**(10,563)**
Disposals / derecognition	-	-	-	(61)	-	-	**(61)**
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	-	4,675	-	2,149	**11,261**
Disposals / derecognition	-	-	-	(22)	-	-	**(22)**
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**	**-**	**146,655**

Note 13.3 Property, plant and equipment financing - 31 March 2026

	Land	Buildings excluding dwellings	Assets under construction	Plant and machinery	Transport equipment	Information technology	Total
	£'000	£'000	£'000	£'000	£'000	£'000	£'000
Owned – purchased	4,207	99,150	25,519	21,690	26	10,080	**160,672**
Total net book value at 31 March 2025	**4,207**	**99,150**	**25,519**	**21,690**	**26**	**10,025**	**160,617**

Note 13.4 Property, plant and equipment financing - 31 March 2025

	Land	Buildings excluding dwellings	Assets under construction	Plant and machinery	Transport equipment	Information technology	Total
	£'000	£'000	£'000	£'000	£'000	£'000	£'000
Owned – purchased	4,169	85,162	17,216	20,388	1	10,730	**137,666**
Owned – donated	-	4,898	-	2,422	-	351	**7,671**
Total net book value at 31 March 2025	**4,169**	**90,060**	**17,216**	**22,810**	**1**	**11,081**	**145,337**

Note 13.5 Revaluations of property, plant and equipment

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 £29.7m to the carrying value of the land and buildings which has been taken to the SOCIE.

Note 13.6 Donations of property, plant and equipment

	31 March 2026	31 March 2025
	£'000	£'000
Land and buildings	514	1,375
IT equipment	-	6
Medical equipment	584	1,990
	1,098	**3,371**

Note 14 Right of use assets - 2025/26

	Property (Land and buildings)	Plant and machinery	Transport equipment	Total
	£'000	£'000	£'000	£'000
Valuation/gross cost at 1 April 2025	**99**	**714**	**-**	**813**
Additions	3,795	391	-	**4,186**
Disposals / derecognition	-	(14)	-	**(14)**
Valuation/gross cost at 1 April 2026	**3,894**	**1,091**	**-**	**4,985**
Accumulated depreciated at 1 April 2025	33	549	-	**582**
Provided during the year	247	-	-	**247**
Accumulated depreciation at 31 March 2026	**280**	**549**	**-**	**829**
Net book value at 31 March 2026	**3,614**	**542**	**-**	**4,156**
Net book value at 31 March 2025	**66**	**165**	**-**	**231**

Note 14.1 Right of use assets - 2024/25

	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 / derecognition	-	-	(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**

Note 15 Reconciliation of the carrying value of lease liabilities

	2025/26	2024/25
	£'000	£'000
Carrying value at 1 April	**234**	**413**
	4,186	285
Interest charge arising in year	62	-
Lease payments (cash outflows)	(296)	(464)
	4,186	**234**

Lease payments for short term leases, leases of low value underlying assets and variable lease payments not dependent on an index or rate are recognised in operating expenditure.

These payments are disclosed in Note 6. Cash outflows in respect of leases recognised on SoFP are disclosed in the reconciliation above.

Note 15.1 Maturity analysis of future lease payments

	Total 31 March 2026	of which leases from DHSC group bodies: 31 March 2026	Total 31 March 2025	of which leases from DHSC group bodies: 31 March 2025
	£'000	£'000	£'000	£'000
Undiscounted future lease payments payable in:				
not later than one year	187	187	168	-
later than one year and not later than five years	3,999	3,608	66	-
later than five years	-	-	-	-
Total gross future lease payments	**4,186**	**3,795**	**234**	**-**
Finance charges allocated to future periods	-	-	-	-
Net lease liabilities at 31 March 2026	**4,186**	**3,795**	**234**	**-**

Note 16 Inventories

	31 March 2026	31 March 2025
	£'000	£'000
Drugs	1,734	1,639
Consumables	1,450	1,466
Energy	124	142
Total inventories	**3,308**	**3,247**
Of which:		
Held at fair value less cost to sell	-	-

Note 17 Receivables

	31 March 2026	31 March 2025
	£'000	£'000
Current		
Contract receivables	5,123	3,179
Allowance for impaired contract receivables	(896)	(639)
Prepayments (non-PFI)	3,196	3,660
PDC dividend receivable	-	33
VAT receivable	222	812
Other receivables	1,106	1,617
Total current receivables	**8,751**	**8,662**
Non-current		
Contract receivables	514	391
Total non-current receivables	**514**	**391**
Of which receivable from NHS and DHSC group bodies:		
Current	**4,559**	**2,741**
Non-current	**-**	**-**

Note 17.1 Allowances for credit losses

	2025/26 Contract receivables and contract assets £'000	2024/25 Contract receivables and contract assets £'000
Allowances as at 1 April	**639**	**833**
New allowances arising	257	99
Utilisation of allowances (write offs)	-	(293)
Changes arising following modification of contractual cash flows	-	-
Allowances as at 31 March 2026	**896**	**639**

Note 17.2 Exposure to credit risk

In assessing the required expected credit loss (ECL), the Trust takes a number of factors into account, including historic, current, and forward looking information. Factors include the age of the debt, past history of losses with a particular debtor (either individually or as a group with similar characteristics), and any known factors which may increase the likelihood of default for a particular debtor. There is no expected credit loss at 31 March 2026.

Note 18 Cash and Cash equivalents

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.

	2025/26 £'000	2024/25 £'000
At 1 April	**21,974**	**28,399**
Net change in year	10,075	(6,425)
At 31 March	**32,049**	**21,974**
Broken down into:		
Cash at commercial banks and in hand	129	120
Cash with the Government Banking Service	31,920	21,854
Total cash and cash equivalents as in the Statement of Financial Position	**32,049**	**21,974**
Total cash and cash equivalents as in the Statement of Cashflows	**32,049**	**21,974**

Note 18.1 Third 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 2026	31 March 2025
	£'000	£'000
Bank balances	1	4
Monies on deposit	-	-
Total third-party assets	**1**	**4**

Note 19 Trade and other payables

	31 March 2026	31 March 2025
	£'000	£'000
Current		
Trade payables	23,678	19,659
Capital payables	7,647	3,387
Accruals	17,753	19,696
Social security costs	2,609	2,205
Other taxes payable	2,684	2,550
Pension contributions payable	2,916	2,721
Other payables	122	10
Total current trade and other payables	**57,409**	**50,228**
Non-current		
Trade payables	-	-
Accruals	259	909
Total current trade and other payables	**259**	**909**
Of which payables from NHS and DHSC group bodies:		
Current	12,779	11,643
Non-current	-	-

Note 19.1 Other liabilities

Other liabilities are deferred incomes for contract liabilities.

Note 19.2 Borrowings

Borrowings relate fully to lease liabilities.

Note 20 Provisions for liabilities and charges analysis

	Pensions: early departure costs	Pensions: injury benefits	Other	Total
	£000	£000	£000	£000
At 1 April 2025	**37**	**204**	**158**	**399**
Change in the discount rate	3	(9)	-	**(6)**
Arising during the year	12	17	20	**49**
Utilised during the year	(16)	(30)	-	**(46)**
Reversed unused	-	-	-	**-**
Unwinding of discount	1	6	-	**7**
At 31 March 2026	**37**	**188**	**178**	**403**
Expected timing of cash flows:				
Not later than one year;	13	26	178	217
Later than one year and not later than five years	24	162	-	186
Later than five years	-	-	-	-
Total	**37**	**188**	**178**	**403**

Provisions relate to claims for staff injury and early retirement.

Note 21 Clinical negligence liabilities

At 31 March 2026, £69,425K 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 2025: £75,801K).

Note 22 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 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. 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 within the Trust's standing financial instructions and policies agreed by the Board of Directors.

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.

Credit risk

As 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 exposure at 31 March is in receivables from customers, as disclosed in the receivables note.

Interest rate risk

The Trust is not exposed to interest rate risk as it does not hold any borrowings or investments.

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.

Note 22.1 Carrying values of financial assets

All financial assets held by the Trust are classified in the category 'held at amortised cost'. The carrying value shown below is consistent with the fair value of the assets.

	31 March 2026	31 March 2025
	£'000	£'000
Trade and other receivables excluding non-financial assets	6,646	3,138
Cash and cash equivalents	32,049	21,974
Total at 31 March	**38,695**	**25,112**

Note 22.2 Carrying values of financial liabilities

	31 March 2026	31 March 2025
	£'000	£'000
Obligations under leases	4,186	234
Trade and other payables	54,743	48,398
Provisions under contract	-	-
Total at 31 March	**58,929**	**48,632**

Note 22.3 Maturity of financial liabilities

	31 March 2026	31 March 2025
	£'000	£'000
In one year or less	54,930	47,590
In more than one year but not more than five years	3,999	1,042
Total	**58,929**	**48,632**

Note 23 Losses and special payments

	2025/26		2024/25	
	Total number of cases	Total value of cases	Total number of cases	Total value of cases
	Number	£'000	Number	£'000
Losses				
Overpayment of salary	23	23	31	29
Fruitless payments and constructive losses	24	443	28	277
Bad debts and claims abandoned	-	-	178	293
Total losses	**47**	**466**	**237**	**599**
Special payments				
Compensation under court order or legally binding arbitration award	-	-	5	45
Special severance payments	1	99	-	-
Ex-gratia payments	31	75	28	12
Total special payments	**32**	**174**	**33**	**57**
Total losses and special payments	**159**	**640**	**270**	**656**

Note 24 Revaluation reserve

	31 March 2026		Total 2026	Total 2025
	Land	Buildings	Total	Total
	£'000	£'000	£'000	£'000
Balance at 1 April 2025	**818**	**2,321**	**3,139**	**818**
Revaluations	38	2,269	2,307	2,321
Balance at 31 March 2026	**856**	**4,590**	**5,446**	**3,139**

Note 25 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. Balances that have exceeded 0.5% of turnover have been disclosed. Balances and transactions with other members of the Norfolk and Waveney University Hospital Group have been disclosed in full.

	Income 2025/26	Expenditure 2025/26	Income 2024/25	Expenditure 2024/25
	£'000	£'000	£'000	£'000
Transactions with Board members outside payments for Trust related work	-	-	-	-
HM Revenue and Customs	-	25,313	-	19,506
NHS Pension Scheme	-	35,393	-	19,853
Cambridge University Hospital NHS Foundation Trust	746	1,507	1,096	3,357
Norfolk and Norwich University Hospital NHS Foundation Trust	5,058	11,346	3,638	8,655
NHS Cambridgeshire and Peterborough ICB	42,774	140	41,563	-
NHS Norfolk and Waveney ICB	257,646	190	214,236	-
NHS England	23,690	1,146	23,749	93
NHS Norfolk Community Health and Care Trust	1,792	900	2,426	847
NHS Lincolnshire ICB	16,438	-	16,518	-
NHS Resolution	-	7,212	-	6,547
James Paget University Hospitals NHS Foundation Trust	237	171	151	477

Salaries paid to non-executive and executive directors are included in the operating expenses note.

Remuneration of key management personnel

Disclosure of compensation and other transactions with management and Board members is made in the Remuneration Report. All transactions with management and Board members were made in the ordinary course of the Trust's operations. All transactions with parties related to Government Ministers were also made in the ordinary course of the Trust's operations.

	Receivables 31 March 2026 £'000	Payables 31 March 2026 £'000	Receivables 31 March 2025 £'000	Payables 31 March 2025 £'000
HM Revenue and Customs	-	5,413	-	1,569
NHS Pension Scheme	-	2,916	-	1,638
Cambridge University Hospital NHS Foundation Trust	138	126	-	328
Norfolk and Norwich University Hospital NHS Foundation Trust	589	10,303	327	4,730
NHS Cambridgeshire and Peterborough ICB	5	95	5	4
NHS Norfolk and Waveney ICB	2,681	22	119	2,806
NHS England	66	1,141	-	238
NHS Norfolk Community Health and Care Trust	516	518	1,408	459
NHS Resolution	-	-	-	-
James Paget University Hospitals NHS Foundation Trust	16	132	11	153

The Trust has also received revenue and capital payments amounting to £732k (£1,969k 2024/25 from The Queen Elizabeth Hospital King's Lynn Trust Charitable Fund, the Trustees of which make up the Trust Board.

At 31 March 2026 £43k (2025: £414k) was owed to the Trust by the Charitable Fund.

Note 26 Capital Commitments

The Trust has £30.2m (2025: £26.8m) of contractual capital commitments at 31 March 2026 predominantly related to intangible assets, building schemes in progress and our involvement in the New Hospital Programme.

Note 27 Contingent Liabilities and Assets

The Trust has no contingent liabilities or assets at 31 March 2026.

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