Queen Victoria Hospital
NHS Foundation Trust

QUEEN VICTORIA HOSPITAL
NHS FOUNDATION TRUST

Annual Report and Accounts 2024/25

QUEEN VICTORIA HOSPITAL NHS FOUNDATION TRUST

Annual Report and Accounts 2024/25

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

CONTENTS

1 Introduction

Chair's introduction

I am pleased to be able to introduce the 2024/25 Annual Report and Accounts for Queen Victoria Hospital NHS Foundation Trust (QVH). This Annual Report is testament to the hard work of everyone at QVH, whether in a clinical or non-clinical role. Once again, the dedication of our colleagues has been exceptional during the last year and this is reinforced by the delivery of the high quality care that we have provided for our patients.

In the latest Care Quality Commission Adult Inpatient Survey our patients rated their overall experience of care at QVH as the best in the country. The two areas where QVH excelled were in questions specifically about nurses and the experience of our patients leaving hospital. In the latest NHS National Cancer Patient Experience Survey in response to the statement the "Patient was always able to discuss worries and fears with hospital staff" was positive.

I would like to thank our governors and Board members, old and new, for their dedication to ensure that we do the very best for our patients and staff. This year we have welcomed to the Board Edmund Tabay as Chief Nursing Officer and Tamara Everington as Chief Medical Officer. We have said goodbye to Nicky Reeves who retired following a 40 year career in nursing and to Karen Norman who served as one of our Non-executive directors for six years, and most recently our Senior independent director. We also welcomed Jo Emmanuel as Non-Executive Director, along with Aleema Shivji and Vivek Chaudhri as our Associate Non-Executive Directors. I was pleased to welcome several new governors who joined our Council of Governors during the year.

Our people are our greatest asset and it is important that we take the time to hear and learn from our colleagues' experience of working here. In the NHS Staff Survey 2024 93% of our colleagues said they would recommend the care the Trust provides to family or friends. When asked if care was our top priority 88.7% of those who responded agreed and 76.3% said they would recommend QVH as a place to work. We saw some key improvements around colleagues feeling encouraged by their immediate manager, having a better work life balance and teams meeting more often to discuss their effectiveness. However, we are also aware there are areas where we can improve to help us more effectively ensure that all of our staff feel included, supported and valued.

I would like to extend my thanks to our volunteers who give their time to support our patients and services. I would also like to acknowledge the important work of our QVH Charity and League of Friends of Queen Victoria Hospital who support a range of initiatives for patients and staff outside of core NHS funding. Thank you.

In our last Annual Report I spoke about the development of our new QVH strategy 2025-2030 and I am pleased to say that this was approved at our public Board meeting in November 2024.

Shaped and co-produced with over 3,000 patients and a wide variety of stakeholders from across Kent, Surrey and Sussex, the *QVH Strategy 2025-2030* sets out our refreshed vision, values, key strategic objectives and future focus and direction. It includes our ambitions for QVH's patient services and the key enablers to help us deliver our strategy.

Through our strategy we recognise the importance of being agile and dynamic, and with the changing national context, we will be focusing on how we can deliver it in line with the evolving NHS priorities.

There are challenges ahead, but there are also many opportunities which we will embrace as we continually strive to provide the best care we can for our patients.

Jackie Smith

Trust Chair

26 June 2025

2. The performance report

Overview of performance

The Performance Report provides information about Queen Victoria Hospital NHS Foundation Trust and its main objectives, and outlines how the Trust performed during the year 2024/25.

Statement from the Chief Executive Officer

Queen Victoria Hospital NHS Foundation Trust (QVH) has not been alone in navigating a year of challenges in an ever-changing healthcare environment. As always, our staff have worked tirelessly to provide safe, compassionate and high quality care to our patients.

A key focus across the NHS in the last 12 months has been to reduce the elective care backlog and enhance efficiency. Opened in March, our Local Anaesthetic Unit for minor operations has allowed us to prioritise more complex surgeries in our main theatres and increase the number of patients we were able to treat. We are now exploring options to expand this further to accommodate a wider range of patient activity. QVH also played a key role in supporting the Sussex healthcare system by offering mutual aid to help reduce the number of patients waiting over 65 weeks for their treatment. In the second half of the year 110 patients from University Hospitals Sussex chose to transfer to QVH for treatment.

The number of patients referred to QVH on an urgent suspected cancer pathway rose by 12% for skin cancer and 8.9% for head and neck cancer. Meeting the 62-day treatment target proved challenging with performance at 77.3% in Q4, affected by late referrals and complex patient pathways. However, QVH remained in the top quartile for cancer performance across the South East Region and consistently met the Faster Diagnosis Standard, achieving 85.2% in Q4 against a national target of 75%. We continue to work closely with the Surrey and Sussex Cancer Alliance to improve efficiency and patient outcomes.

Our Minor Injuries Unit also experienced an increase in the number of patients needing timely and effective care. We consistently exceeded the national target of 95% for the 4-hour standard, maintaining 99%+ compliance across all quarters. Our diagnostic waiting times and activity (DMO1) performance also exceeded national and regional averages, meeting the 95% national target for 6 out of the 12 months despite the challenges of increased demand and workforce constraints.

A significant milestone has been the launch of the *QVH Strategy 2025-2030* in November 2024. Shaped and co-produced with over 3,000 patients, volunteers, staff, health and care partners, a wide variety of stakeholders from across Kent, Surrey and Sussex, and supported by a considerable amount of data, it sets out our refreshed organisation vision, values, strategic objectives, future focus and direction. Through our strategy we recognised the importance of being agile and dynamic and this has never been more important than it will be in the coming year, one of the most challenging in the history of the NHS.

We want QVH to be the best hospital it can be. In the last year we have embarked on a three year programme of developing and embedding *The QVH Way*, a bespoke continuous improvement programme to help us consistently improve how we deliver care and services. It is already helping us drive meaningful and sustainable improvements that enhance patient care and organisational performance. During the year we also introduced a new integrated

quality and performance framework to improve access to performance information and progress against our strategic objectives from directorate to Board level.

Our workforce remains one of our greatest strengths. In the latest NHS Staff Survey 93% of our colleagues would recommend our care to family and friends. While 76.3% of staff would endorse QVH as a good place to work, we are aware we have areas needing improvement, particularly around inclusivity, staff feeling valued, and fostering an environment where employees feel safe to speak up.

Financially, we delivered a breakeven position in 2024/25, however the changing landscape and evolving expectations across the NHS mean financial sustainability remains a priority for the coming year as we look to make significant efficiency savings, reduce corporate costs and navigate inflationary pressures.

As we look ahead, we remain committed to delivering high-quality care, advancing our strategic goals, and ensuring that both patients and staff receive the best possible support.

Abigail Jago

Acting Chief Executive Officer

26 June 2025

Purpose and activities of the Trust

Queen Victoria Hospital NHS Foundation Trust (QVH) is a leading specialist centre for reconstruction and sleep. It also provides essential healthcare services for local people.

QVH is a regional and national centre for maxillofacial, reconstructive plastic and corneoplastic (eye) surgery, as well as for the treatment of burns and sleep disorders. It is also a surgical centre for skin cancer, head and neck cancer, and provides microvascular reconstruction services for breast cancer patients following, or in association with, mastectomy.

QVH has links with the operational delivery network for cancer and trauma care covering Kent, Surrey, and Sussex. In addition, it is involved in a number of multidisciplinary teams throughout the region.

In 2024/25, the principal activities of the Trust were the provision of:

- plastic surgery (including reconstructive surgery for those affected by accidents or illness including cancer) and burns care
- corneoplastic surgery and an eye bank
- head, neck, and dental services (including associated cancer surgery, orthognathic surgery and orthodontics)
- sleep disorder services
- a wide range of therapy services, community-based and direct access diagnostic services, and a minor injuries unit.

QVH operates a networked model from its 'hub' hospital site in East Grinstead, West Sussex and 'spoke' facilities at other healthcare sites across Kent, Surrey and Sussex.

History of the Trust and Statutory background

QVH was authorised as one of the country's first NHS foundation trusts in July 2004. A foundation trust is a public benefit corporation providing NHS services in line with the core NHS principles: that care should be universal, comprehensive, and free at the point of need. The Trust is licensed as a foundation trust to provide these services by the independent regulator; NHS England. The services are regulated by the Care Quality Commission.

As a foundation trust, QVH is accountable to local people through its public members across Kent, Surrey, Sussex and the boroughs of South London.

The Trust is corporate trustee to the Queen Victoria Hospital NHS Trust Charitable Fund, also known as QVH Charity. The charitable fund was first registered with the Charity Commission in 1996, registration number 1056120. As corporate trustee, the Trust is responsible for controlling the work, management and administration of the charity on behalf of its beneficiaries who are the hospital, its patients and its staff.

Principal risks and delivery of objectives

In common with all provider trusts, QVH faces continual challenges in balancing the delivery of high-quality patient care with rising demand, increasing complexity of healthcare needs, and the ongoing national ask to increase productivity and efficiency. Strategic and transformational change for the Trust, and for the health and care systems within which it operates, will play an important role in addressing operational and financial risks. The Trust faces significant operational and strategic challenges, most notably around waiting lists, resources, and the difficult financial environment. Developing and maintaining collaborative relationships with partner organisations is critical to its future sustainability.

The Trust's eight strategic risks against achieving its key strategic objectives have been the major risks for the organisation during 2024/25. These are set out in more detail within the Annual Governance Statement included within this Annual Report and Accounts.

At the time of writing this report, the Trust has agreed its key strategic objectives and priorities for 2025/26 as quality or care; innovation and improvement; to be an excellent employer; to deliver sustainable services; and to increase and focus on collaboration with others for the benefit of patients.

Going concern disclosure

The Trust has submitted a plan for 2025/26 to generate a breakeven position. As of 31 March 2025 the Trust holds £12.9m of cash reserves and has a forecast cash balance of £1.9m at 31 March 2026. Although lower, this represents the use of cash for capital projects with sufficient cash for ongoing operations.

The Board is confident that there is a reasonable expectation the Trust will continue to have adequate cash resources to service its operational activities in cash terms for the next 12 months and into 2026/27. The impact of changes in the funding and cash regime have been considered for the Trust's plans and projections, including cash flows, liquidity and income base.

After making enquiries, the directors have a reasonable expectation that the services provided by the NHS foundation trust will continue to be provided by the public sector for the foreseeable future. For this reason, the directors have adopted the going concern basis in preparing the accounts, following the definition of going concern in the public sector adopted by HM Treasury's Financial Reporting Manual.

Performance analysis

Measuring performance

During 2024/25, the Trust introduced a new integrated quality and performance framework to facilitate the flow of information from Directorate to Board level, and to collectively report performance monthly across all its 5 key strategic objectives.

Integrated quality and performance meetings are held monthly with key information and insights scrutinised by the Directorate Leadership Teams and the Executive Leadership Team. It is also discussed at the Finance and Performance Committee, Quality and Safety Committee, and at Trust Board

During 2024/25 the Trust introduced a continuous improvement programme called *The QVH Way.* The Executive Leadership Team and directorate teams use weekly team huddles to review performance and suggest future areas for improvement.

Operational performance

2024/25 was a challenging year for the NHS with continued focus on reducing the elective care backlog following the pandemic.

In March 2024, QVH opened a Local Anaesthetic Unit to increase capacity for minor operations and ensure more complex activity utilised its main theatres. Two procedure rooms accommodate non-complex treatments which has successfully enabled the Trust to treat more patients in 2024/25 than in previous years. A number of options are being explored to develop an expanded local anaesthetic unit able to accommodate the full range of local anaesthetic activity. This would further improve the Trust's capacity.

QVH was an early adopter of the community diagnostic centre (CDC) model which delivers a coordinated set of diagnostic tests for patients referred by their general practitioner (GP) closer to home. The aim of the model is to increase access to tests enabling accurate and fast diagnosis on a range of a clinical pathways, in as few visits as possible. The development of a new dedicated modular diagnostic facility is planned for 2025/26. It will enhance the Trust's diagnostic imaging as well as providing additional clinical space for a wide range of physiological and pathology testing. Through clinical pathway redesign, CDCs will also focus on prevention, supporting primary care and community services to better target interventions at those groups most at risk.

Elective waiting times

A key objective for all NHS trusts during 2024/25 was to reduce the number of patients waiting over 65 weeks for treatment. QVH provided mutual aid to the wider Sussex system meaning in the second half of the year, 110 patients who had waited more than 65 weeks chose to transfer from University Hospital Sussex to QVH to be treated. This impacted the number of patients waiting over 52 weeks for treatment at QVH but supported some of the longest waiting patients across Sussex. The Trust's focus on treating the longest waiting patients has also impacted the referral to treatment (RTT) 18 week performance as fewer patients have been treated within 18 weeks.

The Trust had 26 patients waiting over 65 weeks at the yearend in two challenged specialties, an improved position against the forecast. Insourcing solutions and additional recruitment are being explored to achieve a more sustainable solution within these two specialties into 2025/26.

QVH continues to work closely with the Integrated Care Systems to assess performance trends and identify opportunities for improvement.

Elective Care performance

	Quarter 1	Quarter 2	Quarter 3	Quarter 4
Total patients waiting longer than 65 weeks	69	14	73	26
Deliver or exceed activity target of 107%	115%	118%	125%	121%
Increase the proportion of all outpatient attendances attracting a procedure tariff to 46% across 2024/25	44.5%	43.2%	42.4%	44.4%
The metrics below continue to be reported but were not specific targets within the 2024/25 planning guidance				
Referral to treatment (RTT) within 18 weeks (92% standard)	61.9%	57.6%	56.1%	56.5%
Total patients waiting longer than 52 weeks	434	365	501	362
Total waiting list size	18,925	18,907	19,592	18,187

Figures shown are month end for each quarter.

Cancer

During 2024/25 the Trust continued to see a significant increase in the number of patients referred on an urgent suspected cancer pathway (12% increase in skin urgent suspected cancer referrals and an 8.9% increase in head and neck urgent suspected cancer referrals), which has impacted cancer waiting times.

The Trust experienced challenges in meeting the 62 day performance target, impacted by late referrals from other trusts, complex pathways and capacity challenges. As such, the Trust has seen an increase in the number of patients waiting over 62 days for treatment.

Despite the increase in demand, the Trust has continued to perform in the top quartile across the South East Region for 62 day cancer performance and consistently met the Faster Diagnosis target throughout the year.

Improvement plans are in place around key areas of challenge, and the Trust continues to work closely with the Surrey and Sussex Cancer Alliance.

Cancer performance

	Target	Quarter 1	Quarter 2	Quarter 3	Quarter 4*
First definitive treatment within 62 days	Constitutional standard 85% 2024/25 national target 70%	86.3%	79.2%	75.2%	77.3%
Faster diagnosis standard	Constitutional standard/national target 75%	80.5%	79.1%	87.2%	85.2%
	The metrics below continue to be reported but were not specific targets within the 2024/25 planning guidance				
31 day decision to treat	Constitutional standard 96%	87.8%	90.7%	89.2%	84.9%
Total number of patients waiting over 62 days		57	63	72	61

*Figures shown are month end for each quarter * Quarter 4 cancer performance is M11 given reporting is a month in arrears.*

Urgent and Emergency Care performance

The Trust has continued to deliver against the 95% 4 hour Urgent and Emergency Care Standard each month of 2024/25.

	Target	Quarter 1	Quarter 2	Quarter 3	Quarter 4
4 hour standard	Constitutional standard 95% 2024/25 national target 78%	98.8%	99.1%	99.6%	99%

Figures shown are month end for each quarter

Diagnostic waiting times

The Trusts' reported diagnostic waiting times and activity (DMO1) performance has met the 95% national target for 6 out of the 12 months of 2024/25. The Trust was challenged in the latter part of the year by capacity constraints in sleep studies due to increased demand, lack of outsourcing solutions for overnight sleep procedures, and workforce constraints. Despite these challenges, the Trust's performance continues to exceed both the national and regional averages, respectively.

	Target	Quarter 1	Quarter 2	Quarter 3	Quarter 4
Diagnostic 6 week wait performance	Constitutional standard 99% 2024/25 national target 95%	96.7%	96%	89.1%	86.2%

Financial performance

In 2022/23, the Trust moved to reporting a consolidated group position that incorporated the Trust's charity. Due to the balance of the QVH Charity accounts the Trust is still reporting a consolidated group position. These accounts are appended at the end of this report.

On this basis, the following analysis includes a combination of metrics for both Group and Trust only performance, which are clearly denoted. The Group figures will include the financial performance of QVH Charity.

Performance metrics

Control total (Trust performance after technical adjustments) - Trust only

	Plan £000	**Actual £000**
Reported financial performance	**0**	**16**

This represents a planned and delivered break even position after technical adjustments.

Prior to technical adjustment, the 2024/25 accounts report a surplus of £24k. After these technical adjustments are applied, the Trust achieved a £16k surplus. This is calculated and shown in the table below (with prior year comparative).

Statement of comprehensive income: Group

Below is an extract of the table from the consolidated group accounts (section 6) that shows the total value for income and expenditure for the financial year.

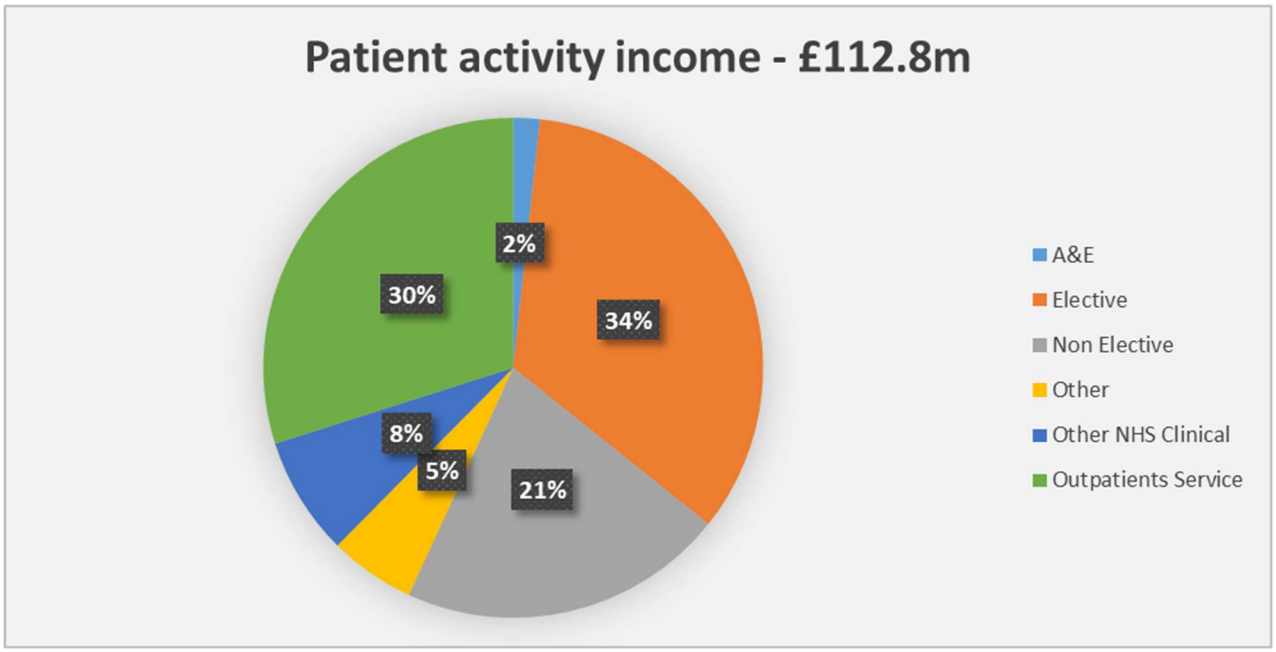
Group income

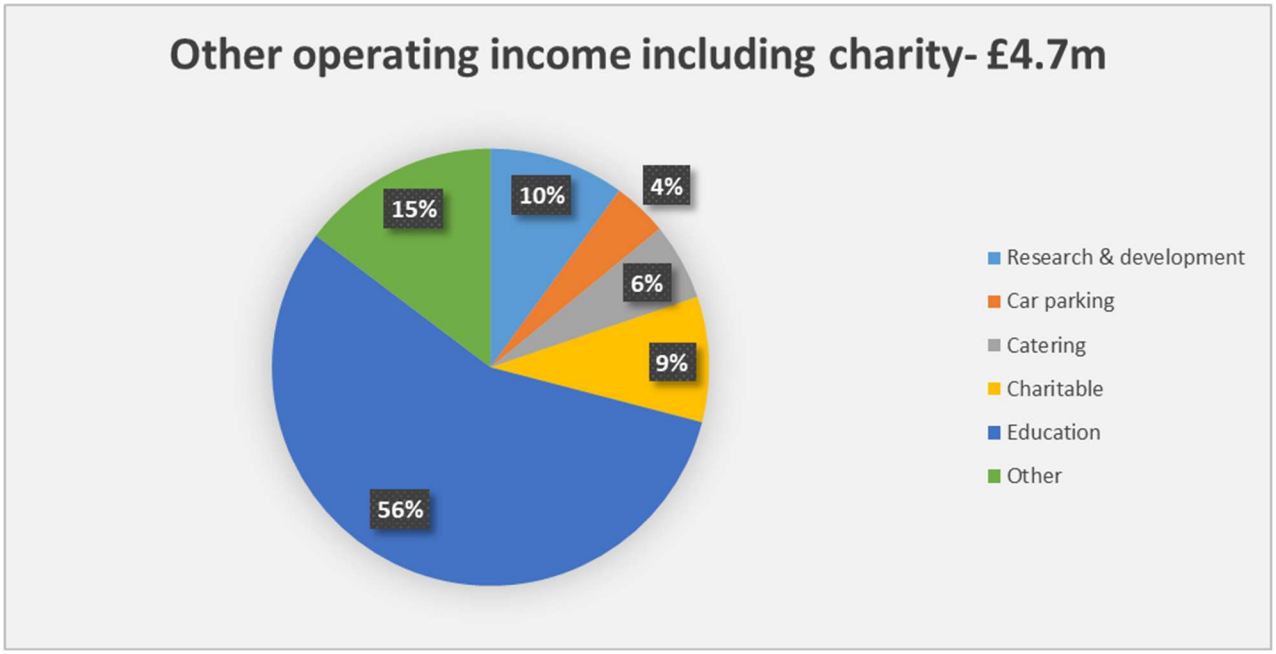
In common with other NHS foundation trusts, QVH receives funding income from two key sources:

- Patient activity income from NHS commissioners for providing services to patients. The chart below shows the relative proportions.
    1.1. Elective patients are those whose treatment is planned in advance, such as day case or inpatient operations
    1.2. Non-elective are generally those needing urgent care which has not been planned in advance
    1.3. Outpatients are generally those who come to the hospital for an initial consultation, an outpatient procedure, or a follow-up meeting with a clinician.
- Other operating income for a range of non-patient activity sources such as catering.

Note that other income for 2024/25 is prepared on a group basis and includes QVH Charity.

Figure one: 2024/25 income (group)





Group expenditure

Expenditure is sub-divided into two key components, these are:

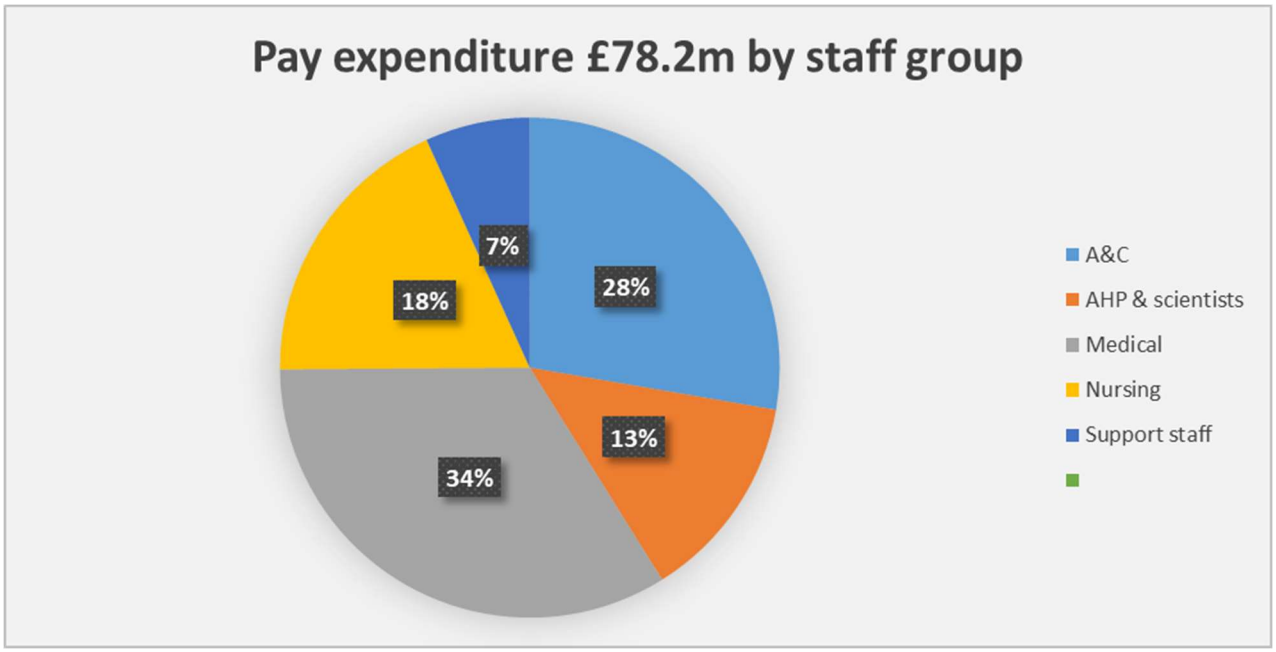
- Pay expenditure
- Non-pay expenditure

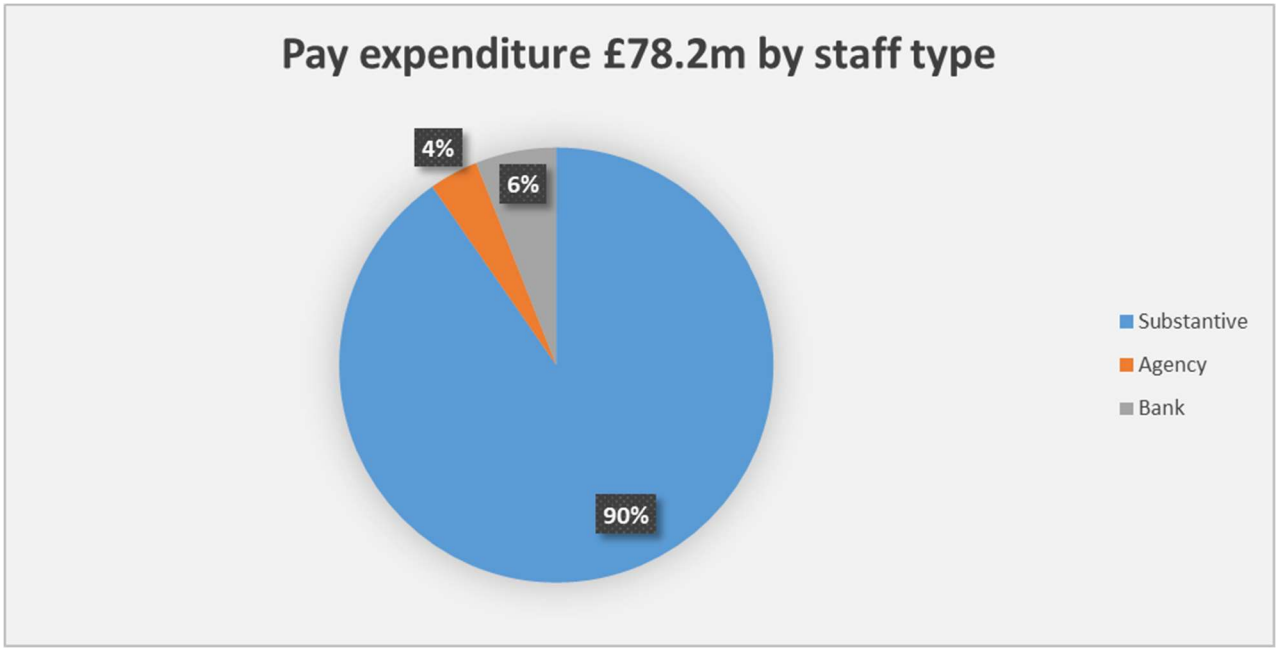
These are summarised in the following paragraphs and charts.

Group pay expenditure

The Trust spent £78.2m on staff to provide patient services in 2024/25. The breakdown of pay expenditure into staff groups is shown in the charts below.

Figure two: 2024/25 pay expenditure (group)





** Key*

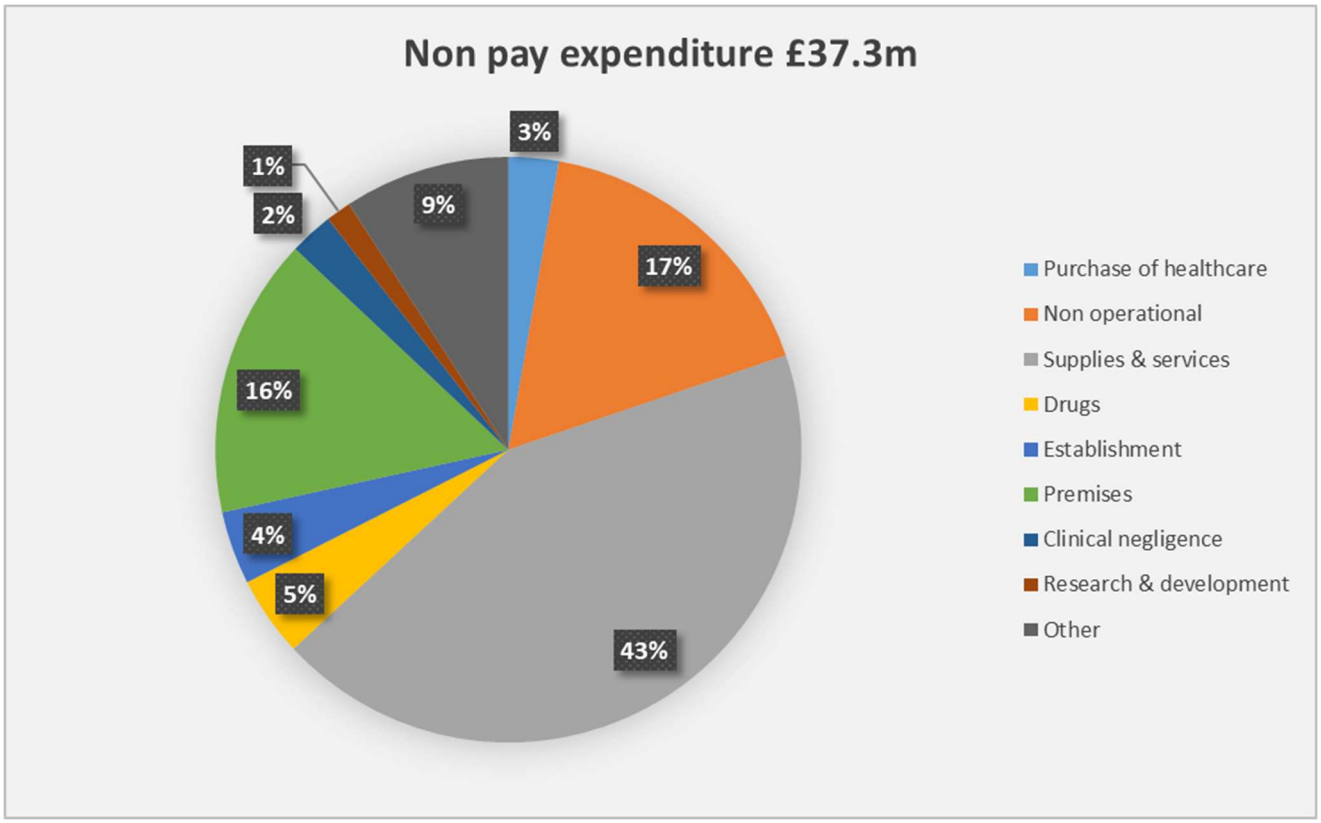
A&C - Admin and Clerical

AHP - Allied Health Professional

Group non-pay expenditure

The Trust spent £37.3m on non-pay items in 2024/25 and this is illustrated by category in the chart below.

Figure three: 2024/25 non-pay expenditure (group)



Valuation of buildings and assets: group

The QVH Charity does not hold any assets in its own right. The Trust's land and buildings were revalued as of 31 March 2025 by professionally qualified, Royal Institute of Chartered Surveyors (RICS) registered valuers Newmark Gerald Eve LLP. The 2023/24 valuation was undertaken on a desktop basis with the 2024/25 being a full valuation. For 2024/25 the valuer, in arriving at the 31 March 2025 valuation, applied the following considerations:

- Operational assets continue to be valued using a modern equivalent asset valuation (MEA) on an alternative site basis.
- The valuation took account of changes in building cost market values since the last valuation was undertaken on 31 March 2024.
- The valuer considered the costs of significant capital improvements completed since the last valuation on 31 March 2024.
- The Trust sold a small parcel of land (approximately 1.5 hectares) in June 2024 and this sale was considered in the new valuation as of 31 March 2025.

Capital expenditure

The Trust invested £3.34m of its internal capital resource limit (CRL) on capital assets (see below for breakdown) together with funded capital on the electronic patient record (EPR) programme £4.99m and community diagnostic centre (CDC) programme £1.43m. In addition, the Trust secured additional funding of £0.43m to digitise diagnostics along with £2.80m of critical infrastructure funding to remove Reinforced Autoclaved Aerated Concrete (RAAC) from one of its non-inpatient buildings and carry out fire infrastructure works. The Trust was allocated additional CRL to procure under IFRS 16 a temporary boiler lease for £0.81m. This is a total capital expenditure of £13.79m within the financial year.

The QVH Charity does not incur any capital expenditure, therefore all capital expenditure is attributable to the Trust. The land sale proceeds were not used in 2024/25 to cover capital purchases and will be available in 2025/26 to support the capital programme.

Capital investment Scheme	**£m**
Internal CRL	
IT hardware	0.67
Medical devices and equipment	0.83
Building and Maintenance	1.84
	3.34
Funded Capital	
EPR	4.99
CDC	1.43
Critical Infrastructure	2.80
Digital Histopathology / Diagnostics	0.43
	9.64
IFRS16 Right of use asset	
Temporary Boiler	0.81
Total Capital Investment	**13.79**

Financial risk

In 2025/26, the Trust faces several financial risks. These include:

- Delivering required efficiency savings. The Trust is required to deliver a £7.5m efficiency saving to achieve a breakeven position. There is a risk that QVH cannot identify sufficient efficiencies to fully address the financial challenge; that they cannot be delivered recurrently deteriorating the Trust underlying position; or that they cannot be delivered at the required pace. Failure to deliver a breakeven position could potentially lead to regulatory intervention under the NHS Oversight Framework.

- Corporate costs. All NHS organisations are required to reduce their corporate overheads in 2025/26. QVH is a small trust but is required to produce statutory reports and run core functions like larger NHS trusts. The scale of the organisation makes the corporate cost reduction very challenging for the Trust, which could put the breakeven position at risk or lead to increased regulatory oversight.

- Clinical income risk. The Trust has contracts with commissioners which contain significant proportion of 'block' income, and this presents a risk where activity levels could run above those which are funded. In addition, the Trust has forecast significant improvement in productivity and utilisation, however the corresponding elective recovery fund (ERF) income has not been agreed by commissioners. This carries the risk that work will be undertaken that is not funded and will require the Trust increasing its efficiency programme to achieve a breakeven position.

- Operational capacity. The Trust is aiming to improve its constitutional standards as per NHS requirements and expects to deliver the national waiting times standards. However, any further ask of the Trust would be difficult to deliver and the cost of the activity may be greater than the anticipated income especially with limited funds within the Integrated Care Boards.

- Excess inflation costs. Inflationary costs are running at significantly higher levels than those funded through contract uplifts. Additional funding to cover inflation has been built into the plan, however the extent to which the funding meets these increased costs presents a significant risk. When risks materialise, management action will be taken to decisively and rapidly mitigate them.

- Implementation of EPR. The Trust is in the process of implementing a new electronic patient record system (EPR). This is going to take significant resource to implement and involve changes to practice and clinical record keeping. There is a risk that this will reduce the Trust's activity during the changeover resulting in reduced performance against national standards and reduced income.

Environment and sustainability

Queen Victoria Hospital recognises that it is not only part of the NHS but plays an integral role in its local community. The Trust's Green Plan will soon be updated in line with NHS England guidelines and Care without Carbon, part of Sussex Community NHS Foundation Trust, has been approached to support QVH work to achieve Net Zero Carbon Emissions by 2040.

Recent work at QVH to support its journey to Net Zero Carbon Emissions have included:

- Purchasing LED lights to install across the estate to eliminate all fluorescent tube lighting.
- Introducing additional waste and recycling bins with more to be added in 2025 to meet new waste regulations.
- Ensuring new plant and equipment is energy efficient.
- Applying for funding to design and build a new energy centre to replace old inefficient boilers across the site.
- Recruitment of a specialist Waste Manager to lead all waste and recycling initiatives.
- Ensuring the build of the new Community Diagnostic Centre will be carbon neutral.
- Energy purchasing to ensure the best rate.
- Trust-wide communications to encourage staff to turn off equipment and lights when not in use.
- The Procurement Team undertaking relevant training to enable the Trust to support stakeholder proposals linked to sustainability The Trust is currently procuring a new waste service contract and a key element has been the need to ensure relevant sustainability levers are inserted in the future contract.

- A new contract management policy including monitoring supplier's alignment to QVH's Green Plan strategy.

Task force on climate related disclosures (TFCD)

NHS England's NHS foundation trust annual reporting manual has adopted a phased approach to incorporating the 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 the HM Treasury TCFD aligned disclosure application guidance, will be implemented in sustainability reporting requirements on a phased basis up to the 2025/26 financial year. Local NHS bodies are not required to disclose scope 1, 2 and 3 greenhouse gas emissions under TCFD requirements as these are computed nationally by NHS England.

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

The Trust recognises that climate change is a significant crisis facing the global community, and one that the UK will need to confront head on amid the greater chance of warmer, wetter winters and hotter, dryer summers, plus more variable rainfall and more severe storms. The rise in sea levels increases the risk to buildings and infrastructure and extreme weather such as flooding, storms and heatwaves.

The Trust Board, through the Finance and performance committee, has responsibility for the oversight and delivery of our commitments relating to environmental sustainability and climate related issues, as set out within our Green Plan approved by our Board which commits us to becoming a more sustainable healthcare provider and meet the ambitious net zero carbon targets to become a new zero carbon provider by 2040. Our care without carbon framework sets out to address three key aims: reducing our environmental impact, improving wellbeing and investing in the future. These are the Trust's metrics for assessing and managing climate related issues. Our Green Plan will be updated during 2025. The Board considers climate related issues when reviewing organisational plans and monitoring performance, most recently with the development of the QVH strategy 2025-2030.

The Trust has established a management led Estates and facilities sub-group of the Executive leadership team which is responsible for day to day oversight and management of climate related responsibilities.

Information about our approach to managing risks, including climate based risks, is set out within our Annual Governance Statement within this Annual report.

Health inequalities

Throughout the year the Trust has worked with partners across the wider health and care systems to develop and publish the QVH Health Inequalities Strategy 2025-2030 in line with national and regional strategic priorities to support QVH understand and address health inequalities.

The Trust is committed to improving the quality of data it collects and analyses to determine how it can better support patients and the local population. This year, in preparation for the delivery of its Health Inequalities Strategy, QVH has completed extensive data analysis, including working with population health experts, as well as analysis of joint strategic needs assessments, detailed insight surveys from clinicians, and data relating to patient protected

characteristics. This understanding has created actionable insights about the people QVH cares for, where inequalities exist and how to reduce them.

There has been a continued focus on preventative initiatives such as support to quit smoking, with a tobacco dependency advisor helping patients referred to them stop smoking within four weeks. For younger patients, the Trust has continued delivering the Mouth Care Matters programme, highlighting the importance of good oral health.

We continue to strive to ensure that our services meet the needs of everyone regardless of their age, disability, ethnicity, sex, religion of beliefs, gender reassignment, sexual orientation, pregnancy and maternity, and marriage or civil partnership, in accordance with the Equality Act 2010 and our Public Sector Equality Duty. We strive to ensure that all of our processes, practices and outcomes are fair for all and this work is supported by our workforce team. We undertake equality due regard assessments on all of our policies to ensure that our policies and functions are fair and equitable.

Social, community, anti-bribery and human rights issues

The rules and procedures relating to bribery are set out in the Trust's counter fraud policy, and those relating to the provision of gifts and hospitality are set out within the Trust's Standards of Business Conduct Policy. The Trust maintains a register of gifts, hospitality and sponsorship received and staff are made aware of the need to declare any potential conflict of interest.

The Trust has a counter fraud, bribery and corruption response plan that follows NHS Counter Fraud Authority's (NHSCFA) strategic guidance. The work plan and resource allocation are aligned to the objectives of the strategy and locally identified risks. The Trust has carried out comprehensive local risk assessments to identify fraud, bribery and corruption risks and has plans in place relative to the level of risk identified.

Risk analysis is carried out in line with Government Counter Fraud Profession fraud risk assessment methodology and is recorded and managed in keeping with the organisation's risk management policy. Risks are included on the appropriate risk registers. Measures to mitigate identified risks are included in an organisational work plan, with progress monitored at a senior level within the organisation and results fed back to the Audit and Risk Committee. The plan is reviewed, evaluated and updated as required, and levels of staff awareness are measured. The Board level evaluation of the effectiveness of counter fraud, bribery and corruption work undertaken is documented and where recommendations have been made to the Trust by NHSCFA, QVH reports on how it has met the requirements set. Trust counter fraud, bribery and corruption work has been assessed internally and independently and rated as green.

Where there is concern regarding possible slavery or human trafficking of a patient, to determine appropriate action, the patient is seen alone and an independent translator is used, in line with the Trust's safeguarding procedures. If this did not resolve any concerns, then a referral would be made to the police. No cases of slavery or human trafficking were identified in 2024/25.

We work alongside partner organisations to promote the safety, health and well-being of patients, service users and their families and carers. The Trust's safeguarding strategy includes a human rights framework covering the protection of vulnerable patients.

Significant events since the end of the last financial year affecting the Trust

There have been no significant events since the end of the 2024/25 financial year affecting the Trust.

Overseas operations

The Trust has no overseas operations.

3. Accountability report

Director's report

In 2024/25, the following individuals served as directors of Queen Victoria Hospital NHS Foundation Trust.

Name	Position
Jon Bell	Interim Chief Finance Officer (voting) from 09/12/2024
Tania Cubison	Chief Medical Officer (voting) until 30/09/2024
Vivek Chaudhri	Associate Non-Executive Director (non-voting) from 30/01/2025
Jane Dickson	Interim Chief Nursing Officer (voting) from 15/07/2024 until 12/01/2025 Interim Deputy Chief Executive (non-voting) from 04/03/2025
Paul Dillon-Robinson	Non-Executive Director (voting)
Helen Edmunds	Chief People Officer (non-voting)
Jo Emmanuel	Non-Executive Director (voting) from 29/01/2025
Tamara Everington	Chief Medical Officer (voting) from 01/10/2024
Russell Hobby	Non-Executive Director (voting)
Abigail Jago	Chief Strategy Officer (non-voting) Acting Chief Executive Officer (voting) from 10/02/2025
James Lowell*	Chief Executive Officer
Karen Norman	Non-Executive Director (voting)
Peter O'Donnell	Non-Executive Director (voting)
Shaun O'Leary	Non-Executive Director (voting)
Clare Pirie	Director of Communications & Corporate Affairs (non-voting) until 07/04/2024
Nicky Reeves	Chief Nursing Officer (voting) until 14/07/2024
Aleema Shivji	Associate Non-Executive Director (non-voting) from 30/01/2025
Jackie Smith	Trust Chair (voting)
Edmund Tabay	Chief Nursing Officer (voting) from 13/01/2025
Kirsten Timmins	Chief Operating Officer (voting)
Maria Wheeler	Chief Finance Officer (voting) until 31/12/2024

**From 10 February 2025, James Lowell was seconded to the Hampshire and Isle of Wight (HIOW) Integrated Care Board (ICB) as Chief Delivery Officer.*

Biographies for the individuals that served as directors of Queen Victoria Hospital NHS Foundation Trust during 2024/25 are provided in appendix 3 to the annual report. Details of other company directorships and significant interests held by directors which may conflict with their management responsibilities are available on the Trust's website within the papers of meetings of the Board of Directors held in public available via this link. The Trust's decision makers declaration of interest register is available on the website via this link.

Compliance with cost allocation and charging guidance

The Trust has complied with the cost allocation and charging guidance issued by HM Treasury.

Political donations

The Trust neither made nor received any political donations in 2024/25 (2023/24 nil).

Better Payment Practice Code

The Better Payment Practice Code requires the Trust to pay all valid invoices in the contracted payment terms or within 30 days of receipt of a valid invoice, whichever is later. The performance achieved in 2024/25 is shown below:

Better Payment Practice Code	**2023/24**	**2023/24**	**2023/24**	**2023/24**
	Number	**£k**	**Number**	**£k**
Total non-NHS trade invoices paid	20,885	70,257	19,257	59,554
Total non-NHS trade invoices paid within target	18,885	63,563	18,051	54,647
Percentage of non-NHS trade invoices paid within target	**90.40%**	**90.50%**	**93.70%**	**91.80%**
Total NHS trade invoices paid	889	4,755	713	3,100
Total NHS trade invoices paid within target	697	3,742	634	2,831
Percentage of NHS trade invoices paid within target	**78.40%**	**78.70%**	**88.90%**	**91.30%**
Percentage of all trade invoices paid within target (%)	**89.90%**	**89.70%**	**93.60%**	**91.70%**

Interest liability

The Trust did not incur any interest charges for late payment of invoices during 2024/25 (2023/24 nil).

NHS England well-led framework

As good practice the Trust uses the NHS England's well-led framework to ensure that it is well-led when considering its organisational performance, internal controls, Board assurance framework and the governance of quality. The Trust strives to have an inclusive and positive culture of continuous learning and improvement which is based on meeting the needs of people who use services and its wider communities, and for all leaders and staff to share this. The leadership team seeks to proactively support staff and collaborate with partners to deliver care that is safe, integrated, person-centred and sustainable, and to reduce inequalities. During the year, the Trust has continued to implement its new patient and public engagement strategy which sets out four ambitions to drive the goal of excellent patient experiences and meaningful public engagement for the Trust.

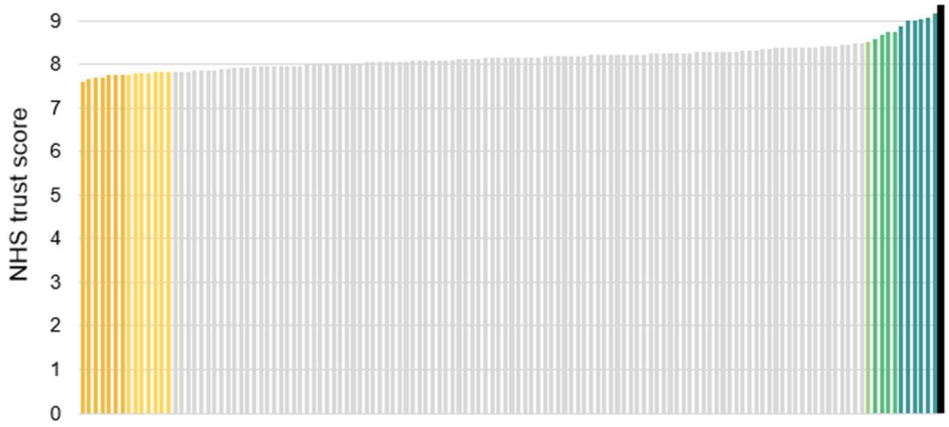
During the year, the Trust has continued to strengthen its compliance to the well-led domain. It has established a continuous improvement methodology called *The QVH Way* and focussed on embedding it across the Trust to drive improvements for patients and staff.

Patient care

Quality is continuously monitored through the Executive Committee for Quality and Risk and the Quality and Safety sub-committee of the Board. A full range of clinical and non-clinical performance indicators are reviewed at Board level with updates reported monthly via the Integrated Quality and Performance Report (IQPR). This report is published on the Trust website ahead of each bi-monthly Board meeting in public, ensuring transparency and accountability regarding our performance. You can access the Board papers via this link.

Under the CQC's regulatory framework, Queen Victoria Hospital is registered to provide services without conditions or restrictions, having complied with all the essential standards for quality and safety. The overall rating for the hospital remains as 'good' with a rating of 'outstanding' for care as per the 2019 CQC inspection.

In the 2023 Care Quality Commission Adult Inpatient Survey, QVH achieved the highest overall patient satisfaction scores in the country from patients who received inpatient care at the hospital.



This shows the range of section scores for all NHS trusts. The colour of the line denotes whether a trust has performed better, worse, or about the same compared with all other trusts (as detailed in the legend). The result for QVH is shown in black. Please note, as a result of the 'expected range' analysis technique used, a trust could be categorised as 'about the same' whilst having a lower score than a 'worse than expected' trust, or categorised as 'about the same' whilst having a higher score than a 'better than expected' trust

Below are examples of quality measures reviewed monthly basis and reported at Board. Throughout the year, cases of patient safety incidents with moderate harm were reported with no incidents resulting in severe harm or death. These measures demonstrate consistently low levels of harm across the year.

KPI Description	Apr 24	May 24	Jun 24	Jul 24	Aug24	Sep 24	Oct 24	No 24	Dec 24	Jan 25	Feb 25	Mar 25
No. of patient safety incidents with moderate harm	0	1*	0	0	0	2(1*)	1*	0	2(1*)	0	0	0
No. of patient safety incidents with severe harm or death	0	0	0	0	0	0	0	0	0	0	0	0
No. of pressure ulcer development category 2 (hospital acquired)	0	1	1	0	0	1	0	1	0	0	0	0

*(*Denotes- moderate harm caused elsewhere)*

The Trust has also identified and delivered key quality priorities in the following areas:

1. Patient Safety.

2. Clinical Effectiveness.

3. Patient Experience.

The Trust continues to implement a range of measures to reduce infections and enhance patient safety. This includes a strong focus on prevention, antibiotic stewardship, improved environmental hygiene, continuous staff engagement, and education. QVH reported three cases where Clostridium difficile (C. diff) was identified with one case not attributable to the Trust. There has been one case of Pseudomonas Aeruginosa bacteraemia, and there have been no hospital attributable MRSA, E Coli or Klebsiella bacteraemia in 2024/25.

The Trust takes complaints very seriously as they are a vital part of learning from patient experiences. We continue to improve our complaints management process. During 2024/25, the Trust received 73 formal complaints, up by 12% from 65 in the previous financial year. In the same period, we received 278 Patient Advice Liaison Service (PALS) requests which is an increase of 20% from the previous financial year.

Stakeholder relations

The Trust began an 18 month programme of work in April 2023 to develop its five year strategy using insight from national and local policy and aligned to the health and care system strategies across Kent, Medway, Surrey and Sussex. Collaborative engagement with stakeholders was fundamental to the organisation developing its *QVH Strategy 2025-2030.* This included patients; staff; volunteers; communities; system partners; three Integrated Care Boards; NHS England; two Cancer Alliances; specialist commissioning; its Council of Governors and Board of Directors. Through the engagement activities the Trust was deliberate

to ensure the patient, clinical and multidisciplinary team voice, expertise and perspectives were at the heart of its future ambition.

The *QVH Strategy 2025-2030* was shaped and co-produced with over 3,000 voices across Kent, Surrey, Sussex and beyond through workshops, one to one meetings, team discussions, online survey, and various system partner and associated commissioning conversations. It was also driven by data which helped inform the organisation's focus for the future – to be a centre of excellence that rebuilds lives and supports communities for a healthier future.

Clinical strategy workshops were also held, exploring how the Trust's clinical services aligned to the agreed direction to continue to be a provider of regional and specialist services as well as offering a suite of services for the local population. In conjunction with the clinical service strategic proposals, patient focus groups were held to gather valuable insights and experiences. Patients were positive regarding the high quality, specialist care and expertise QVH provides however, felt improvements could be made including the expansion and offering of new clinical services.

The Trust has committed to continued engagement with its stakeholders throughout the implementation of the strategy.

Fees and charges (income generation)

During 2024/25 the Trust incurred no external consultancy costs considered material to the accounts (2023/24 nil).

Income disclosures

The Trust has met the requirement of Section 43 (2A) of the NHS Act 2006 (as amended by the Health and Social Care Act 2012), in its income from the provision of goods and services for the purposes of the health service in England being greater than its income from the provisions of goods and services from other purposes.

The impact of other income the Trust has received has been invested in the provision of goods and services for the purpose of the health service in England.

Remuneration report

Annual statement on remuneration

The 2024/25 very senior manager (VSM) pay guidance from NHS England was received in September 2024. The correspondence received from the Chief of Workforce, Training and Education at NHS England confirmed that the Secretary of State for Health and Social Care accepted the Senior Salaries Review Body's (SSRB's) pay recommendations in full on 29 July 2024 in a written ministerial statement. This announced the pay award for VSM's as an across-the-board increase of 5%, backdated to 1 April 2024. The guidance also recommended a variable percentage pay uplift to ensure that all VSM's are paid at least 5% above the higher-level rate of an Agenda for Change Band 9 salary.

Following the receipt of this guidance, the Trust's Nomination and Remuneration Committee met in October 2024 and the salaries of the Executive Directors were reviewed alongside the guidance. The committee approved the backdated uplift in VSM salaries in line with the recommendation plus a minimum baseline rate of pay of 5% above the top of the Agenda for Change Band 9 salary.

During the year there were no other major decisions on senior managers remuneration, or substantial changes relating to senior managers remuneration.

The committee remained assured that executive pay was in line with the comparable benchmark data for VSM salaries.

Jackie Smith

Trust Chair

26 June 2025

Senior managers' remuneration policy

The salary and pension entitlements of very senior managers (VSM) are set out in the section below showing information subject to audit. The QVH approach to remuneration continues to be influenced by national policy, benchmarks and local market factors. The majority of staff receive pay awards determined by the Department of Health and Social Care in accordance with their national terms and conditions, such as Agenda for Change, and the pay review bodies for doctors and dentists.

QVH does not intend to implement separate arrangements for performance related pay or bonuses unless further guidance from NHS England is issued.

All very senior managers' pay arrangements are subject to approval by the Nomination and Remuneration sub-committee of the Board of Directors.

In terms of new appointments, the committee is cognisant of the Trust's data in relation to gender pay gap, Workforce Race Equality Standard and Workforce Disability Equality Standard which are summarised in the Trust's annual equalities and diversity report. When vacancies have arisen the Trust has proactively encouraged applications from all communities.

In relation to agreeing and reviewing VSM pay, the Nomination and Remuneration Committee refers to the existing guidance on pay for very senior managers in NHS trusts and foundation trusts published by NHS England. The annual pay award for executive directors is recommended by NHS England as described above.

The members of QVH's Nomination and Remuneration Committee have agreed simple principles in relation to setting, agreeing and reviewing VSM pay.

For new VSM appointments, the Chief People Officer will review benchmarking data as well as seeking market intelligence on the salaries being offered to VSMs which will also take account of supply and demand at that time. The review of existing VSM pay will continue to take place once a year, the timing is dependent on information being published by NHS England. The committee will also take account of:

- The outcome of annual appraisal conducted by the Chief Executive Officer (or Chair in the case of the Chief Executive Officer's pay)
- The level of the national pay award for the workforce on Agenda for Change
- Any extenuating circumstances/market conditions highlighted by the Chief Executive Officer
- Updated benchmarking information and guidance.

The effectiveness and performance of VSMs is determined through a performance appraisal linked to the Trust's five key strategic objectives. From this a set of individual objectives is developed for each VSM. These are reviewed through the year by the Chief Executive Officer (or Chair in the case of the Chief Executive Officer) to determine progress and achievement. The Trust's key strategic objectives also underpin the Board Assurance Framework which is reviewed at every board meeting and committee to the board.

The table below gives a description of each of the components of the remuneration package for senior managers which comprise senior managers' remuneration.

Component ***How it supports the short- and long-term strategic objectives of the foundation trust***	***How the component operates***	***Maximum potential value of component***	***Description of framework used to assess performance***
Base pay Base pay is determined using benchmarked data to attract, reward and retain individuals of the right calibre to lead the delivery of the Trust's aims and objectives.	This is determined by the Nomination and Remuneration Committee using benchmarking data. Salaries are reviewed annually to account for the cost of living and considered in the context of performance. Any changes are normally effective from 1 April each year.	N/A	The Trust's appraisal and objective setting process is used for all staff, including Executive Directors. The Nomination and Remuneration Committee considers a summary of this performance assessment.
Pension related benefits Pension benefits (which may be opted out of) are part of the total remuneration of Executive Directors to attract, reward and retain individuals of the right calibre to lead the delivery of the Trust's aims and objectives.	Pension is available as a benefit to Executive Directors and follows the national NHS Pension Scheme contribution rules.	Contributions and entitlements are in accordance with the NHS Pension Scheme for all employees who are members.	N/A
The fee payable to Non-Executive Directors is £15k per annum. The fee payable to the Trust Chair is £52,500 per annum. There are no additional fees payable for any other duties to the Trust.			

The majority of staff, whether on national terms and conditions or local arrangements, are contracted on a permanent, full time or less than full time basis. Exceptions to this are in positions where it is felt that an individual needs to be recruited on a fixed-term contract or through an appropriate employment agency partner to carry out a specific project which is time limited. This approach enhances control of staffing resources and enables flexibility where this is appropriate to the role.

National guidance on notice periods for Agenda for Change staff is followed and is determined by salary banding. The maximum in such cases is three months' salary and is in line with current employment legislation.

During 2024/25 the Executive Leadership Team continued to oversee robust pay and vacancy controls for all roles through weekly meetings.

Remuneration tables

The salary and pension entitlements of persons in senior positions having authority or responsibility for directing or controlling the major activities of QVH are set out in the tables below. The information is subject to audit. The descriptor above means those who influence the decisions of the foundation trust as a whole, and such persons include advisory and non-executive Board members. Throughout this annual report, such persons are referred to as 'senior managers'.

During the year one senior manager was paid more than £150,000. The Trust took steps to ensure this salary was reasonable, including the nomination and remuneration committee reviewing benchmarking data for other Chief Executive Officer roles.

Service contracts obligations

There are no service contract obligations to disclose.

Policy on payment for loss of office

Termination payments are made within the contractual rights of the employee and are therefore subject to income tax and national insurance contributions. This applies to very senior managers whose remuneration is set by the nomination and remuneration committee. Where a VSM receives payment for loss of office, this is determined by their notice period. For the Chief Executive Officer the notice period is six months and for all other executive directors three months.

Statement of consideration of employment conditions elsewhere in the foundation trust

The pay and conditions of employees were considered by the Nomination and Remuneration Committee in the context of national guidance on remuneration for very senior managers, which has kept uplifts at or below those provided to staff on Agenda for Change terms and conditions. The foundation trust does not have a separate senior managers remuneration policy. The QVH approach to remuneration continues to be influenced by national policy, benchmarks and local market factors.

The Nomination and Remuneration Committee and governor-led Appointments Committee recognise diversity and inclusion are a vital part of the continued effectiveness of the Board and are committed to seeking diversity within the Board's composition. Prior to any appointment made to the Executive Leadership Team, the Nomination and Remuneration Committee evaluates the balance of skills, knowledge, experience and diversity of the team and, in the light of the evaluation, the committee reviews a description of the role and capabilities required for a particular appointment. The committee ensures the appointment process is designed to attract the best candidates, using a range of open advertising and/or the services of external advisers to facilitate the search. It also ensures appointments to the Board of Directors are subject to a formal, rigorous and transparent procedure.

In 2024/25 Board-level recruitment was supported by recruitment agencies which included taking active steps to attract the best candidates, including those who would increase diversity at Board level. The agencies selected evidenced embedding diversity and inclusion in relation to all protected characteristics into their process, alongside other requirements.

The Trust's Recruitment and Selection Policy requires all interview panels to be diverse, and for posts which are Agenda for Change band 8B and above.

Annual report on remuneration

Service contracts for senior managers

The following table includes those persons in senior positions having authority or responsibility for directing or controlling the major activities of the NHS Foundation Trust.

Name	Position	Start date	End Date	Term	Notice period
Tania Cubison	Chief Medical Officer (voting)	19 January 2022	20 October 2024	Permanent	3 Months
Helen Edmunds	Chief People Officer (non-voting)	11 March 2024		Permanent	3 Months
Abigail Jago	Chief Strategy Officer (non-voting) Acting Chief Executive (voting)	6 February 2023 10 February 2025		Permanent Interim	3 Months
James Lowell *	Chief Executive Officer (voting)	18 September 2023		Permanent	6 Months
Nicky Reeves	Chief Nursing Officer (voting)	12 November 2020	31 August 2025	Permanent	3 Months
Kirsten Timmins	Chief Operating Officer (voting)	4 March 2024		Permanent	3 Months
Maria Wheeler	Chief Finance Officer (voting)	3 June 2023	31December 2024	Permanent	3 Months
Tamara Everington	Chief Medical Officer (voting)	1 October 2024		Permanent	3 Months
Edmund Tabay	Chief Nursing Officer (voting)	13 January 2025		Permanent	3 Months
Jon Bell	Interim Chief Finance Officer (voting)	10 December 2024	8 May 2025	Interim	NA
Jane Dickson	Interim Chief Nurse (voting) Interim Deputy Chief Executive (non-voting)	1 September 2024 14 February 2025	12 January 2025	Interim Interim	NA

**From 10 February 2025, James Lowell was seconded to the Hampshire and Isle of Wight (HIOW) Integrated Care Board (ICB) as Chief Delivery Officer.*

Nomination and Remuneration Committee

All Non-Executive Directors are full voting members of the Nomination and Remuneration Committee. Details of membership and individual attendance of the committee is set out within appendix one to this Annual Report and Accounts. The Committee met four times formally during 2024/25 and held seven extraordinary meetings.

When appropriate, the Committee was materially assisted in its decision making during 2024/25 by the Chief People Officer, and/ or the Chief Executive Officer.

Disclosures required by the Health and Social Care Act - information subject to audit

Remuneration Table 2024/25			**Salary and fees (in bands of £5,000)**			**Taxable benefits (total to the nearest £100)**	**Annual performance-related bonuses (in bands of £5,000)**			**Long-term performance-related bonuses (in bands of £5,000)**			**All pension-related benefits (in bands of £2,500) ****			**Other remuneration**			**Total**		
Senior Manager	**Role**	**Date References**	**£000s, bands of £5k**			**£s, to the nearest £100**	**£000s, bands of £5k**			**£000s, bands of £5k**			**£000s, bands of £2.5k**			**£000s, bands of £5k**			**£000s, bands of £5k**		
Edmunds H	Chief People Officer		120	-	125	-	-	-	-		-	-	75.0	-	77.5	-	-	-	**195**	-	**200**
Jago A	Chief Strategy Officer Acting Chief Executive Officer	from 14/02/2025	130	-	135	-	-	-	-	-	-	-	2.5	-	5.0	-	-	-	**130**	-	**135**
Everington T	Chief Medical Officer	from 01/10/2024	95	-	100	-	-	-	-		-	-	72.5	-	75.0	-	-	-	**170**	-	**175**
Cubison T	Chief Medical Officer	until 30/09/2024	50		55	-	-	-	-		-	-	-	-	-	-	-	-	**50**	-	**55**
Dillon-Robinson P	Non-Executive Director		10	-	15	-	-	-	-		-	-	-	-	-	-	-	-	**10**	-	**15**
Wharton J	Interim Chief Finance Officer	from 22/08/2024 until 30/11/2024	30	-	35	-	-	-	-		-	-	-	-	-	-	-	-	**30**	-	**35**
Bell J	Interim Chief Finance Officer	from 10/12/2025	45	-	50	-	-	-	-		-	-	-	-	-	-	-	-	**45**	-	**50**

Wheeler M	Chief Finance Officer	until 31/12/2024	155	-	160	-	-	-	-		-	-	-	-	-	-	-	-	**155**	-	**160**
Lowell J	Chief Executive Officer		175	-	180	-	-	-	-		-	-	282.5	-	285.0	-	-	-	**455**	-	**460**
Timmins K	Chief Operating Officer		135	-	140	-	-	-	-		-	-	35.0	-	37.5		-	-	**170**	-	**175**
Pirie C	Director of communications & Corporate Affairs	until 07/04/2024	50	-	55	-	-	-	-		-	-	-	-	-	-	-	-	**50**	-	**55**
Chaudhri V	Associate Non-Executive Director		0	-	5	-	-	-	-		-	-	-	-	-	-	-	-	**0**	-	**5**
Norman K	Non-Executive Director		10	-	15	-	-	-	-		-	-	-	-	-	-	-	-	**10**	-	**15**
Dickson J	Interim Chief Nursing Officer Interim Deputy Chief Executive Officer	from 15/07/2024 until 12/01/2025 from 04/03/2025	75	-	80	-	-	-	-		-	-	-	-	-	-	-	-	**75**	-	**80**
Reeves N	Chief Nursing Officer	until 31/08/2024	50	-	55	-	-	-	-		-	-	-	-	-	-	-	-	**50**	-	**55**
Tabay E	Chief Nursing Officer	from 13/01/2025	25	-	30	-	-	-	-		-	-	12.5	-	15.0	-	-	-	**40**	-	**45**
Smith J	Trust Chair		45	-	50	-	-	-	-		-	-	-	-	-	-	-	-	**45**	-	**50**
Shivji A	Associate Non-Executive Director		0	-	5	-	-	-	-		-	-	-	-	-	-	-	-	**0**	-	**5**

Emmanuel J	Non-Executive Director		0	-	5	-	-	-	-		-	-	-	-	-	-	-	-	**0**	-	**5**
Hobby R	Non-Executive Director		10	-	15	-	-	-	-		-	-	-	-	-	-	-	-	**10**	-	**15**
O'Donnell P	Non-Executive Director		10	-	15	-	-	-	-		-	-	-	-	-	-	-	-	**10**	-	**15**
O'Leary S	Non-Executive Director		10	-	15	-	-	-	-		-	-	-	-	-	-	-	-	**10**	-	**15**

* 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 derived does not represent an amount that will be received by the individual. It is a calculation that is intended to provide 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.

** The following Directors (VSMs) left the Trust during the year - Wheeler M, Pirie C, Reeves N, Cubison T

SALARY AND PENSION ENTITLEMENTS OF VERY SENIOR MANAGERS									
B) Pension benefits table 2024/25									
			Real increase in pension at pension age (bands of £2,500)	**Real increase in pension lump sum at pension age (bands of £2,500)**	**Total accrued pension at pension age at 31 March 2025 (bands of £5,000)**	**Lump sum at pension age related to accrued pension at 31 March 2025 (bands of £5,000)**	**Cash equivalent transfer value at 01-April-24**	**Real increase in cash equivalent transfer value**	**Cash equivalent transfer value at 31-Mar-25**
			£'000	**£'000**	**£'000**	**£'000**	**£'000**	**£'000**	**£'000**
Edmunds	**H**	**Chief People Officer**	2.5-5	0-2.5	30-35	0-5	419	62	524
Jago	**A**	**Chief Strategy Officer**	0-2.5	0-2.5	35-40	95-100	756	4	826
Lowell	**J**	**Chief Executive Officer**	12.5-15	30-32.5	65-70	165-170	981	262	1331
Pirie	**C**	**Director of communications & Corporate Affairs**	0-2.5	0-2.5	35-40	90-95	727	0	78
Reeves	**N**	**Chief Nursing Officer**	0-2.5	0-2.5	5-10	160-165	1574	0	84
Timmins	**K**	**Chief Operating Officer**	2.5-5	0-2.5	5-10	0-5	72	17	111
Wharton	**J**	**Interim Chief Finance Officer**	0-2.5	0-2.5	25-30	60-65	413	14	525
Everington	**T**	**Chief Medical Officer**	5-7.5	7.5-10	75-80	200-205	1532	84	1826
Tabay	**E**	**Chief Nursing Officer**	0-2.5	0-2.5	25-30	60-65	443	12	547
Wheeler	**M**	**Chief Finance Officer**	0-2.5	0-2.5	35-40	95-100	889	14	958
*Please note C Pirie, N Reeves and M Wheeler left the Trust during the year									
**The employer does not contribute to any stakeholder pension schemes for these managers.									
*** The Consumer Prices Index up to September 2023 was 6.7%, therefore, an increase of 6.7% is applied to pensions and CETV at April 2024. Applying this inflation adjustment to the 31 March 2024 value has in some cases resulted in an adjusted value which exceeds the 31 March 2024 value.									

Governors

Information on the expenses of the governors is provided in the tables below.

1 April 2024-31 March 2025		
Total number of Governors in office	Number of Governors receiving expenses in 2024/25	Aggregate sum of expenses paid in 2024/25 (rounded to the nearest £00)
28 served for all or part of 2024/25	0	£0

Fair pay disclosure

NHS foundation trusts are required to disclose the relationship between the remuneration of the highest-paid director in their organisation and the lower quartile, median and upper quartile remuneration of the organisation's workforce.

Total remuneration includes salary, non-consolidated performance-related pay, benefits-in-kind, but not severance payments. It does not include employer pension contributions and the cash equivalent transfer value of pensions. Note that there was no performance-related pay. Benefits-in-kind are sufficiently low to have no impact on any of the remuneration figures or ratios.

The banded remuneration of the highest-paid director in the organisation in the financial year 2024-25 was £190k to £195k (2023/24, £165k to £170k). This is an increase between years of 15% (2023-24 a decrease of 16%). This is due to a change in the make-up of the Board which has triggered a change in the highest paid Director. Note that these figures are based on annualised, full-time equivalent pay and benefits.

For employees of the Trust as a whole, the range of remuneration in 2024-25 was from £23k to £258k (2023-24 £22k to £235k). The percentage increase in average employee remuneration (based on total for all employees on an annualised basis divided by full time equivalent number of employees) between years is 6% (2023-24 7%). 8 employees received remuneration in excess of the highest-paid director in 2024-25 (2023-24 8).

The remuneration of the employee at the 25th percentile, median and 75th percentile is set out below. The pay ratio shows the relationship between the total pay and benefits of the highest paid director (excluding pension benefits) and each point in the remuneration range for the organisation's workforce.

Percentile Information			
Figures for 2024/25			
	25th Percentile	Median	75th Percentile
Salary and Allowances - All Staff - £k	27.6	40.6	57.8
Salary and Allowances - Highest Paid Director - £k	192.5	192.5	192.5
Salary and Allowances - Ratio	7.0	4.7	3.3
Figures for 2023/24			
	25th Percentile	Median	75th Percentile
Salary and Allowances - All Staff - £k	27.6	38.0	54.0
Salary and Allowances - Highest Paid Director - £k	167.5	167.5	167.5
Salary and Allowances - Ratio	6.1	4.4	3.1

Abigail Jago

Acting Chief Executive Officer

26 June 2025

Staff report

Staff numbers

Staff Group	2024/25 Total No.	2024/25 Permanent No.	2024/25 Other No.
Medical and dental	178	176	2
Ambulance staff	0	0	0
Administration and estates	360	324	36
Healthcare assistants and other support staff	134	130	4
Nursing, midwifery and health visiting staff	256	207	49
Nursing, midwifery and health visiting learners	0	0	0
Scientific, therapeutic and technical staff	78	70	8
Healthcare science staff	123	118	5
Social care staff	0	0	0
Other	0	0	0
Total average numbers	**1129**	**1025**	**104**
Of which:			
Number of employees (WTE) engaged on capital projects	**0**	**0**	**0**

Staff costs

Staff Costs	**2024/25 Total £000**	**2024/25 Permanent £000**	**2024/25 Other £000**
Salaries and wages	58,108	58,108	-
Social security costs	6,247	6,247	-
Apprenticeship levy	271	271	-
Pension cost - employer contributions to NHS pension scheme	6,813	6,813	-
Pension cost - employer contributions paid by NHSE on provider's behalf	4,414	4,414	-
Pension cost - other	18	18	-
Other post employment benefits	-	-	-
Other employment benefits	-	-	-
Termination benefits	-	-	-
Temporary staff - external bank	-	-	-
Temporary staff - agency/contract staff	3,761	-	3,761
NHS charitable funds staff	-	-	-
TOTAL STAFF COSTS	**79,632**	**75,871**	**3,761**
Of which			
Costs capitalised as part of assets	**1,472**	**-**	**1,472**

Breakdown of number of each gender who were directors, senior managers and employees during the year:

2024/25 data						
	Chief Executive Officer	**Executive Directors**	**Non-Executive Directors**	**Other senior managers**	**All other employees**	**Total**
Female	1	3	4	0	919	920
Male	0	2	5	0	305	308
Total						**1239**

Sickness and absence data

2024/25 data		
Total full time equivalent staff years available	**Total days lost**	**Average number of days of sickness absence per full time equivalent employee**
1022	14,174	8.6

Information on staff turnover

2024/25 data												
12 Month Rolling Turnover rate												
	Apr	**May**	**Jun**	**Jul**	**Aug**	**Sep**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**Mar**
Turnover Rate FTE (12m)	11.78%	11.94%	11.75%	12.28%	12.11%	12.38%	11.65%	11.94%	11.83%	11.68%	11.83%	11.63%

Staff policies and actions applied during the financial year

Policy	Date	Comments
Change Management Policy	24/06/2024	Updated to clarify when engagement and consultation processes should be used. Also updated to reflect pregnancy and maternity redundancy protection legislation. A new section on Transfer of Undertakings (Protection of Employment) (TUPE) was included along with an appendix on re-banding of established roles.
Flexible Working and Reasonable Adjustments Policy	26/02/2024	Updated in line with changes to legislation and best practice. A new section on reasonable adjustments was added.
Workforce Investigation Policy	26/06/2024	Policy name was changed from Investigation Policy to Workforce Investigation Policy to avoid confusion with the Incident Reporting and Investigation Policy. No other changes.

Paternity Policy (Maternity/Adoption Support)	26/02/2024	Updated in line with changes to The Paternity Leave Regulations 2024.
Policy for Checking of Professional Registration	24/06/2024	No significant changes. Updated with team/job title amendments.
Redeployment Policy	20/08/2024	Appendices removed and process uploaded as separate guidance documents.
Relationships at Work Policy	24/06/2024	No significant changes. Updated with team/job title amendments.
Relocation Policy	13/08/2024	Reference to specific bands/roles removed to ensure equity across all staff groups and levels of role. Reference added to raising and approving via Easy Expenses (new system). Removal of forms and letters as appendices and links/sign posting used to relevant documentation. Change to process is in line with the new triumvirate structure.
Special Leave Policy	26/02/2024	Section added for Carer's Leave to reflect changes to Carers Leave Regulations.
Study and Professional Leave Policy for Medical and Dental Staff	13/08/2024	Guidance added regarding poster printing and changes to exclusions. Guidance added on what happens if a doctor leaves before the end of their fixed term contract. Guidance updated regarding attending a study day on a non-working day. Updated guidance on examinations.

On an annual basis the Trust undertakes an assessment of its workforce against the national requirements for the Workforce Disability Equality Standards (WDES) which helps the Trust to monitor its performance and progress on a number of metrics that are centrally recorded. These results are made publically available on the Trust's website and highlight the Trust's performance when considering applications for employment, accessing training, and also access to Career development opportunities.

Staff survey

The NHS Staff Survey is conducted annually. Since 2021/22 the survey questions align to the seven elements of the NHS 'People Promise' and retain the two previous themes of engagement and morale. These replaced the ten indicator themes used prior and up to 2020/21. All indicators are based on a score out of 10 for specific questions with the indicator score being the average of those.

The response rate to the 2023/24 survey among Trust staff was 59% (2022/23: 52%). In 2024, the Trust employed a mixed mode survey to ensure all staff could access the survey. A communications and engagement strategy allowed QVH to ensure that information about the survey was shared across the organisation. Internal newsletters, posters, team briefing sessions, Q&A and confidentiality information sheets, a managers' guide, walkabouts and drop-in sessions were coordinated across QVH. Response rates were monitored on a twice-weekly basis and shared with communications team and department leads to encourage staff to complete the survey.

QVH response rates and indicator scores along with the median Acute Specialist Trust results since 2021 are shown within the table below:

We are compassionate and inclusive	7.69	7.50	7.76	7.55	7.69	7.52	Not significant
We are recognised and rewarded	6.19	5.94	6.30	6.12	6.27	6.14	Not significant
We each have a voice that counts	7.12	6.93	7.11	6.93	6.96	6.96	Not significant
We are safe and healthy	6.46	6.20	6.51	6.37	6.47	6.47	Not significant
We are always learning	5.87	5.62	6.06	5.79	5.90	5.81	Not significant
We work flexibly	6.40	6.20	6.58	6.40	6.63	6.63	Not significant
We are a team	6.97	6.85	7.00	6.93	7.03	6.94	Not significant
Staff Engagement	7.44	7.24	7.50	7.29	7.39	7.34	Not significant
Morale	6.18	5.95	6.32	6.14	6.21	6.28	Not significant
Response Rates	56.3 %	51.7 %	58.8%	53.7 %	57.6 %	57.2 %	Not significant

Source: NHS staff surveys

Analysis of the results initially shows QVH has maintained average or above average scores in comparison to its benchmarking group, although it is recognised that morale has dipped slightly below average. The top three most improved questions in the 2024 findings were:

- Don't work any additional unpaid hours per week for this organisation, over and above contracted hours
- Team members often meet to discuss the team's effectiveness
- Don't work any additional paid hours per week for this organisation, over and above contracted hours.

A key area of focus for improvement was from the questions below:

- Staff involved in an error/near miss/incident treated fairly
- Last experience of harassment/bullying/abuse reported
- Feel safe to speak up about anything that concerns me in this organisation

QVH is undertaking a detailed analysis to identify areas of concern. There is a reduction in the number of staff feeling safe to speak up about concerns. Data has also shown that although bullying and harassment for staff with a declared disability has improved, there is a gap in other workplace experiences compared to colleagues without a disability. In 2025, QVH will work in collaboration with colleagues to understand how the organisation can support staff with a declared disability using its Cultural Transformation Steering Group, Listening to Action events and survey data to inform a course of action.

Since the survey was completed, QVH has seen some improvements in staff speaking up but will continue promoting and working with the independent guardian service, Employee Relations team and utilising tools to stress the importance and confidentiality of doing so.

Moving forward, QVH will work with department leads to gather feedback and ideas from staff to improve workplace experiences. Departments have been asked to identify Staff Survey Champions to gain invaluable feedback and enable the Trust to make improvements. The People Pulse Survey will also help the organisation triangulate feedback to understand what staff are saying. Departments have a new toolkit of suggestions to help them consider priorities and action plans at a local level and utilise team posters to communicate and share results and next steps.

Trade union facility time disclosures

Table 1

Relevant union officials

What was the total number of your employees who were relevant union officials during the relevant period?

Number of employees who were relevant union officials during the relevant period	*Full-time equivalent employee number*
6	*5.4*

Table 2

Percentage of time spent on facility time

How many of your employees who were relevant union officials employed during the relevant period spent a) 0%, b) 1%-50%, c) 51%-99% or d) 100% of their working hours on facility time?

Percentage of time	*Number of employees*
0%	
1-50%	6
51%-99%	
100%	

Table 3

Percentage of pay bill spent on facility time

Provide the figures requested in the first column of the table below to determine the percentage of your total pay bill spent on paying employees who were relevant union officials for facility time during the relevant period.

First Column	*Figures*
Provide the total cost of facility time	£8,822
Provide the total pay bill	£79,632,000
Provide the percentage of the total pay bill spent on facility time, calculated as: (total cost of facility time ÷ total pay bill) x 100	0.011%

Table 4

Paid trade union activities

As a percentage of total paid facility time hours, how many hours were spent by employees who were relevant union officials during the relevant period on paid trade union activities?

Time spent on paid trade union activities as a percentage of total paid facility time hours calculated as: *(total hours spent on paid trade union activities by relevant union officials during the relevant period ÷ total paid facility time hours) x 100*	28%

Expenditure on consultancy

During 2024/25 the Trust incurred no external consultancy costs (2023/24 Nil).

Off-payroll engagements

During 2024/25 there were no off-payroll engagements (2023/24 Nil).

Exit packages

A total of 4 contractual exit packages were undertaken by the Trust in 2024/25.

Exit package cost band	Number of compulsory redundancies	Number of other departures agreed	Total number of exit packages by cost band
<£10,000		2	2
£10,000 – £25,000			
£25,001 – £50,000		1	1
£50,001 – £100,000	1		1
£100,000 – £150,000			
£150,001 – £200,000			
Total number of exit packages by type	1	3	4
Total resource cost	£77,017	£65,768	£142,786

	Agreements Number	**Total Value of Agreements £000**
Voluntary redundancies including early retirement contractual costs	*0*	*0*
Mutually agreed resignations (MARS) contractual costs	*0*	*0*
Early retirements in the efficiency of the service contractual costs	*0*	*0*
Contractual payments in lieu of notice	*3*	*£65,768*
Exit payments following Employment Tribunals or court orders	*0*	*0*
Non-contractual payments requiring HMT approval *	*0*	*0*
Total	*3*	*£65,768*
Of which: non-contractual payments requiring Treasury approval made to individuals where the payment value was more than 12 months of their annual salary.	0	0

Gender pay gap

The Trust's Gender Pay Gap report 2024 can be found here by clicking this link.

Our organisational structure

Disclosures set out within the Code of governance for NHS provider trusts.

QVH is an NHS foundation trust and has a Board of Directors, a Council of Governors and a public membership. The Trust Chair is Chair of the Board of Directors and the Council of Governors. The Board of Directors is responsible for all aspects of the performance of the Trust, and the Council of Governors holds the non-executive directors to account for the performance of the Board. QVH is subject to statutory requirements and duties but is also held accountable to local people through its members who elect the governors. The governors appoint the non-executive directors and the non-executive directors appoint the executive directors.

Council of Governors

Within the Trust's Constitution there are roles for 20 public governors, three staff governors and three stakeholder governors. Public and staff governors are elected by their constituency, and stakeholder governors are appointed by the stakeholder organisation. The Trust's stakeholder governors represent the League of Friends of Queen Victoria Hospital, East Grinstead Town Council, and West Sussex County Council. During the year, 11 public governors were elected unopposed and at the time of writing this report, three public governor vacancies remain. All QVH governors are appointed for a term of three years and will serve a maximum of two terms. A full register of members of the Council of Governors during 2024/25 is included at appendix 2 to this Annual Report and Accounts.

The Council of Governors plays a vital role in the work of the Trust, representing the interests of our public members, staff and stakeholder organisations. It has several statutory duties, including:

- Holding the non-executive directors to account for the performance of the Board
- Representing the interests of the members and members of public
- Appointing the Chair and non-executive directors, and deciding their remuneration
- Approving the appointment of the Chief Executive Officer
- Receiving the Trust's Annual Report and Accounts and the auditor's report on them.

The Council of Governors receives regular updates on the development of the Trust's strategy.

The Council of Governors has two formal sub-committees; an Appointments Committee which is responsible for making recommendations to the Council of Governors regarding the appointment and remuneration of the Chair and non-executive directors, and a Governor Steering Committee responsible for setting the agenda for Council of Governor meetings and facilitating communication between the Board of Directors and Council of Governors. It has established a working group to support the Council of Governors in discharging its statutory duty of representing the interests of the members and member of the public.

The process for the appointment of the Chair and non-executive directors is set out within the Trust's Constitution. The Council of Governors is responsible for appointing the Chair and non-executive directors, considering the views of the Board on the qualities, skills and experience

required for each position. The Appointments Committee will make recommendations of appointments to the Council of Governors following a process which involves advertising for the vacancy, shortlisting against the specification, and interviewing candidates.

During the year, the Council of Governors appointed one clinical non-executive director who joined the Board in January 2025 for a term of three years upon recommendation from the Appointments Committee. The Trust engaged Anderson Quigley to support identify and appoint this non-executive director. The Board appointed two associate non-executive directors who joined the Board in January 2025 for a term of three years. The Trust also engaged Anderson Quigley to support with these appointments.

The Council of Governors holds regular informal meetings for governors to raise issues and ask questions. These help support the governors in discharging their statutory responsibilities and maintain good relationships with the Board. There are also a number of governor working groups aligned to the Board sub-committees to support governors in their statutory duty of holding the non-executive directors to account for the performance of the Board.

QVH received a notice of imposition of additional licence conditions in October 2021, under section 111 of the Health and Social Care Act 2012. These relate to the need for the Council of Governors to implement arrangements to work effectively with the Board and to ensure that the Trust has sufficient and effective Board leadership, capacity and capability. Throughout the year, the Board and Council of Governors have continued to be mindful of the additional licence conditions and have taken action to comply with them. These actions include the continued building of effective relationships through informal meetings, effective communication, and increased opportunities to support governors in undertaking their statutory duties and training.

During the year, the Council of Governors completed a review of its own effectiveness, the results of which demonstrate that the relationship between the Board and Council of Governors has much improved and that behaviour of governors is in line with the Nolan principles. The Trust also developed a Code of Conduct with the Council of Governors which is now in place and reflects the requirement for governors to adhere to the Nolan principles and outlines the approach to be taken where these principles are breached.

The Code of governance for NHS provider trusts requires the Trust to set out within its Annual Report and Accounts how disagreements between the Board and Council of Governors will be resolved. In the event of a disagreement the Chair, on the advice of the Company Secretary, shall seek to resolve the dispute. If the Chair is unable to resolve the dispute they will appoint a special committee comprising equal numbers of directors and governors to consider the circumstances and to make recommendations to the Council of Governors and Board of Directors to resolve the dispute. If this is unsuccessful the Chair may refer the matter back to the Board of Directors who shall make the final decision.

Members can find information about how to contact the Council of Governors via this link.

Board of Directors

The Board of Directors is a unitary Board which means that within the Board of Directors, the executive directors and the non-executive directors make decisions as a single group and share the same responsibility and liability. At QVH the Board of Directors is made up of a Chair, five other non-executive directors and five voting executive directors including the Chief Executive Officer. A full register of the Board of Directors is included within appendix 1.

Descriptions of each of director's skills, expertise and experience is included within appendix three.

The Board's role is to:

- Set the overall strategic directions for the Trust within the context of NHS priorities
- Ensure the Trust provides high quality, effective and patient focussed services
- Monitor performance and risks against objectives
- Ensure adequate systems are in place and maintained to measure and monitor the Trusts effectiveness, and economy
- Ensure high standards of corporate governance
- Assess and monitor culture
- Promote effective dialogue between the Trust and the populations we serve.

The membership of the QVH Board is balanced and in line with the requirements within the Trust's Constitution. The Board notes the circumstances listed within the Code of governance for NHS provider trusts which could be seen to impair a non-executive director's independence. The Board is content its non-executive directors are independent and continue to demonstrate objective oversight and scrutiny. The Trust's non-executive directors are appointed for a term of three years and can serve a maximum of two terms to maintain independence. A list of the non-executive directors is included at appendix 1 to this Annual report.

During 2024/25, QVH had the following Board sub-committees:

- The Audit and Risk Committee
- The Nomination and Remuneration Committee
- The Strategic Development Committee
- The Quality and Safety Committee
- The Finance and Performance Committee.

Terms of reference for all Board sub-committees are available on the Trust's website via this link

Membership of the Audit and Risk Committee and Nomination and Remuneration Committee comprises non-executive directors only.

The Annual report should provide the number of times that the Board and its sub-committees have met during the year, and individual director attendance. This information is set out within appendix1.

The Board of Directors interacts regularly with the Council of Governors, ensuring they understand their views and those of its foundation trust membership. Governors are invited to attend and observe all public Board meetings, and all Board members are invited to attend Council of Governors meetings. The Board and Council of Governors attend the annual members meeting where there is an opportunity to hear directly from the Trust's members.

The Trust's Executive Leadership Team is made up of the Chief Executive Officer as accountable officer and other voting and non-voting executive directors. The Executive Leadership Team's role is to:

- Support the Board in establishing and monitoring a culture which aligns to the Trust's values, promoting equality, diversity and inclusion
- Prioritise and allocate resources

- Oversee the development and management of the Trust's external partnerships and relationships locally, regionally and nationally
- Monitor the quality of care, operational performance and financial performance of the Trust, ensuring it adheres to guidelines and meets statutory standards
- Effective management of strategic risks
- Oversight of progress against delivery of the Trust's key strategic objectives.

During the year, the Board's focus has been to develop the Trust's strategy to secure its sustainable future. In November 2024 the Board agreed the *QVH Strategy 2025-2030* and its new vision and values for the future. Extensive stakeholder engagement has been undertaken regarding the development of the Trust's strategy, including with the Council of Governors.

The Board of Directors has actively addressed opportunities to work with other providers to tackle shared challenges and deliver the NHS Sussex Improving Lives Together strategy. The Trust has played a key role in establishing the NHS Sussex provider collaborative, created to deliver the ambitions of the *Improving Lives Together Strategy.* It will also focus on working at scale, standardisation, and sharing resources to improve outcomes for people in Sussex and make it a more sustainable Health and Care system for the future.

During the year, the NHS Sussex Committee in Common was established and held its first meeting on 8 May 2024. It brings together health providers from across Sussex to deliver new, integrated, and affordable models of care over the next five years. The purpose of the Committee in Common is to ensure collective ownership and shared direction, grip and oversight of the integrated care strategy, financial sustainability and clinical transformation.

The Trust has applied the principles of the Code of governance for NHS provider trusts on a 'comply or explain' basis during 2024/25. The Code of governance for NHS provider trusts is based on the principles of the UK Corporate governance code. There is one instance where the Trust diverged from the recommended practice it sets out which is explained within the Annual Governance Statement.

NHS Oversight Framework

NHS England's NHS Oversight Framework outlines NHS England's approach to overseeing NHS trusts, foundation trusts and integrated care boards, including identifying potential support needs. NHS organisations are allocated to one of four 'segments'.

A segmentation decision indicates the scale and general nature of support needs, from no specific support needs (segment 1) to a requirement for mandated intensive support (segment 4). A segment does not determine specific support requirements. By default, all NHS organisations are allocated to segment 2 unless the criteria for moving into another segment are met. These criteria have two components:

a) objective and measurable eligibility criteria based on performance against the six oversight themes using the relevant oversight metrics (the themes are: quality of care, access and outcomes; people; preventing ill-health and reducing inequalities; leadership and capability; finance and use of resources; local strategic priorities)

b) additional considerations focused on the assessment of system leadership and behaviours, and improvement capability and capacity.

An NHS foundation trust will be in segment 3 or 4 only where it has been found to be in breach or suspected breach of its licence conditions.

QVH has been placed into segment 3 and remains the Trust's position as of March 2025. Current segmentation information for NHS trusts and foundation trusts is published on NHS England's website: www.england.nhs.uk/publication/nhs-system-oversight-framework-segmentation/.

Statement of the chief executive's responsibilities as the accounting officer of Queen Victoria Hospital NHS Foundation Trust

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

NHS England has given Accounts Directions which require Queen Victoria Hospital NHS Foundation Trust to prepare 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 Queen Victoria Hospital NHS Foundation Trust, 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, and
- 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 the financial position of the NHS foundation trust at any time and to enable them to ensure the accounts comply with requirements outlined in the NHS Act 2006. The Accounting Officer is also responsible for safeguarding the assets of the NHS foundation trust and take reasonable steps around the prevention and detection of fraud and other irregularities.

As far as I am aware, there is no relevant audit information which the foundation trust's auditors are not aware of. I have taken all the steps required 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.

Abigail Jago

Acting Chief Executive Officer

26 June 2025

Annual governance statement

Scope of responsibility

As Accounting Officer, I have responsibility for maintaining a sound system of internal control that supports the Trust achieving its policies, aims and objectives, whilst safeguarding the public funds and departmental assets for which I am personally responsible, in accordance with the responsibilities assigned to me. I am also responsible for ensuring that the NHS foundation trust is administered prudently and economically and that resources are applied efficiently and effectively. I also acknowledge my responsibilities as set out in the NHS 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 at Queen Victoria Hospital NHS Foundation Trust; to evaluate the likelihood of those risks being realised and the impact should any happen; and to manage them efficiently, effectively and economically. The system of internal control has been in place in Queen Victoria Hospital NHS Foundation Trust for the year ended 31 March 2025 and up to the date of approval of the Annual Report and Accounts.

Capacity to handle risk

Leadership of the risk management process

The CQC well-led domain requires the Board to have effective systems and process in place to manage risks. As acting Chief Executive Officer, I am responsible for overseeing risk management across all organisational, financial and clinical activities. All executive directors report to me and their performance is held to account through individual objectives which reflect the strategic objectives of the Board. All executive directors and directorate triumvirate leadership teams have a role in ensuring a strong risk management approach is embedded in all aspects of our operational activities. Risk management is a core component in job descriptions of our senior managers. Our Audit and Risk Committee enables non-executive oversight of our risk management function and leadership.

During the year, we have revised our operational and management governance arrangements and these will be kept under regular review. An Executive Committee for Quality and Risk has been established to provide operational oversight of organisational risk management, as well as several executive sub-committees. These support increased accountability and leadership for effective risk management, with clear alignment to Board sub-committees. The degree and rigour of oversight that the Board has over the Trust's capacity to handle risk is apparent within the minutes of Board and Board sub-committee meetings. The Board continues to receive assurance reports from its sub-committees including risk updates. The Trust's Board assurance framework, which is being updated at the time of writing this statement, aligns with national guidance and during the year has reflected assurance on our high level strategic risks that are deemed the most significant.

At the beginning of the year, our internal auditor's undertook a review of our Board assurance framework. The audit concluded reasonable assurance, reporting that overall controls in place relating to risk management were designed and operating effectively. The Trust Board approved our revised Risk Management Framework in September 2024 and an internal audit

of the embedding of our new framework took place within quarter four of 2024/25. The internal audit concluded partial assurance.

Board and Board sub-committee agendas are structured around a comprehensive work plan linked to the Trust's statutory and regulatory responsibilities. This helps ensure the Board is sighted on the Trust's compliance and can take timely action where risks to compliance arise.

During the year, we revised our Risk Management Framework, which I own as Chief Executive Officer. The framework sets out the accountability, reporting and oversight arrangements for risk management. It aims to support the development of a positive culture towards effective risk management and provides clear guidance about how we record, describe, assess and manage our risks.

Equipping staff to manage risks

Managers at all levels within the organisation have a responsibility to actively identify, describe, assess, and manage their local risks whilst promoting a positive risk culture. Comprehensive guidance is available to staff within the Trust's Risk Management Framework and training opportunities have been available during the year for all directorates and business units.

Each directorate has a local risk register, and they are responsible, with their respective business units, for overseeing the management of risks within their areas of the organisation. Risks which meet the threshold for escalation onto our organisational risk register are escalated through our operational and management governance structure. The organisational risk register is reviewed by the Executive Committee for Quality and Risk monthly which is attended by members of our Executive Leadership Team. Executive performance review meetings with directorates are in place to provide assurance that risks are being effectively managed.

Trust guidance and policies are authorised statements setting out how the Trust seeks to manage particular inherent risks. All guidance and policies are available to staff on our intranet.

Learning

The Trust learns from good practice and incidents and risks internally and externally, reviewing national publications and investigations to identify relevant recommendations and learning to be shared throughout the Trust, taking part in clinical audits, peer review and continued professional development. Learning from investigations, particularly in relation to patient safety, is now managed through our Patient safety and incident response framework (PSIRF). Patient and staff stories are also shared at Board meetings to support learning.

The risk and control framework

Risk management framework

Risk management is guided by the Trust's Risk Management Framework which was revised during the period. The process starts with the systemic identification of a risk which is then described in line with the cause and effect model and scored with the Trust's risk assessment matrix. Risks are managed on local risk registers or escalated for inclusion on the organisational risk register if they score more than 15 or are overarching in nature.

A risk management matrix with risk descriptors and tolerance levels is used to support a consistent approach to assessing and responding to clinical and non-clinical risks. The Trust seeks to reduce risks as far as possible; however it is recognised that delivering healthcare carries inherent risks that can never be completely eradicated. The Board and its committees are aligned to assure that there is independent and strategic focus on both risk and assurance.

The Trust's risk appetite for risk types is agreed by the Board annually and included within the Risk Management Framework.

The Board Assurance Framework sets out the Trust's risks to achieving its key strategic objectives and sets out controls and assurance on the management of these. Each year the Board will complete a formal review of its strategic risks to identify risks which may threaten the Trust achieving its strategy. At the time of writing, these risks are being reviewed. The highest scoring strategic risks during the period are related to:

- Providing effective, safe, timely and quality patient services
- The Trust's physical infrastructure being fit for purpose
- The Trust securing its long-term sustainability
- The Trust experiencing a material legislative or compliance breach
- The Trust developing and maintaining collaborative relationships.

Key controls, assurance and actions on these risks include:

Controls	Assurance	Actions
• Governing documents including policies • Processes • Key people in roles • Staff training and guidance • Freedom to speak up framework.	• Oversight from the Board sub-committees • Board visibility visits programme • Internal and external audit • External counter fraud support • Reviews and reporting of serious incidents.	• Engagement plan • CQC self-assessments • Implementation of the NHS fit and proper persons framework • Refreshed Freedom to Speak Up framework.

The responsibilities and accountabilities of the Board members and sub-committees of the Board are well defined within the governance structure. The Trust monitors compliance with its NHS foundation trust licence condition 4 (systems and processes for good governance), by several means, including:

- Public Board meetings are held bi-monthly. There are detailed reports which include all key national performance measures on quality, operational performance, finance and workforce. There is opportunity for robust challenge and debate about these reports. In addition to this, the Non-executive Chair of each Board sub-committee presents a report to the Board about the level of assurance and key items for approval or discussion. All actions are monitored via a Board action log.
- The Quality and Safety Committee and the Finance and Performance Committee are sub-committees of the Board chaired by Non-executive directors. They receive detailed reports on quality, operational performance, finance and human resources and there

is an opportunity for scrutiny and challenge by the membership. Both committees monitor completion of actions via a committee action log.

- The Audit and Risk Committee seeks assurance on risk management by commissioning internal audits and other independent reviews as part of the audit work programme or in response to specific issues. It requires evidence that effective systems and processes are in place to mitigate and manage risk.
- NHS England information, guidance and monitoring requests are responded to in a timely manner and the Executive Leadership Team attend quarterly NHS England performance reviews.
- Provider engagement meetings are held with the Care Quality Commission to ensure compliance with regulatory standards and compassionate care.
- The governance of data security and priority work in this area is described under information governance below.
- Equality impact assessments are integrated into core business. Each new or revised policy requires an equality due regard assessment to be completed to ensure the Trust meets legislative requirements and does not discriminate against protected characteristic groups. The equality due regard assessment is completed by the manager writing the policy and signed off by their line manager prior to approval by the relevant ratifying committee.
- The Council of Governors receive quarterly updates from the Non-executive director Chairs of the Quality and safety, Finance and performance and Audit and risk Board sub-committees about quality, performance and risk.
- The effectiveness of emergency planning, response and resilience (EPRR) and business continuity systems are assured through several mechanisms including exercises and lockdown drills, partnership working with commissioners including peer review and NHS England's Emergency Planning Core Standards Assessments
- The Trust has implemented a new fit and proper persons test (FPPT) policy to ensure it meets the requirements within legislation and the NHS England FPPT framework for Board members published in August 2023.

In October 2021, QVH received a notice of imposition of additional licence conditions under section 111 of the Health and Social Care Act 2012. These relate to the need for the Council of Governors to work more effectively with the Board and ensure the Trust has sufficient and effective Board leadership, capacity and capability. During the period, the Trust has continued to work towards the removal of these additional licence conditions.

At times during the year all Board positions have been substantively filled. The Trust Chair has remained in post during 2024/25. At the time of writing this report, the Trust has an acting Chief executive officer and interim Chief finance officer. The Board and Council of Governors have focussed on implementing arrangements to work effectively together which has had a positive impact. The Board has engaged extensively with governors as key stakeholders in developing the organisational strategy, seeking feedback on hopes, fears and ideas for the future of QVH. There has been an increase in relationship building opportunities for the Board and Council of Governors during the year as well as increased opportunities for governors to discharge their statutory duty of holding the non-executive directors to account for the performance of the Board, with the establishment of informal Council of Governors meetings, training provided for governors and other practices such as governors being invited to join non-executive directors on service visits. Governor working groups aligned to each of the Board sub-committees have also been established, and governors are invited to ask questions at each Board meeting related to the agenda items.

A Code of conduct has been developed with governors which reflects the requirement for them to adhere to the Nolan principles and outlines the approach to be taken where these principles are breached. This includes the process for the removal of a governor, in line with the last remaining recommendation from the independent review of the Trust's handling of challenges encountered in progressing a merger with University Hospitals Sussex carried out during 2021/22 by Carnall Farrar.

During the period, the Trust has departed from the recommended best practice within the Code of governance for NHS provider trusts in the following areas:

E.2.2 Levels of remuneration for the Chair and other non-executive directors should reflect the ***Chair and non-executive director remuneration structure*** (published by NHS England Dec 2019).	The Council of Governor Appointments Committee is responsible for setting the Chair and non-executive director (NED) remuneration. All NEDs receive the same remuneration. QVH NED and Chair remuneration is slightly above NHS England's recommended remuneration due to the complexities of the role and time commitment required which is higher than other Trusts.

This is in to comparison to last year, where the Trust reported non-compliance in relation to the Senior Independent Director (SID) also being Chair of the Audit and Risk Committee for a period, the lack of a succession plan, and the development of the Council of Governors code of conduct.

Quality governance

The Trust's new quality governance framework developed during 2024/25 is built upon the principles described within the eight domains of NHS England's well-led framework and the five quality domains outline by the CQC. The Board regularly and actively engages in discussions regarding quality of care with patients, the public and staff through a range of different mechanisms. Quality targets and measures are reported in the Trust's integrated quality and performance reporting which is reviewed at directorate and Board level.

The Finance and Performance Committee of the Trust Board receive bi-annual reports regarding cyber risks and how these are being managed. Data security training is mandated for all staff at QVH in line with the national requirement. Staff receive data security training as part of their induction and are subsequently required to complete the training annually. Compliance with mandatory and statutory training during the year has been monitored via the integrated quality and performance report which has been included in our public Board meeting papers. In 2024/25, the Trust exceeded the 95% data security protection toolkit requirement for information governance and cyber security training. Cyber and data requirements are supported by Trust policies. The data security and protection toolkit sets out the national data guardian's data security standards. These standards apply to all health and social care organisations and provide assurance to every person who uses our services that their information is handled correctly and protected throughout its lifecycle from unauthorised access, loss, damage or destruction. Completing the toolkit self-assessment by providing evidence against assertions, demonstrates the Trust is meeting the national data guardian standards. This increases public confidence that confirms the NHS and its partners can be trusted with data. The toolkit can be accessed by members of the public to view the assessments of participating organisations.

All mandatory requirements were achieved meaning that the Trust gained a 'standards met' grade for the submission during the period.

Well led

Foundation trust Boards are required to undertake an external review of governance every five years to ensure that governance arrangements remain fit for purpose. During Q4 of 2022/23, QVH appointed an external team at Deloitte LLP to carry out this review. The detailed findings were outlined in the 2023/24 Annual governance statement. Work on implementing the recommendations from the review has continued into this period, including the revised Risk Management Framework and establishment of the Executive Committee for Quality and Risk, revised organisational structure, and the operational and management governance structure, to ensure QVH is clinically led with appropriate oversight and assurance mechanisms in place for the Executive Leadership Team.

Assurance statements

Compliance with the Developing Workforce Safeguards25 recommendations

During the period, The Trust developed a People Strategy aligned with the Trust's overall strategy. As part of the annual business planning cycle an annual workforce planning process is run to triangulate staffing with predicted activity levels and finance plans.

Workforce metrics are monitored regularly to ensure safe staffing levels. The Trust Board receives regular reports from the Guardian of Safe Working and a six-monthly nursing workforce review report. Trust-wide processes are in place to support the recruitment and retention of staff and reduce its reliance on temporary staff.

To ensure staff have the right skills to undertake their role, a wide range of training and development is provided. Ongoing training requirements are monitored through annual appraisal and revalidation, performance development reviews and monthly statutory and mandatory training reports. Staffing levels are reviewed regularly, and e-rostering systems are in place for all staff. Key performance metrics related to the Trust's workforce are monitored by the Finance and Performance Committee and the Board.

Care Quality Commission (CQC)

The foundation trust is fully compliant with the registration requirements of the Care Quality Commission.

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 NHS27 guidance.

Pension scheme

As an employer with staff entitled to membership of the NHS Pension Scheme, the Trust has control measures in place to ensure all employer obligations contained within the Scheme regulations are complied with. This includes ensuring 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 line with the timescales detailed in the Regulations.

Equality, diversity and human rights

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

Green Plan

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 ended the financial year with a breakeven position [subject to audit], however, this position was achieved using non-recurrent benefits and the Trust has an underlying deficit position. This is listed as a significant control issue.

The Trust Board receives regular updates from the Chief finance officer on financial performance within the Integrated quality and performance report to the Board. Financial reporting has been strengthened during the year to ensure that there is visibility of the Trust's underlying deficit position.

The Trust works to ensure economy, efficiency and effectiveness in a number of ways including:

- Through the annual business planning process
- Pay and non-pay budgetary system
- Financial controls including value for money
- Tendering procedures
- Establishment controls
- Efficiencies.

The Trust's resources are managed within the framework of its primary governing documents including its Standing Financial Instructions and Scheme of Delegation and Reservation of Powers. Weaknesses have been identified in the governance arrangements during the year. I have described the actions taken to address weaknesses identified in my review of effectiveness below.

The Trust has a challenging Cost improvement programme for 2025/26 of £7.5m. This is a risk for the Trust and delivery will be overseen by an executive led Efficiency steering group with progress updates to the Board through the Integrated quality and performance report.

Information governance

The Trust reports significant data and confidentiality breaches to the Information Commissioners Office (ICO) as soon as it is made aware. During the period, two confidentiality breaches were reported to the ICO. One related to intraoperative images being shared with a third party without consent. There has been no further action by the ICO but advice was given to the Trust on appropriate actions and an investigation is ongoing. The other related to the inappropriate sharing of information. There has been no further action by the ICO but advice was given to the Trust on appropriate actions and an internal process was completed.

Data quality and governance

Data quality refers to the tools and processes that result in the creation of the correct, complete, and valid data required to support patient care and sound decision making. The Trust's integrated data warehouse system has increased the transparency and visibility of data issues during the year. The Trust has established a new integrated quality and performance report which demonstrates how it is achieving its key strategic objectives and highlights where key performance indicators (KPI's) are being met. It is working to strengthen its business intelligence team to support and strengthen the quality and accuracy of data.

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 NHS foundation 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, the Audit and Risk Committee and a plan to address weaknesses and ensure continuous improvement of the system is in place.

- The Board and its sub-committees have met regularly and kept arrangements for internal control under review, as well as monitoring outcomes. As standard practice, the Board regularly reviews the Board Assurance Framework and organisational risk register, as well as receiving regular assurance reports by the Chairs of the Board sub-committees. The Board last reviewed the Board assurance framework in November 2024. The Board agreed at its meeting in November 2024 that the Board assurance framework should be revised in light of the new QVH Strategy 2025-2030 and Key strategic objectives.
- The Audit and Risk Committee has provided the Board with an independent and objective review of financial and corporate governance and internal controls through its regular assurance reporting and its annual report to the Board. The committee regularly reviews findings from internal and external audits.
- The Quality and Safety Committee reviews feedback when received from external assessments on the quality of services including from NHS England, Healthwatch, Care Quality Commission, NHS Resolution and audit, as well as ensuring internal quality measures are regularly tested and standards are met.

The Audit and Risk committee identified instances of non-compliance with the Standing Orders, Standing Financial Instructions and Scheme of Delegation and Reservation of Powers, as well as challenges with budgetary control and business planning during the period up to quarter 3 of the financial year. The Trust also identified weaknesses in contract management controls and processes. These indicated an internal control environment which was not as robust as it should have been. The Trust has taken steps to address these challenges and a review of contracts has provided assurance that there were no breaches of the Trust's governing documents during quarter four of 2024/25. The Trust has also strengthened its approach to business planning and budget setting for 2025/26.

The Trust's internal audit programme provides a further mechanism for assessing the effectiveness of the organisation's control environment. The internal audit plan for the period 2024/25 was developed to ensure focus on areas where there have been challenges to support improvement going forwards. This plan was reviewed and approved by the Audit and Risk Committee.

The Trust's internal auditors identify high, medium and low priority actions within their reports, progress against which is monitored by the Executive Leadership Team with oversight from the Audit and Risk Committee. The Audit and Risk Committee receive regular updates regarding progress against management actions from the internal auditors.

The table below summarises the outcome and assurance rating for each internal audit undertaken during the period:

Internal audit	**Assurance rating**	**Management actions accepted**			
		High priority	**Medium priority**	**Low priority**	**Total**
Planned waiting lists	Partial assurance	2	3	0	5
Project management & benefits realisation	Partial assurance	1	7	1	9
Performance management and data quality	Partial assurance (sickness) Substantial assurance (diagnostic waiting times)	1	0	0	1
Cash flow management and payroll	Partial assurance	1	5	2	8
Follow up on contract management internal audit from 2023/24	Little progress made in implementing actions	1	6	0	7
Recruitment and on boarding processes	Reasonable assurance	0	7	1	8
Data security protection toolkit 2023/24 submission	Substantial assurance	0	1	5	6
Risk Management	Partial assurance	1	6	1	7

During the year, no internal audits have concluded a rating of inadequate. Five internal audits concluded a rating of partial assurance and six high priority actions were raised.

Weaknesses in contract management controls and processes were identified by the Trust during 2023/24. This was during a period of staff vacancies. This led to an internal audit being completed on contract management which concluded partial assurance. During 2024/25, a follow up internal audit was completed which concluded that little progress had been made against the actions of the original audit.

Weaknesses in recruitment and establishment controls were also identified by the Trust during 2024/25. In response to this, the internal auditors also completed an advisory review related to recruitment to certain posts during the period. A review of Q4 of 2024/25 has provided assurance that recruitment to senior posts undertaken during this period was in line with Trust policy and governing documents.

The overall head of internal audit opinion for the period is that there are weaknesses in the framework of governance, risk management and internal control such that it could become inadequate and ineffective.

During the period, the Audit and Risk Committee has overseen the completion of management actions and improvements made in the areas where the Trust received a partial assurance rating for an audit. The Trust has now made progress in addressing the issues raised by the contract management audit in 2023/24 and the follow up review during this period which will support improvements in the Trust's value for money arrangements. There has been improvement in contract management during quarter four of 2024/25, supported by a new contract database and contract management policy.

Outline of actions taken or proposed to deal with significant internal control issues and gaps in control

Weaknesses in governance arrangements

- A comprehensive review of the Trust's Scheme of Delegation and Reservation of Powers, and Standing Financial Instructions has been completed during Quarter 1 of 2025/26. The changes seek to ensure that the documents are accessible to staff, and staff will receive training on the key requirements
- We will also develop a Trust-wide governance handbook during 2025/26.
- Retrospective approval has been sought by the Board for any contracts which were approved outside of the Scheme of Delegation and Reservation of Powers during 2024/25.
- We have worked to minimise the use of single tender waivers. We have established a reliable contract database and contract management policy to support strengthened procurement processes, and an appropriately planned capital programme.
- We have strengthened the capability of the Procurement Team.
- There has been a revised approach to the business planning and budget setting process and guidance for 2025/26.
- There is now in place routine forecasting of the outturn income and expenditure capital position in sufficient detail.

Conclusion

Significant internal control issues have been identified. Where significant controls issues have been identified, appropriate plans are in place to deliver the required improvement. An outline of the key actions taken or proposed to deal with these are in this statement. The significant control issues identified are:

- Weaknesses in governance arrangements as described in my review of effectiveness

- The Trust's underlying deficit position
- Five internal audits completed during the period concluded partial assurance
- The overall Head of Internal Audit opinion is that there are weaknesses in the framework of governance, risk management and internal control such that it could become inadequate and ineffective.

Abigail Jago

Acting Chief Executive Officer

26 June 2025

4. Independent Auditor's Report to the Council of Governors of Queen Victoria Hospital NHS Foundation Trust

Report on the audit of the financial statements

Opinion on the financial statements

We have audited the financial statements of Queen Victoria Hospital NHS Foundation Trust (the 'Trust') and its subsidiary (the 'Group') for the year ended 31 March 2025, which comprise the Consolidated Statement of Comprehensive Income, the Statements of Financial Position, the Consolidated Statement of Changes in Taxpayers Equity, the Statement of Changes in Taxpayers Equity, the Statements of Cash Flows and notes to the financial statements, including accounting policies and other information. The financial reporting framework that has been applied in their preparation is applicable law and UK adopted international accounting standards, in conformity with the requirements of the Accounts Directions issued under Schedule 7 of the National Health Service Act 2006, as interpreted and adapted by the Department of Health and Social Care Group Accounting Manual 2024 to 2025.

In our opinion, the financial statements:

- give a true and fair view of the financial position of the Group and of the Trust as at 31 March 2025 and of the Group's and Trust's expenditure and income for the year then ended; and
- have been properly prepared in accordance with UK adopted international accounting standards, as interpreted and adapted by the Department of Health and Social Care Group Accounting Manual 2024 to 2025; and
- have been prepared in accordance with the requirements of the National Health Service Act 2006.

Basis for opinion

We conducted our audit in accordance with International Standards on Auditing (UK) (ISAs (UK)), applicable law and Practice Note 10 'Audit of Financial Statements and Regularity of Public Sector Bodies in the United Kingdom', as required by the Code of Audit Practice ("the Code of Audit Practice") approved by the Comptroller and Auditor General. Our responsibilities under those standards are further described in the 'Auditor's responsibilities for the audit of the financial statements' section of our report. We are independent of the Group and the Trust in accordance with the ethical requirements that are relevant to our audit of the financial statements in the UK, including the FRC's Ethical Standard, and we have fulfilled our other ethical responsibilities in accordance with these requirements. We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our opinion.

Conclusions relating to going concern

In auditing the financial statements, we have concluded that the Accounting Officer's use of the going concern basis of accounting in the preparation of the financial statements is appropriate.

Based on the work we have performed, we have not identified any material uncertainties relating to events or conditions that, individually or collectively, may cast significant doubt on the Group's and the Trust's ability to continue as a going concern for a period of at least twelve months from the date when the financial statements are authorised for issue.

Our responsibilities and the responsibilities of the Accounting Officer with respect to going concern are described in the relevant sections of this report.

Other information

The other information comprises the information included in the Annual Report, other than the financial statements and our auditor's report thereon. The Accounting Officer is responsible for the other information contained within the Annual Report. Our opinion on the financial statements does not cover the other information and, except to the extent otherwise explicitly stated in our report, we do not express any form of assurance conclusion thereon.

Our responsibility is to read the other information and, in doing so, consider whether the other information is materially inconsistent with the financial statements or our knowledge obtained in the audit or otherwise appears to be materially misstated.

If we identify such material inconsistencies or apparent material misstatements, we are required to determine whether this gives rise to a material misstatement in the financial statements themselves. If, based on the work we have performed, we conclude that there is a material misstatement of this other information, we are required to report that fact.

We have nothing to report in this regard.

Opinion on other matters required by the Code of Audit Practice

In our opinion:

- The parts of the Remuneration Report and the Staff Report to be audited have been properly prepared in accordance with the requirements set out in the NHS foundation trust annual reporting manual 2024/25; and
- Based on the work undertaken in the course of the audit of the financial statements, the other information published together with the audited financial statements in the Annual Report for the financial year for which the financial statements are prepared is consistent with the financial statements.

Matters on which we are required to report by exception under the Code of Audit Practice

Under the Code of Audit Practice, we are required to consider whether the Annual Governance Statement does not comply with the disclosure requirements set out in the NHS foundation trust annual reporting manual 2024/25 or is misleading or inconsistent with information of which we are aware from our audit. We are not required to consider whether the Annual Governance Statement addresses all risks and controls or that risks are satisfactorily addressed by internal controls.

We have nothing to report in respect of the above matters.

Responsibilities of the Accounting Officer

As explained more fully in the Statement of Accounting Officer's Responsibilities (set out on pages 47 to 48), the Chief Executive, as Accounting Officer, is responsible for the preparation of the financial statements in the form and on the basis set out in the Accounts Directions, for being satisfied that they give a true and fair view, and for such internal control as the Accounting Officer determines is necessary to enable the preparation of financial statements that are free from material misstatement, whether due to fraud or error.

In preparing the financial statements, the Accounting Officer is responsible for assessing the Trust's and Group'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 the Accounting Officer has been informed by the relevant national body of the intention to dissolve the Trust and the Group without the transfer of its services and functions to another public sector entity. The Accounting Officer is required to comply with the requirements set out in the Department of Health and Social Care Group Accounting Manual 2024 to 2025.

Auditor's responsibilities for the audit of the financial statements

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 an auditor's report that includes our opinion. Reasonable assurance is a high level of assurance, but is not a 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 the aggregate, they could reasonably be expected to influence the economic decisions of users taken on the basis of these financial statements.

A further description of our responsibilities for the audit of the financial statements is located on the Financial Reporting Council's website at: www.frc.org.uk/auditorsresponsibilities. This description forms part of our auditor's report.

Extent to which the audit was considered capable of detecting irregularities, including fraud

Irregularities, including fraud, are instances of non-compliance with laws and regulations. We design procedures in line with our responsibilities, outlined above, to detect material misstatements in respect of irregularities, including fraud. Owing to the inherent limitations of an audit, there is an unavoidable risk that material misstatements in the financial statements may not be detected, even though the audit is properly planned and performed in accordance with the ISA's (UK).

The extent to which our procedures are capable of detecting irregularities, including fraud is detailed below:

We obtain and update our understanding of the Trust and Group, their activities, control environment, and likely future developments, including in relation to the legal and regulatory framework applicable and how the Group and Trust is complying with that framework. We determined that the most significant legal and regulatory frameworks that are applicable to the Trust and Group, which are directly linked to specific assertions in the financial statements, are those related to the financial reporting frameworks. These include the National Health Service Act 2006 and international accounting standards, as interpreted and adapted by the Department of Health and Social Care Group Accounting Manual 2024 to 2025.

Based on this understanding, we identify and assess the risks of material misstatement of the financial statements, whether due to fraud or error, design and perform audit procedures responsive to those risks, and obtain audit evidence that is sufficient and appropriate to provide a basis for our opinion. This includes consideration of the risk of acts by the Group or the Trust that were contrary to applicable laws and regulations, including fraud.

In response to the risk of irregularities and non-compliance with laws and regulations, including fraud, we designed procedures which included:

- Enquiry of management, internal audit, and those charged with governance concerning the Group and Trust's operations, the key policies and procedures, and the establishment of internal controls to mitigate risks related to fraud and non-compliance with laws and regulations, together with their knowledge of any actual or potential litigation and claims and actual, suspected and alleged fraud;
- Reviewing minutes of meetings of those charged with governance;
- Assessing the extent of compliance with the laws and regulations considered to have a direct material effect on the Group and Trust's financial statements and the operations of the Group and Trust through enquiry and inspection;
- Reviewing financial statement disclosures and testing to supporting documentation to assess compliance with applicable laws and regulations;
- Performing audit work over the risk of management bias and override of controls, including testing of high-risk journal entries and other adjustments for appropriateness, including evaluating the rationale of any significant transactions outside the normal course of business and reviewing key accounting estimates including property plant and equipment valuations for indicators of potential bias;
- Other audit procedures responsive to the risk of fraud, non-compliance with laws and regulation or irregularity include testing the accuracy and occurrence of non-block contract income and the existence of receivables, assessing the completeness of non-pay expenditure and assessing the existence and valuation of accruals; and
- Assessing whether the engagement team collectively had the appropriate competence and capabilities to identify or recognise non-compliance with laws and regulations. We concluded that more experienced audit team members needed to be allocated to perform work on the significant risks identified and engaged audit specialists to support our work on IT General controls

We also communicated potential non-compliance with laws and regulations, including potential fraud risks to all engagement team members and remained alert to any indications of fraud or non-compliance with laws and regulations throughout the audit.

Because of the inherent limitations of an audit, there is a risk that we will not detect all irregularities, including those leading to a material misstatement in the financial statements or non-compliance with regulations. This risk increases the more that compliance with a law or regulation is removed from the events and transactions reflected in the financial statements, as we will be less likely to become aware of instances of non-compliance. The risk of not detecting a material misstatement resulting from fraud is higher than for one resulting from error, as fraud may involve collusion, forgery, intentional omissions, misrepresentations, or the override of internal control.

Report on other legal and regulatory matters

Reports in the public interest or to the regulator

Under the Code of Audit Practice, we are required to report to you if:

- we issue a report in the public interest under Schedule 10 (3) of the National Health Service Act 2006; or
- we refer a matter to the regulator under Schedule 10 (6) of the National Health Service Act 2006, because we have reason to believe that the Trust, or an officer of the Trust, is about to make, or has made, a decision which involves or would involve the incurring of unlawful expenditure, or is about to take, or has begun to take a course of action

which, if followed to its conclusion, would be unlawful and likely to cause a loss or deficiency.

We have nothing to report in respect of the above 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 to you if, in our opinion, we have not been able to satisfy ourselves that the Trust has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources for the year ended 31 March 2025.

We have nothing to report in respect of the above except:

- on 24 June 2025 we reported one significant weakness in how the body monitors and assesses risk and how the body gains assurance over the effective operation of internal controls, including arrangements to prevent and detect fraud. This was in relation to instances of non-compliance with Trust policies during 2024/25. We recommended that the Trust Board monitor delivery of the action plans designed to address the weaknesses identified.

Responsibilities of the Accounting Officer

The Chief Executive, as Accounting Officer, is responsible for putting in place proper arrangements to secure economy, efficiency and effectiveness in the Trust's use of resources, to ensure proper stewardship and governance, and to review regularly the adequacy and effectiveness of these arrangements.

Auditor's responsibilities for the review of the Trust's arrangements for securing economy, efficiency and effectiveness in its use of resources

We are required under Schedule 10(1)(d) of the National Health Service Act 2006 to be satisfied 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 have undertaken our review in accordance with the Code of Audit Practice, having regard to the guidance issued by the Comptroller and Auditor General in November 2024. This guidance sets out the arrangements that fall within the scope of 'proper arrangements.' When reporting on these arrangements, the Code of Audit Practice requires auditors to structure their commentary on arrangements under three specified reporting criteria:

- Financial sustainability: how the Trust plans and manages its resources to ensure it can continue to deliver its services;
- Governance: how the Trust ensures that it makes informed decisions and properly manages its risks; and
- Improving economy, efficiency and effectiveness: how the Trust uses information about its costs and performance to improve the way it manages and delivers its services.

We have documented our understanding of the arrangements the Trust has in place for each of these three specified reporting criteria, gathering sufficient evidence to support our risk assessment and commentary which will be included in our Auditor's Annual Report. In

undertaking our work, we have considered whether there is evidence to suggest that there are significant weaknesses in arrangements.

Delayed certificate

We cannot formally conclude the audit and issue an audit certificate for Queen Victoria Hospital NHS Foundation Trust for the year ended 31 March 2025 in accordance with the requirements of the National Health Service Act 2006 and the Code of Audit Practice (the "Code") until we have completed all our responsibilities mandated by the Code.

We have completed our Consolidated NHS Provider Accounts (CPA) group audit work for the year ended 31 March 2025, as mandated under the Part 1 of the National Audit Office's group instructions, but the National Audit Office has yet to confirm whether this audit will be selected as an additional sample for their group audit testing.

We are satisfied that this work does not have a material effect on the financial statements, or on our conclusion on the Trust's arrangements for securing economy, efficiency, and effectiveness in its use of resources for the year ended 31 March 2025.

Use of our report

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 Trust's Council of Governors 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 Trust and the Trust's Council of Governors, as a body, for our audit work, for this report, or for the opinions we have formed.

Andrew Reid

Andrew Reid, Key Audit Partner

for and on behalf of Azets Audit Services, Local Auditor
Birmingham

27 June 2025

5. Annual accounts 2024/25

Foreword to the accounts

These accounts, for the year ended 31 March 2025, have been prepared by Queen Victoria Hospital NHS Foundation Trust in accordance with paragraphs 24 & 25 of Schedule 7 within the National Health Service Act 2006.

Abigail Jago

Acting Chief Executive Officer

26 June 2025

Consolidated Statement of Comprehensive Income

		Group	
		2024/25	2023/24
	Note	£000	£000
Operating income from patient care activities	3	112,837	99,928
Other operating income	4	4,696	5,178
Operating expenses	6,8	(115,528)	(104,737)
Operating surplus/(deficit) from continuing operations		**2,005**	**369**
Finance income	10	449	670
Finance expenses	11	(146)	(75)
PDC dividends payable		(2,236)	(1,732)
Net finance costs		**(1,933)**	**(1,137)**
Surplus / (deficit) for the year from continuing operations		**72**	**(768)**
Other comprehensive income			
Will not be reclassified to income and expenditure:			
Impairments	7	-	(1,387)
Revaluations	19	4,168	3,319
Total comprehensive income / (expense) for the period		**4,240**	**1,164**
Surplus/ (deficit) for the period attributable to:			
Queen Victoria Hospital NHS Foundation Trust		72	(768)
TOTAL		**72**	**(768)**
Total comprehensive income/ (expense) for the period attributable to:			
Queen Victoria Hospital NHS Foundation Trust		4,240	1,164
TOTAL		**4,240**	**1,164**

Statements of Financial Position

		Group		Trust	
		31 March 2025	31 March 2024	31 March 2025	31 March 2024
	Note	£000	£000	£000	£000
Non-current assets					
Intangible assets	14	12,237	8,141	12,237	8,141
Property, plant and equipment	16	68,311	61,445	68,311	61,445
Right of use assets	20	3,573	3,177	3,573	3,177
Receivables	27	305	276	305	276
Total non-current assets		**84,426**	**73,039**	**84,426**	**73,039**
Current assets					
Inventories	26	1,170	1,219	1,170	1,219
Receivables	27	9,413	8,864	9,413	8,864
Cash and cash equivalents	31	16,182	16,107	12,941	12,787
Total current assets		**26,765**	**26,190**	**23,524**	**22,870**
Current liabilities					
Trade and other payables	32	(20,539)	(20,348)	(20,459)	(20,141)
Borrowings	34	(2,018)	(2,133)	(2,018)	(2,133)
Provisions	36	(50)	(2,117)	(50)	(2,117)
Other liabilities	33	(535)	(262)	(535)	(262)
Total current liabilities		**(23,142)**	**(24,860)**	**(23,062)**	**(24,653)**
Total assets less current liabilities		**88,049**	**74,369**	**84,888**	**71,256**
Non-current liabilities					
Borrowings	34	(915)	(1,286)	(915)	(1,286)
Provisions	36	(815)	(648)	(815)	(648)
Total non-current liabilities		**(1,730)**	**(1,934)**	**(1,730)**	**(1,934)**
Total assets employed		**86,319**	**72,435**	**83,158**	**69,322**
Financed by					
Public dividend capital		41,299	31,655	41,299	31,655
Revaluation reserve		24,439	20,271	24,439	20,271
Income and expenditure reserve		17,420	17,396	17,420	17,396
Charitable fund reserves	25	3,161	3,113	-	-
Total taxpayers' equity		**86,319**	**72,435**	**83,158**	**69,322**

The notes on pages 71 to 112 form part of these accounts.

Abigail Jago

Acting Chief Executive Officer

26 June 2025

Consolidated Statement of Changes in Equity for the year ended 31 March 2025

Group	Public dividend capital	Revaluation reserve	Other reserves	Income and expenditure reserve	Charitable fund reserves	Total
	£000	£000	£000	£000	£000	£000
Taxpayers' and others' equity at 1 April 2024 - brought forward	**31,655**	**20,271**	**-**	**17,396**	**3,113**	**72,435**
Surplus/(deficit) for the year	-	-	-	24	48	**72**
Impairments	-	-	-	-	-	**-**
Revaluations	-	4,168	-	-	-	**4,168**
Public dividend capital received	9,644	-	-	-	-	**9,644**
Taxpayers' and others' equity at 31 March 2025	**41,299**	**24,439**	**-**	**17,420**	**3,161**	**86,319**

Consolidated Statement of Changes in Equity for the year ended 31 March 2024

Group	Public dividend capital	Revaluation reserve	Other reserves	Income and expenditure reserve	Charitable fund reserves	Total
	£000	£000	£000	£000	£000	£000
Taxpayers' and others' equity at 1 April 2023 - brought forward	**24,546**	**18,339**	**-**	**18,177**	**3,099**	**64,161**
Surplus/(deficit) for the year	-	-	-	(782)	14	**(768)**
Impairments	-	(1,387)	-	-	-	**(1,387)**
Revaluations	-	3,319	-	-	-	**3,319**
Public dividend capital received	7,109	-	-	-	-	**7,109**
Taxpayers' and others' equity at 31 March 2024	**31,655**	**20,271**	**-**	**17,396**	**3,113**	**72,435**

Statements of Cash Flows

	Note	Group 2024/25 £000	Group 2023/24 £000	Trust 2024/25 £000	Trust 2023/24 £000
Cash flows from operating activities					
Operating surplus / (deficit)		2,005	369	2,027	415
Non-cash income and expense:					
Depreciation and amortisation	6.1	4,588	5,338	4,588	5,338
Net impairments	7	(238)	509	(238)	509
(Increase) / decrease in receivables and other assets		(578)	(493)	(578)	(369)
(Increase) / decrease in inventories		49	(147)	49	(147)
Increase / (decrease) in payables and other liabilities		1,707	(5,864)	1,707	(5,705)
Increase / (decrease) in provisions		(1,909)	(206)	(1,909)	(206)
Movements in charitable fund working capital		(127)	204	-	(158)
Other movements in operating cash flows		(1)	1	(1)	-
Net cash flows from / (used in) operating activities		**5,496**	**(289)**	**5,645**	**(323)**
Cash flows from investing activities					
Interest received		379	610	379	610
Purchase of intangible assets		(7,211)	(783)	(7,211)	(783)
Sales of intangible assets		-	-		-
Purchase of PPE and investment property		(7,121)	(3,038)	(7,121)	(3,038)
Sales of PPE and investment property		2,250	-	2,250	-
Net cash flows from charitable fund investing activities		70	60	-	-
Net cash flows from / (used in) investing activities		**(11,633)**	**(3,151)**	**(11,703)**	**(3,211)**
Cash flows from financing activities					
Public dividend capital received		9,644	7,109	9,644	7,109
Public dividend capital repaid		-	-	-	-
Movement on loans from DHSC		(778)	(778)	(778)	(778)
Capital element of lease liability repayments		(513)	(42)	(513)	(42)
Interest on loans		(49)	(71)	(49)	(71)
Interest paid on lease liability repayments		(93)	-	(93)	-
PDC dividend (paid) / refunded		(1,999)	(1,622)	(1,999)	(1,622)
Net cash flows from / (used in) financing activities		**6,212**	**4,596**	**6,212**	**4,596**
Increase / (decrease) in cash and cash equivalents		**75**	**1,156**	**154**	**1,062**
Cash and cash equivalents at 1 April - brought forward		**16,107**	**14,951**	**12,787**	**11,725**
Prior period adjustments			-	-	
Cash and cash equivalents at 1 April - restated		**16,107**	**14,951**	**12,787**	**11,725**
Cash and cash equivalents transferred under absorption accounting	47	-	-	-	-
Unrealised gains / (losses) on foreign exchange		-	-	-	-
Cash and cash equivalents at 31 March	31	**16,182**	**16,107**	**12,941**	**12,787**

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 2024/25 issued by the Department of Health and Social Care. The accounting policies contained in the GAM follow International Financial Reporting Standards to the extent that they are meaningful and appropriate to the NHS, as determined by HM Treasury, which is advised by the Financial Reporting Advisory Board. Where the GAM permits a choice of accounting policy, the accounting policy that is judged to be most appropriate to the particular circumstances of the Trust for the purpose of giving a true and fair view has been selected. The particular policies adopted are described below. These have been applied consistently in dealing with items considered material in relation to the accounts.

Accounting convention

These accounts have been prepared under the historical cost convention modified to account for the revaluation of property, plant and equipment, intangible assets, inventories and certain financial assets and financial liabilities.

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.

Note 1.3 Consolidation

NHS Charitable Funds

The trust is the corporate trustee to The Queen Victoria Hospital NHS Trust Charitable Fund. The trust has assessed its relationship to the charitable fund and determined it to be a subsidiary because the trust is exposed to, or has rights to, variable returns and other benefits for itself, patients and staff from its involvement with the charitable fund and has the ability to affect those returns and other benefits through its power over the fund.

The charitable fund's statutory accounts are prepared to 31 March in accordance with the UK Charities Statement of Recommended Practice (SORP) which is based on UK Financial Reporting Standard (FRS) 102. On consolidation, necessary adjustments are made to the charity's assets, liabilities and transactions to:

- recognise and measure them in accordance with the trust's accounting policies and
- eliminate intra-group transactions, balances, gains and losses.

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.

High costs drugs and devices excluded from the calculation of national prices are reimbursed by NHS England based on actual usage or at a fixed baseline in addition to the price of the related service.

In 2023/24, fixed payments were set at a level assuming the achievement of elective activity targets within aligned payment and incentive contracts. These payments are accompanied by a variable-element to adjust income for actual activity delivered on elective services and advice and guidance services. Where actual elective activity delivered differed from the agreed level set in the fixed payments, the variable element either increased or reduced the income earned by the Trust at a rate of 75% of the tariff price.

The Trust also receives income from commissioners under Commissioning for Quality Innovation (CQUIN) and Best Practice Tariff (BPT) schemes. Delivery under these schemes is part of how care is provided to patients. As such CQUIN and BPT payments are not considered distinct performance obligations in their own right; instead they form part of the transaction price for performance obligations under the overall contract with the commissioner and are accounted for as variable consideration under IFRS 15. Payment for CQUIN and BPT on non-elective services is included in the fixed element of API contracts with adjustments for actual achievement being made at the end of the year. BPT earned on elective activity is included in the variable element of API contracts and paid in line with actual activity performed.

Where the relationship with a particular integrated care board is expected to be a low volume of activity (annual value below £0.5m), an annual fixed payment is received by the provider as determined in the NHSPS documentation. Such income is classified as 'other clinical income' in these accounts.

Elective recovery funding provides additional funding to integrated care boards to fund the commissioning of elective services within their systems. Trusts do not directly earn elective recovery funding, instead earning income for actual activity performed under API contract arrangements as explained above. The level of activity delivered by the trust contributes to system performance and therefore the availability of funding to the trust's commissioners.

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 grants 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 Property, plant and equipment

Recognition

Property, plant and equipment is capitalised where:

• it is held for use in delivering services or for administrative purposes
• it is probable that future economic benefits will flow to, or service potential be provided to, the trust
• it is expected to be used for more than one financial year
• the cost of the item can be measured reliably
• the item has a cost of at least £5,000, or
• collectively, a number of items have a cost of at least £5,000 and individually have a cost of more than £250, where the assets are functionally interdependent, have broadly simultaneous purchase dates, are anticipated to have similar disposal dates and are under single managerial control.
• or form part of the initial equipping and setting up cost of a new building, ward or unit, irrespective of the individual or collective cost.

Where a large asset, for example a building, includes a number of components with significantly different asset lives, e.g. plant and equipment, then these components are treated as separate assets and depreciated over their own useful lives.

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.

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 modern equivalent asset basis.

For specialised assets, current value in existing use is interpreted as the present value of the asset's remaining service potential, which is assumed to be at least equal to the cost of replacing that service potential. Specialised assets are therefore valued at their depreciated replacement cost (DRC) on a modern equivalent asset (MEA) basis. An MEA basis assumes that the asset will be replaced with a modern asset of equivalent capacity and meeting the 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.

The freehold property known as the Queen Victoria Hospital NHS Foundation Trust was valued as at 31 March 2025 by an external valuer, Gerald Eve LLP, a regulated firm of Chartered Surveyors. The valuation was prepared in accordance with the requirements of the RICS Valuation – Global Standards 2022 and the national standards and guidance set out in the UK national supplement (November 2018), the International Valuation Standards, and IFRS as adapted and interpreted by the Financial Reporting Manual (FReM). The valuations of specialised properties were derived using the Depreciated Replacement Cost (DRC) method.

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.

Depreciation

Items of property, plant and equipment are depreciated over their remaining useful 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’ cease to be depreciated upon the reclassification. Assets in the course of construction and residual interests in off-Statement of Financial Position PFI contract assets are not depreciated until the asset is brought into use or reverts to the trust, respectively.

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’.

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.

De-recognition

Assets intended for disposal are reclassified as 'held for sale' once the criteria in IFRS 5 are met. The sale must be highly probable and the asset available for immediate sale in its present condition.

Following reclassification, the assets are measured at the lower of their existing carrying amount and their 'fair value less costs to sell'. Depreciation ceases to be charged and the assets are not revalued, except where the 'fair value less costs to sell' falls below the carrying amount. Assets are de-recognised when all material sale contract conditions have been met.

Property, plant and equipment which is to be scrapped or demolished does not qualify for recognition as 'held for sale' and instead is retained as an operational asset and the asset's useful life is adjusted. The asset is de-recognised when scrapping or demolition occurs.

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.

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:

	Min life Years	Max life Years
Buildings, excluding dwellings	6	89
Plant & machinery	1	15
Information technology	3	25

Note 1.9 Intangible assets

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.

Internally generated intangible assets

Internally generated goodwill, brands, mastheads, publishing titles, customer lists and similar items are not capitalised as intangible assets.

Expenditure on research is not capitalised. Expenditure on development is capitalised where it meets the requirements set out in IAS 38.
Software

Software which is integral to the operation of hardware, eg 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, eg application software, is capitalised as an intangible asset where it meets recognition criteria.

Measurement
Intangible assets are recognised initially at cost, comprising all directly attributable costs needed to create, produce and prepare the asset to the point that it is capable of operating in the manner intended by management.

Subsequently intangible assets are measured at current value in existing use. Where no active market exists, intangible assets are valued at the lower of depreciated replacement cost and the value in use where the asset is income generating. Revaluations gains and losses and impairments are treated in the same manner as for property, plant and equipment. An intangible asset which is surplus with no plan to bring it back into use is valued at fair value where there are no restrictions on sale at the reporting date and where they do not meet the definitions of investment properties or assets held for sale.

Intangible assets held for sale are measured at the lower of their carrying amount or fair value less costs to sell.

Amortisation
Intangible assets are amortised over their expected useful lives in a manner consistent with the consumption of economic or service delivery benefits.

Useful lives of intangible assets
Useful lives reflect the total life of an asset and not the remaining life of an asset. The range of useful lives are shown in the table below:

	Min life Years	Max life Years
Software licences	3	5

Note 1.10 Inventories
Inventories are valued at the lower of cost and net realisable value. The cost of inventories is measured using the first in, first out (FIFO) method.

Between 2020/21 and 2023/24 the Trust received inventories including personal protective equipment from the Department of Health and Social Care at nil cost. In line with the GAM and applying the principles of the IFRS Conceptual Framework, the Trust has accounted for the receipt of these inventories at a deemed cost, reflecting the best available approximation of an imputed market value for the transaction based on the cost of acquisition by the Department. Distribution of inventories by the Department ceased in March 2024.

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.

In the Statement of Cash Flows, cash and cash equivalents are shown net of bank overdrafts that are repayable on demand and that form an integral part of the Trust's cash management. Cash, bank and overdraft balances are recorded at current values.

Note 1.12 Financial assets and financial liabilities

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.

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 or financial liabilities in respect of assets acquired or disposed of through leasing arrangements are recognised and measured in accordance with the accounting policy for leases described below.

Financial assets are classified as subsequently measured at amortised cost.

Financial liabilities classified as subsequently measured at amortised cost.

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. In the case of loans held from the Department of Health and Social Care, the effective interest rate is the nominal rate of interest charged on the loan.

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).

For financial assets that have become credit impaired since initial recognition (stage 3), expected credit losses at the reporting date are measured as the difference between the asset's gross carrying amount and the present value of estimated future cash flows discounted at the financial asset's original effective interest rate.

Expected losses are charged to operating expenditure within the Statement of Comprehensive Income and reduce the net carrying value of the financial asset in the Statement of Financial Position.

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.

The Trust as a 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 4.72% applied to new leases commencing in 2024 and 4.81% to new leases commencing in 2025.

The Trust does not apply the above recognition requirements to leases with a term of 12 months or less or to leases where the value of the underlying asset is below £5,000, excluding any irrecoverable VAT. Lease payments associated with these leases are expensed on a straight-line basis over the lease term or other systematic basis. Irrecoverable VAT on lease payments is expensed as it falls due.

Subsequent measurement
As required by a HM Treasury interpretation of the accounting standard for the public sector, the Trust employs a revaluation model for subsequent measurement of right of use assets, unless the cost model is considered to be an appropriate proxy for current value in existing use or fair value, in line with the accounting policy for owned assets. Where consideration exchanged is identified as significantly below market value, the cost model is not considered to be an appropriate proxy for the value of the right of use asset.

The Trust subsequently measures the lease liability by increasing the carrying amount for interest arising which is also charged to expenditure as a finance cost and reducing the carrying amount for lease payments made. The liability is also remeasured for changes in assessments impacting the lease term, lease modifications or to reflect actual changes in lease payments. Such remeasurements are also reflected in the cost of the right of use asset. Where there is a change in the lease term or option to purchase the underlying asset, an updated discount rate is applied to the remaining lease payments.

The Trust as a 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 2025:

		Nominal rate	Prior year rate
Short-term	Up to 5 years	4.03%	4.26%
Medium-term	After 5 years up to 10 years	4.07%	4.03%
Long-term	After 10 years up to 40 years	4.81%	4.72%
Very long-term	Exceeding 40 years	4.55%	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	2.60%	3.60%
Year 2	2.30%	1.80%
Into perpetuity	2.00%	2.00%

Early retirement provisions and injury benefit provisions both use the HM Treasury's post-employment benefits discount rate of 2.40% in real terms (prior year: 2.45%).

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 36.3 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 37 where an inflow of economic benefits is probable.

Contingent liabilities are not recognised, but are disclosed in Note 37, unless the probability of a transfer of economic benefits is remote.

Contingent liabilities are defined as:

• possible obligations arising from past events whose existence will be confirmed only by the occurrence of one or more uncertain future events not wholly within the entity's control; or

• present obligations arising from past events but for which it is not probable that a transfer of economic benefits will arise or for which the amount of the obligation cannot be measured with sufficient reliability.

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.

Note 1.18 Climate change levy

Expenditure on the climate change levy is recognised in the Statement of Comprehensive Income as incurred, based on the prevailing chargeable rates for energy consumption.

Note 1.19 Foreign exchange

The functional and presentational currency of the trust is sterling.

A transaction which is denominated in a foreign currency is translated into the functional currency at the spot exchange rate on the date of the transaction.

Where the trust has assets or liabilities denominated in a foreign currency at the Statement of Financial Position date:

• monetary items are translated at the spot exchange rate on 31 March
• non-monetary assets and liabilities measured at historical cost are translated using the spot exchange rate at the date of the transaction and
• non-monetary assets and liabilities measured at fair value are translated using the spot exchange rate at the date the fair value was determined.

Exchange gains or losses on monetary items (arising on settlement of the transaction or on re-translation at the Statement of Financial Position date) are recognised in income or expense in the period in which they arise.

Exchange gains or losses on non-monetary assets and liabilities are recognised in the same manner as other gains and losses on these items.

Note 1.20 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.

Note 1.21 Losses and special payments

Losses and special payments are items that Parliament would not have contemplated when it agreed funds for the health service or passed legislation. By their nature they are items that ideally should not arise. They are therefore subject to special control procedures compared with the generality of payments. They are divided into different categories, which govern the way that individual cases are handled. Losses and special payments are charged to the relevant functional headings in expenditure on an accruals basis.

The losses and special payments note is compiled directly from the losses and compensations register which reports on an accrual basis with the exception of provisions for future losses.

Note 1.22 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 1.23 Early adoption of standards, amendments and interpretations

No new accounting standards or revisions to existing standards have been early adopted in 2024/25.

Note 1.24 Standards, amendments and interpretations in issue but not yet effective or adopted

The DHSC GAM does not require the following IFRS Standards to be applied in 2024/25:

IFRS 17 Insurance Contracts – The Standard is effective for accounting periods beginning on or after 1 January 2023. IFRS 17 has been adopted by the FReM from 1 April 2025. Adoption of the Standard for NHS bodies will therefore be in 2025/26. The Standard revises the accounting for insurance contracts for the issuers of insurance. Application of this standard from 2025/26 is not expected to have a material impact on the financial statements.

IFRS 18 Presentation and Disclosure in Financial Statements - The Standard is effective for accounting periods beginning on or after 1 January 2027. The Standard is not yet UK endorsed and not yet adopted by the FReM. Early adoption is not permitted. The expected impact of applying the standard in future periods has not yet been assessed.

IFRS 19 Subsidiaries without Public Accountability: Disclosures - The Standard is effective for accounting periods beginning on or after 1 January 2027. The Standard is not yet UK endorsed and not yet adopted by the FReM. Early adoption is not permitted. The expected impact of applying the standard in future periods has not yet been assessed.

Changes to non-investment asset valuation – Following a thematic review of non-current asset valuations for financial reporting in the public sector, HM Treasury has made a number of changes to valuation frequency, valuation methodology and classification which are effective in the public sector from 1 April 2025 with a 5 year transition period. NHS bodies are adopting these changes to an alternative timeline.

Changes to subsequent measurement of intangible assets and PPE classification / terminology to be implemented for NHS bodies from 1 April 2025:

- Withdrawal of the revaluation model for intangible assets. Carrying values of existing intangible assets measured under a previous revaluation will be taken forward as deemed historic cost.
- Removal of the distinction between specialised and non-specialised assets held for their service potential. Assets will be classified according to whether they are held for their operational capacity.

These changes are not expected to have a material impact on these financial statements.

Changes to valuation cycles and methodology to be implemented for NHS bodies in later periods:

- A mandated quinquennial revaluation frequency (or rolling programme) supplemented by annual indexation in the intervening years.
- Removal of the alternative site assumption for buildings valued at depreciated replacement cost on a modern equivalent asset basis. The approach for land has not yet been finalised by HM Treasury.

The impact of applying these changes in future periods has not yet been assessed.

The revised valuation assumption away from an alternate site basis may have a material or significant impact on PPE measurement in future periods.

Note 1.25 Critical judgements in applying accounting policies

The following are the judgements, apart from those involving estimations (see below) that management has made in the process of applying the trust accounting policies and that have the most significant effect on the amounts recognised in the financial statements:

- Valuation of Land and Buildings -The Trust has applied the concept of Modern Equivalent Asset (MEA) to estimate the valuation of its property assets, as applicable, under the guidance of the DHSC GAM and independent professional valuers. This may result in impairment costs or reversals falling to be recognised in reserves or the income and expenditure statement as appropriate.

Note 1.26 Sources of estimation uncertainty

The following are assumptions about the future and other major sources of estimation uncertainty that have a significant risk of resulting in a material adjustment to the carrying amounts of assets and liabilities within the next financial year:

- Valuation of land and buildings 2024/25 £52,704,000 (2023/24 £50,633,000)

This is the most significant estimate in the accounts and is based on the professional judgement of the Trust's independent valuer with extensive knowledge of the physical estate and market factors. The value does not take into account potential future changes in market value which cannot be predicted with any certainty.

- **Accruals of Income**

The major income streams derive from the treatment of patients or from funding provided by government bodies and can be predicted with reasonable accuracy. Provisions are made where there is doubt about the likelihood of the Trust actually receiving the income due.

- **Accruals of Expenditure**

Where goods or services have been received by the Trust but have not been invoiced at the end of the financial year, estimates are based on the best information available at the time, and where possible, on known prices and volumes. See note 32.1.

Note 3 Operating income from patient care activities

All income from patient care activities relates to contract income recognised in line with accounting policy 1.4

Note 3.1 Income from patient care activities (by nature)

	2024/25 £000	2023/24 £000
Income from commissioners under API contracts - variable element*	-	-
Income from commissioners under API contracts - fixed element*	104,417	93,154
High cost drugs income from commissioners	-	530
Other NHS clinical income	2,153	1,730
Private patient income	32	270
National pay award central funding***	222	67
Additional pension contribution central funding**	4,414	2,576
Other clinical income	1,599	1,601
Total income from activities	**112,837**	**99,928**

*Aligned payment and incentive contracts are the main form of contracting between NHS providers and their commissioners. More information can be found in the 2023/25 NHS Payment Scheme documentation. https://www.england.nhs.uk/pay-syst/nhs-payment-scheme/

**Increases to the employer contribution rate for NHS pensions since 1 April 2019 have been funded by NHS England. NHS providers continue to pay at the former rate of 14.3% with the additional amount being paid over by NHS England on providers' behalf. The full cost of employer contributions (23.7%, 2023/24: 20.6%) and related NHS England funding (9.4%, 2023/24: 6.3%) have been recognised in these accounts.

***Additional funding was made available directly to providers by NHS England in 2024/25 and 2023/24 for implementing the backdated element of pay awards where government offers were finalised after the end of the 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)

Income from patient care activities received from:	2024/25 £000	2023/24 £000

NHS England	18,127	15,382
Integrated care boards	90,926	80,945
Department of Health and Social Care	-	-
Other NHS providers	2,153	1,730
NHS other	-	-
Local authorities	-	-
Non-NHS: private patients	32	270
Non-NHS: overseas patients (chargeable to patient)	219	25
Injury cost recovery scheme	239	212
Non NHS: other	1,141	1,364
Total income from activities	**112,837**	**99,928**
Of which:		
Related to continuing operations	112,837	99,928

Note 3.3 Overseas visitors (relating to patients charged directly by the provider)

	2024/25	2023/24
	£000	£000
Income recognised this year	219	25
Cash payments received in-year	26	17
Amounts added to provision for impairment of receivables	201	20
Amounts written off in-year	68	-

Note 4 Other operating income (Group)

	2024/25			2023/24		
	Contract income	Non-contract income	Total	Contract income	Non-contract income	Total
	£000	£000	£000	£000	£000	£000
Research and development	472	-	**472**	287	-	**287**
Education and training	2,647	-	**2,647**	2,249	-	**2,249**
Charitable and other contributions to expenditure		257	**257**		725	**725**
Charitable fund incoming resources		169	**169**		194	**194**
Other income*	1,151	-	**1,151**	1,723	-	**1,723**
Total other operating income	**4,270**	**426**	**4,696**	**4,259**	**919**	**5,178**
Of which:						
Related to continuing operations			4,696			5,178
Related to discontinued operations			-			-

*Other income includes catering income, car park income and various service recharges

Note 4.1 Breakdown of Other Income

Car parking income	191
Catering	268
Clinical excellence awards	71
Other income not already covered (recognised under IFRS 15)	621
Total before consolidation of charitable funds	**1,151**

Note 5.1 Additional information on contract revenue (IFRS 15) recognised in the period

	2024/25 £000	2023/24 £000
Revenue recognised in the reporting period that was included in within contract liabilities at the previous period end	-	-
Revenue recognised from performance obligations satisfied (or partially satisfied) in previous periods	-	-

Note 5.2 Transaction price allocated to remaining performance obligations

Revenue from existing contracts allocated to remaining performance obligations is expected to be recognised:	31 March 2025 £000	31 March 2024 £000
within one year	-	-
after one year, not later than five years	-	-
after five years	-	-
Total revenue allocated to remaining performance obligations	**-**	**-**

The trust has exercised the practical expedients permitted by IFRS 15 paragraph 121 in preparing this disclosure. Revenue from (i) contracts with an expected duration of one year or less and (ii) contracts where the trust recognises revenue directly corresponding to work done to date is not disclosed.

Note 5.3 Income from activities arising from commissioner requested services

Within the 2024/25 financial statements, management have taken the view that commissioner requested services are those which are provided for the healthcare of NHS patients, being all income except that associated with private and overseas patients.

	2024/25 £000	2023/24 £000
Income from services designated as commissioner requested services	112,586	99,633
Income from services not designated as commissioner requested services	251	295
Total	**112,837**	**99,928**

Note 6.1 Operating expenses (Group)

	2024/25	2023/24

	£000	£000
Purchase of healthcare from NHS and DHSC bodies	-	-
Purchase of healthcare from non-NHS and non-DHSC bodies	1,018	2,948
Purchase of social care	-	-
Staff and executive directors costs	77,838	68,412
Remuneration of non-executive directors	143	134
Supplies and services - clinical (excluding drugs costs)	15,991	12,397
Supplies and services - general	1,203	1,006
Drug costs (drugs inventory consumed and purchase of non-inventory drugs)	1,633	1,489
Inventories written down	75	-
Consultancy costs	-	-
Establishment	1,491	1,296
Premises	5,707	6,816
Transport (including patient travel)	404	290
Depreciation on property, plant and equipment	3,695	4,446
Amortisation on intangible assets	893	892
Net impairments	(238)	509
Movement in credit loss allowance: contract receivables / contract assets	215	153
Movement in credit loss allowance: all other receivables and investments	-	-
Increase/(decrease) in other provisions	-	-
Change in provisions discount rate(s)	-	(3)
Fees payable to the external auditor		
audit services- statutory audit	136	130
other auditor remuneration (external auditor only)	-	-
Internal audit costs	57	77
Clinical negligence	892	899
Legal fees	638	104
Insurance	54	62
Research and development	273	256
Education and training	510	364
Early retirements	-	-
Redundancy	52	-
Car parking & security	369	398
Hospitality	-	-
Losses, ex gratia & special payments	-	-
Grossing up consortium arrangements	-	-
Other services, eg external payroll	108	140
Other NHS charitable fund resources expended	191	235
Other*	2,180	1,289
Total	**115,528**	**104,737**
Of which:		
Related to continuing operations	115,528	104,737
Related to discontinued operations	-	-

*Other includes professional fees for out-sourced services.

Note 6.3 Limitation on auditor's liability (Group)

The limitation on auditor's liability for external audit work is £1 million (2023/24: £1 million).

Note 7 Impairment of assets (Group)

	2024/25 £000	2023/24 £000
Net impairments charged to operating surplus / deficit resulting from:		
Loss or damage from normal operations	-	-
Over specification of assets	-	-
Abandonment of assets in course of construction	-	-
Unforeseen obsolescence	-	-
Loss as a result of catastrophe	-	-
Changes in market price	(238)	509
Impairments of charitable fund assets	-	-
Other	-	-
Total net impairments charged to operating surplus / deficit	**(238)**	**509**
Impairments charged to the revaluation reserve	-	1,387
Total net impairments	**(238)**	**1,896**

Note 8 Employee benefits (Group)

	2024/25 Total £000	2023/24 Total £000
Salaries and wages	58,108	52,312
Social security costs	6,247	5,727
Apprenticeship levy	271	247
Employer's contributions to NHS pensions	11,227	8,493
Pension cost - other	18	22
Other post employment benefits	-	-
Other employment benefits	-	-
Termination benefits	-	-
Temporary staff (including agency)	3,761	2,256
NHS charitable funds staff	-	-
Total gross staff costs	**79,632**	**69,057**
Recoveries in respect of seconded staff	-	-
Total staff costs	**79,632**	**69,057**
Of which		
Costs capitalised as part of assets	1,472	391

Note 8.1 Retirements due to ill-health (Group)

During 2024/25 there were 2 early retirements from the trust agreed on the grounds of ill-health (2 in the year ended 31 March 2024). The estimated additional pension liabilities of these ill-health retirements is £272k (£195k in 2023/24).

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 2025, is based on valuation data as at 31 March 2024, updated to 31 March 2025 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 to 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.

National Employees Savings Trust (NEST)
The Trust participates in the National Employees Savings Trust (NEST) scheme as an alternative to those employees who are not eligible to join the NHS Pension Scheme. This was part of the auto enrolment requirements introduced by the Government.

NEST is a defined contribution scheme with a phased employer contribution rate which was unchanged at 3% for 2023/24.

Note 10 Finance income (Group)

Finance income represents interest received on assets and investments in the period.

	2024/25 £000	2023/24 £000
Interest on bank accounts	379	610
NHS charitable fund investment income	70	60
Other finance income	-	-
Total finance income	**449**	**670**

Note 11.1 Finance expenditure (Group)

Finance expenditure represents interest and other charges involved in the borrowing of money or asset financing.

	2024/25 £000	2023/24 £000
Interest expense:		
Interest on loans from the Department of Health and Social Care	43	65
Interest on lease obligations	93	-
Total interest expense	**136**	**65**
Unwinding of discount on provisions	10	10
Other finance costs	-	-
Total finance costs	**146**	**75**

Note 13 Trust income statement and statement of comprehensive income

"In accordance with Section 408 of the Companies Act 2006, the trust is exempt from the requirement to present its own income statement and statement of comprehensive income. The trust's surplus for the period was £0.02 million (2023/24 deficit £0.2million). The trust's total comprehensive income/(expense) for the period was a surplus of £5.8 million (2023/24: £1.1 million deficit).

Note 14.1 Intangible assets - 2024/25

Note: The charity has no intangible assets so the group values are also the trust values

Group	Software licences	Intangible assets under construction	Charitable fund intangible assets	Total
	£000	£000	£000	£000
Valuation / gross cost at 1 April 2024 - brought forward	**5,400**	**5,517**	**-**	**10,917**
Transfers by absorption	-	-	-	**-**
Additions	334	4,655	-	**4,989**
Impairments	-	-	-	**-**
Reversals of impairments	-	-	-	**-**
Revaluations	-	-	-	**-**
Reclassifications	-	-	-	**-**
Transfers to / from assets held for sale	-	-	-	**-**
Disposals / derecognition	-	-	-	**-**
Valuation / gross cost at 31 March 2025	**5,734**	**10,172**	**-**	**15,906**
Amortisation at 1 April 2024 - brought forward	**2,776**	**-**	**-**	**2,776**
Transfers by absorption	-	-	-	**-**
Provided during the year	893	-	-	**893**
Impairments	-	-	-	**-**
Reversals of impairments	-	-	-	**-**
Revaluations	-	-	-	**-**
Reclassifications	-	-	-	**-**
Transfers to / from assets held for sale	-	-	-	**-**
Disposals / derecognition	-	-	-	**-**
Amortisation at 31 March 2025	**3,669**	**-**	**-**	**3,669**
Net book value at 31 March 2025	**2,065**	**10,172**	**-**	**12,237**
Net book value at 1 April 2024	**2,624**	**5,517**	**-**	**8,141**

Note 14.2 Intangible assets - 2023/24

Group	Software licences	Intangible assets under construction	Charitable fund intangible assets	Total
	£000	£000	£000	£000
Valuation / gross cost at 1 April 2023 - as previously stated	**4,621**	**691**	**-**	**5,312**
Prior period adjustments	-	-	-	**-**
Valuation / gross cost at 1 April 2023 - restated	**4,621**	**691**	**-**	**5,312**
Transfers by absorption	-	-	-	**-**
Additions	779	4,826	-	**5,605**
Impairments	-	-	-	**-**
Reversals of impairments	-	-	-	**-**
Revaluations	-	-	-	**-**
Reclassifications	-	-	-	**-**
Transfers to / from assets held for sale	-	-	-	**-**
Disposals / derecognition	-	-	-	**-**
Valuation / gross cost at 31 March 2024	**5,400**	**5,517**	**-**	**10,917**
Amortisation at 1 April 2023 - as previously stated	**1,884**	**-**	**-**	**1,884**
Prior period adjustments	-	-	-	**-**
Amortisation at 1 April 2023 - restated	**1,884**	**-**	**-**	**1,884**
Transfers by absorption	-	-	-	**-**
Provided during the year	892	-	-	**892**
Impairments	-	-	-	**-**
Reversals of impairments	-	-	-	**-**
Revaluations	-	-	-	**-**
Reclassifications	-	-	-	**-**
Transfers to / from assets held for sale	-	-	-	**-**
Disposals / derecognition	-	-	-	**-**
Amortisation at 31 March 2024	**2,776**	**-**	**-**	**2,776**
Net book value at 31 March 2024	**2,624**	**5,517**	**-**	**8,141**
Net book value at 1 April 2023	**2,737**	**691**	**-**	**3,428**

Note 16.1 Property, plant and equipment - 2024/25

Note: The charity has no property, plant and equipment assets so the group values are also the trust values

Group	Land	Buildings excluding dwellings	Assets under construction	Plant & machinery	Information technology	Charitable fund PPE assets	Total
	£000	£000	£000	£000	£000	£000	£000
Valuation/gross cost at 1 April 2024 - brought forward	**6,050**	**44,583**	**5,028**	**18,882**	**10,720**	**-**	**85,263**
Transfers by absorption	-	-	-	-	-	-	**-**
Additions	-	737	4,287	2,938	28	-	**7,990**
Impairments	-	-	-	-	-	-	**-**
Reversals of impairments	-	238	-	-	-	-	**238**
Revaluations	730	1,878	-	-	-	-	**2,608**
Reclassifications	-	432	(1,834)	982	420	-	**-**
Transfers to / from assets held for sale	-	-	-	-	-	-	**-**
Disposals / derecognition	(2,250)	-	-	-	-	-	**(2,250)**
Valuation/gross cost at 31 March 2025	**4,530**	**47,868**	**7,481**	**22,802**	**11,168**	**-**	**93,849**
Accumulated depreciation at 1 April 2024 - brought forward	**-**	**-**	**-**	**16,719**	**7,099**	**-**	**23,818**
Transfers by absorption	-	-	-	-	-	-	**-**
Provided during the year	-	1,505	-	720	1,000	-	**3,225**
Impairments	-	-	-	-	-	-	**-**
Reversals of impairments	-	-	-	-	-	-	**-**
Revaluations	-	(1,505)	-	-	-	-	**(1,505)**
Reclassifications	-	-	-	-	-	-	**-**
Transfers to / from assets held for sale	-	-	-	-	-	-	**-**
Disposals / derecognition	-	-	-	-	-	-	**-**
Accumulated depreciation at 31 March 2025	**-**	**-**	**-**	**17,439**	**8,099**	**-**	**25,538**
Net book value at 31 March 2025	**4,530**	**47,868**	**7,481**	**5,363**	**3,069**	**-**	**68,311**
Net book value at 1 April 2024	**6,050**	**44,583**	**5,028**	**2,163**	**3,621**	**-**	**61,445**

Note 16.2 Property, plant and equipment - 2023/24

Group	Land	Buildings excluding dwellings	Assets under construction	Plant & machinery	Information technology	Charitable fund PPE assets	Total
	£000	£000	£000	£000	£000	£000	£000
Valuation / gross cost at 1 April 2023 - as previously stated	**4,000**	**58,651**	**1,107**	**18,550**	**9,335**	**-**	**91,643**
Prior period adjustments	-	-	-	-	-	-	-
Valuation / gross cost at 1 April 2023 - restated	**4,000**	**58,651**	**1,107**	**18,550**	**9,335**	**-**	**91,643**
Transfers by absorption	-	-	-	-	-	-	-
Additions	-	580	3,921	332	1,385	-	**6,218**
Impairments	(200)	(1,696)	-	-	-	-	**(1,896)**
Reversals of impairments	-	-	-	-	-	-	-
Revaluations	2,250	(12,952)	-	-	-	-	**(10,702)**
Reclassifications	-	-	-	-	-	-	-
Transfers to / from assets held for sale	-	-	-	-	-	-	-
Disposals / derecognition	-	-	-	-	-	-	-
Valuation/gross cost at 31 March 2024	**6,050**	**44,583**	**5,028**	**18,882**	**10,720**	**-**	**85,263**
Accumulated depreciation at 1 April 2023 - as previously stated	**-**	**12,537**	**-**	**15,591**	**5,635**	**-**	**33,763**
Prior period adjustments	-	-	-	-	-	-	-
Accumulated depreciation at 1 April 2023 - restated	**-**	**12,537**	**-**	**15,591**	**5,635**	**-**	**33,763**
Transfers by absorption	-	-	-	-	-	-	-
Provided during the year	-	1,484	-	1,128	1,464	-	**4,076**
Impairments	-	-	-	-	-	-	-
Reversals of impairments	-	-	-	-	-	-	-
Revaluations	-	(14,021)	-	-	-	-	**(14,021)**
Reclassifications	-	-	-	-	-	-	-
Transfers to / from assets held for sale	-	-	-	-	-	-	-
Disposals / derecognition	-	-	-	-	-	-	-
Accumulated depreciation at 31 March 2024	**-**	**-**	**-**	**16,719**	**7,099**	**-**	**23,818**
Net book value at 31 March 2024	**6,050**	**44,583**	**5,028**	**2,163**	**3,621**	**-**	**61,445**
Net book value at 1 April 2023	**4,000**	**46,114**	**1,107**	**2,959**	**3,700**	**-**	**57,880**

Note 16.3 Property, plant and equipment financing - 31 March 2025

Note: The charity has no property, plant and equipment assets so the group values are also the trust values

Group	Land	Buildings excluding dwellings	Assets under construction	Plant & machinery	Information technology	Charitable fund PPE assets	Total
	£000	£000	£000	£000	£000	£000	£000
Owned - purchased	4,530	45,700	7,481	5,229	3,069	-	**66,009**
On-SoFP PFI contracts and other service concession arrangements	-	-	-	-	-	-	**-**
Off-SoFP PFI residual interests	-	-	-	-	-	-	**-**
Owned - donated/granted	-	2,168	-	134	-	-	**2,302**
NBV total at 31 March 2025	**4,530**	**47,868**	**7,481**	**5,363**	**3,069**	**-**	**68,311**

Note 16.4 Property, plant and equipment financing - 31 March 2024

Group	Land	Buildings excluding dwellings	Assets under construction	Plant & machinery	Information technology	Charitable fund PPE assets	Total
	£000	£000	£000	£000	£000	£000	£000
Owned - purchased	6,050	42,578	5,028	1,893	3,618	-	**59,167**
On-SoFP PFI contracts and other service concession arrangements	-	-	-	-	-	-	**-**
Off-SoFP PFI residual interests	-	-	-	-	-	-	**-**
Owned - donated/granted	-	2,005	-	270	3	-	**2,278**
NBV total at 31 March 2024	**6,050**	**44,583**	**5,028**	**2,163**	**3,621**	**-**	**61,445**

Note 18 Donations of property, plant and equipment

No capital donations were received by the Trust in 2024-25. (2023/24 Nil)

Note 19 Revaluations of property, plant and equipment

Land and Buildings were revalued as at 31st March 2025 by professionally qualified, Royal Institute of Chartered Surveyors (RICS) registered, external valuers Gerald Eve LLP (see note 1.8). The valuation took account of changes in market values and work carried out by the Trust since the previous valuation as at 31 March 2024. The remaining useful lives of buildings were also reviewed taking account of the passage of time and maintenance and enhancements carried out by the Trust.

Note 20.1 Right of use assets - 2024/25

Group	Property (land and buildings)	Plant & machinery	Total	Of which: leased from DHSC group bodies
	£000	£000	£000	£000
Valuation / gross cost at 1 April 2024 - brought forward	**2,240**	**1,490**	**3,730**	**-**
Transfers by absorption	-	-	**-**	-
Additions	-	811	**811**	-
Remeasurements of the lease liability	-	-	**-**	-
Movements in provisions for restoration / removal costs	-	-	**-**	-
Impairments	-	-	**-**	-
Reversal of impairments	-	-	**-**	-
Revaluations	55	-	**55**	-
Reclassifications	-	-	**-**	-
Disposals / derecognition	-	-	**-**	-
Valuation/gross cost at 31 March 2025	**2,295**	**2,301**	**4,596**	**-**
Accumulated depreciation at 1 April 2024 - brought forward	**244**	**309**	**553**	**-**
Transfers by absorption	-	-	**-**	-
Provided during the year	64	406	**470**	-
Impairments	-	-	**-**	-
Reversal of impairments	-	-	**-**	-
Revaluations	-	-	**-**	-
Reclassifications	-	-	**-**	-
Disposals / derecognition	-	-	**-**	-
Accumulated depreciation at 31 March 2025	**308**	**715**	**1,023**	**-**
Net book value at 31 March 2025	**1,987**	**1,586**	**3,573**	**-**
Net book value at 1 April 2024	**1,996**	**1,181**	**3,177**	**-**

Net book value of right of use assets leased from other NHS providers	-
Net book value of right of use assets leased from other DHSC group bodies	-

Note 20.2 Right of use assets - 2023/24

Group	Property (land and buildings)	Plant & machinery	Total	Of which: leased from DHSC group bodies
	£000	£000	£000	£000
Valuation / gross cost at 1 April 2023 - brought forward	**2,240**	**295**	**2,535**	**-**
Prior period adjustments	-	-	-	-
Valuation / gross cost at 1 April 2023 - restated	**2,240**	**295**	**2,535**	**-**
Transfers by absorption	-	-	-	-
Additions	-	1,195	**1,195**	-
Remeasurements of the lease liability	-	-	-	-
Movements in provisions for restoration / removal costs	-	-	-	-
Impairments	-	-	-	-
Reversal of impairments	-	-	-	-
Revaluations	-	-	-	-
Reclassifications	-	-	-	-
Disposals / derecognition	-	-	-	-
Valuation/gross cost at 31 March 2024	**2,240**	**1,490**	**3,730**	**-**
Accumulated depreciation at 1 April 2023 - brought forward	**118**	**65**	**183**	**-**
Prior period adjustments	-	-	-	-
Accumulated depreciation at 1 April 2023 - restated	**118**	**65**	**183**	**-**
Transfers by absorption	-	-	-	-
Provided during the year	126	244	**370**	-
Impairments	-	-	-	-
Reversal of impairments	-	-	-	-
Revaluations	-	-	-	-
Reclassifications	-	-	-	-
Disposals / derecognition	-	-	-	-
Accumulated depreciation at 31 March 2024	**244**	**309**	**553**	**-**
Net book value at 31 March 2024	**1,996**	**1,181**	**3,177**	**-**
Net book value at 1 April 2023	**2,122**	**230**	**2,352**	**-**

Net book value of right of use assets leased from other NHS providers	-
Net book value of right of use assets leased from other DHSC group bodies	-

Note 20.6 Reconciliation of the carrying value of lease liabilities
Lease liabilities are included within borrowings in the statement of financial position. A breakdown of borrowings is disclosed in note 34.1.

	Group		Trust	
	2024/25	2023/24	2024/25	2023/24
	£000	£000	£000	£000
Carrying value at 1 April	1,469	316	1,469	316
Prior period adjustments		-		-
Carrying value at 1 April - restated	**1,469**	**316**	**1,469**	**316**
Transfers by absorption	-	-	-	-
Lease additions	811	1,195	811	1,195
Lease liability remeasurements	-	-	-	-
Interest charge arising in year	93	-	93	-
Early terminations	-	-	-	-
Lease payments (cash outflows)	(606)	(42)	(606)	(42)
Other changes	-	-	-	-
Carrying value at 31 March	**1,767**	**1,469**	**1,767**	**1,469**

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 6.1. Cash outflows in respect of leases recognised on-SoFP are disclosed in the reconciliation above.

Note 20.7 Maturity analysis of future lease payments at 31 March 2025

	Group		Trust	
	Total 31 March 2025 £000	Of which leased from DHSC group bodies: 31 March 2025 £000	Total 31 March 2025 £000	Of which leased from DHSC group bodies: 31 March 2025 £000
Undiscounted future lease payments payable in:				
- not later than one year;	1,231	-	1,231	-
- later than one year and not later than five years;	536	-	536	-
- later than five years.	-	-	-	-
Total gross future lease payments	**1,767**	**-**	**1,767**	**-**
Finance charges allocated to future periods	-	-		
Net lease liabilities at 31 March 2025	**1,767**	**-**	**1,767**	**-**
Of which:				
Leased from other NHS providers		-		-
Leased from other DHSC group bodies		-		-

Note 20.8 Maturity analysis of future lease payments at 31 March 2024

	Group		Trust	
	Total 31 March 2024 £000	Of which leased from DHSC group bodies: 31 March 2024 £000	Total 31 March 2024 £000	Of which leased from DHSC group bodies: 31 March 2024 £000
Undiscounted future lease payments payable in:				
- not later than one year;	1,339	-	1,339	-
- later than one year and not later than five years;	130	-	130	-
- later than five years.	-	-	-	-
Total gross future lease payments	**1,469**	**-**	**1,469**	**-**
Finance charges allocated to future periods	-	-	-	-
Net finance lease liabilities at 31 March 2024	**1,469**	**-**	**1,469**	**-**
Of which:				
Leased from other NHS providers		-		-
Leased from other DHSC group bodies		-		-

Note 24 Disclosure of interests in other entities

Note 25 Analysis of charitable fund reserves

These accounts include the financial results for The Queen Victoria Hospital NHS Trust Charitable Fund, Registered Charity No. 1056120

	31 March 2025 £000	31 March 2024 £000
Unrestricted funds:		
Unrestricted income funds	512	341
Other reserves	-	-
Endowment funds	-	-
Other restricted income funds	2,649	2,772
	3,161	**3,113**

Unrestricted income funds are accumulated income funds that are expendable at the discretion of the trustees in furtherance of the charity's objects. Unrestricted funds may be earmarked or designated for specific future purposes which reduces the amount that is readily available to the charity.

Restricted funds may be accumulated income funds which are expendable at the trustee's discretion only in furtherance of the specified conditions of the donor and the objects of the charity. They may also be capital funds (e.g. endowments) where the assets are required to be invested, or retained for use rather than expended.

Note 26 Inventories

All inventories relate to the Trust	**Group**	
	31 March 2025	**31 March 2024**
	£000	**£000**
Drugs	159	161
Consumables	1,011	1,058
Charitable fund inventory	-	-
Total inventories	**1,170**	**1,219**
of which:		
Held at fair value less costs to sell	-	-

Inventories recognised in expenses for the year were £5,005k (2023/24: £4,484k). Write-down of inventories recognised as expenses for the year were £75k (2023/24: £0k).

In response to the COVID 19 pandemic, the Department of Health and Social Care centrally procured personal protective equipment and passed these to NHS providers free of charge. During 2023/24 the Trust received £143k of items purchased by DHSC. Distribution of inventory by the Department ceased in March 2024.

These inventories were recognised as additions to inventory at deemed cost with the corresponding benefit recognised in income. The utilisation of these items is included in the expenses disclosed above.

Note 27.1 Receivables

	Group		Trust	
	31 March 2025 £000	31 March 2024 £000	31 March 2025 £000	31 March 2024 £000
Current				
Contract receivables	8,272	7,436	8,272	7,436
Allowance for impaired contract receivables / assets	(833)	(740)	(833)	(740)
Prepayments (non-PFI)	1,094	1,362	1,094	1,362
VAT receivable	804	593	804	593
Other receivables	76	213	76	213
NHS charitable funds receivables	-	-	-	-
Total current receivables	**9,413**	**8,864**	**9,413**	**8,864**
Non-current				
Other receivables	305	276	305	276
NHS charitable funds receivables	-	-	-	-
Total non-current receivables	**305**	**276**	**305**	**276**
Of which receivable from NHS and DHSC group bodies:				
Current	5,662	4,817	5,662	4,817
Non-current	305	276	305	276

1 The majority of trade was with NHS Integrated Care Boards (ICBs) and NHS England as commissioners for NHS patient care services. Both were funded by Government to buy NHS patient care services and so no credit scoring is deemed to be necessary.

2 The provision for the cost for the clinicians pension tax scheme (£313k) is offset with an associated future funding stream.

Note 27.2 Allowances for credit losses - 2024/25

	Group		Trust	
	Contract receivables and contract assets £000	All other receivables £000	Contract receivables and contract assets £000	All other receivables £000
Allowances as at 1 Apr 2024 - brought forward	**740**	**-**	**740**	**-**
Transfers by absorption	-	-	-	-
New allowances arising	463	-	463	-
Changes in existing allowances	-	-	-	-
Reversals of allowances	(248)	-	(248)	-
Utilisation of allowances (write offs)	(122)	-	(122)	-
Changes arising following modification of contractual cash flows	-	-	-	-
Foreign exchange and other changes	-	-	-	-

Allowances as at 31 Mar 2025	**833**	**-**	**833**	**-**

Note 27.3 Allowances for credit losses - 2023/24

	Group		Trust	
	Contract receivables and contract assets	**All other receivables**	**Contract receivables and contract assets**	**All other receivables**
	£000	**£000**	**£000**	**£000**
Allowances as at 1 Apr 2023 - as previously stated	**587**	**-**	587	-
Prior period adjustments	-	-	-	-
Allowances as at 1 Apr 2023 - restated	**587**	**-**	**587**	**-**
Transfers by absorption	-	-	-	-
New allowances arising	153	-	153	-
Changes in existing allowances	-	-	-	-
Reversals of allowances	-	-	-	-
Utilisation of allowances (write offs)	-	-	-	-
Changes arising following modification of contractual cash flows	-	-	-	-
Foreign exchange and other changes	-	-	-	-
Allowances as at 31 Mar 2024	**740**	**-**	**740**	**-**

Note 27.4 Exposure to credit risk

This note discloses future lease payments receivable from lease arrangements classified as finance leases where the Queen Victoria Hospital NHS Foundation Trust is the lessor.

For 2024/25 there are no arrangements where the Trust is a lessor

Note 31.1 Cash and cash equivalents movements

Cash and cash equivalents comprise cash at bank, in hand and cash equivalents. Cash equivalents are readily convertible investments of known value which are subject to an insignificant risk of change in value.

	Group		Trust	
	2024/25	2023/24	2024/25	2023/24
	£000	£000	£000	£000
At 1 April	**16,107**	**14,951**	**12,787**	**11,725**
Prior period adjustments		-	-	-
At 1 April (restated)	**16,107**	**14,951**	**12,787**	**11,725**
Transfers by absorption	-	-	-	-
Net change in year	75	1,156	154	1,062
At 31 March	**16,182**	**16,107**	**12,941**	**12,787**
Broken down into:				
Cash at commercial banks and in hand	5,465	4,745	2,224	1,425
Cash with the Government Banking Service	10,717	11,362	10,717	11,362
Deposits with the National Loan Fund	-	-	-	-
Other current investments	-	-	-	-
Total cash and cash equivalents as in SoFP	**16,182**	**16,107**	**12,941**	**12,787**
Bank overdrafts (GBS and commercial banks)	-	-	-	-
Drawdown in committed facility	-	-	-	-
Total cash and cash equivalents as in SoCF	**16,182**	**16,107**	**12,941**	**12,787**

Note 31.2 Third party assets held by the trust

Queen Victoria Hospital NHS Foundation Trust held Nil cash and cash equivalents which relate to monies held by the Trust on behalf of patients or other parties. This has been excluded from the cash and cash equivalents figure reported in the accounts.

Note 32.1 Trade and other payables

	Group		Trust	
	31 March 2025	31 March 2024	31 March 2025	31 March 2024
	£000	£000	£000	£000
Current				
Trade payables	2,016	3,554	2,016	3,554
Capital payables	8,170	9,523	8,170	9,523
Accruals	7,045	4,010	7,045	4,010
Social security costs	781	789	781	789
Other taxes payable	942	887	942	887
PDC dividend payable	365	128	365	128
Pension contributions payable	1,037	915	1,037	915
Other payables	103	335	103	335
NHS charitable funds: trade and other payables	80	207		
Total current trade and other payables	**20,539**	**20,348**	**20,459**	**20,141**
Non-current				
Trade payables	-	-	-	-
Capital payables	-	-	-	-
NHS charitable funds: trade and other payables	-	-		
Total non-current trade and other payables	**-**	**-**	**-**	**-**
Of which payables from NHS and DHSC group bodies:				
Current	4,772	3,164	4,772	3,164
Non-current	-	-	-	-

Note 32.2 Early retirements in NHS payables above

The payables note above includes amounts in relation to early retirements as set out below:

Group and Trust	31 March 2025 £000	31 March 2025 Number	31 March 2024 £000	31 March 2024 Number
- to buy out the liability for early retirements over 5 years	-		-	
- number of cases involved		-		-

Note 33 Other liabilities

	Group & Trust	
	31 March 2025	31 March 2024
	£000	£000
Current		
Deferred income: contract liabilities	535	262
Total other current liabilities	**535**	**262**
Non-current		
Deferred income: contract liabilities	-	-
Total other non-current liabilities	**-**	**-**

Note 34.1 Borrowings

	Group & Trust	
	31 March 2025	31 March 2024
	£000	£000
Current		
Bank overdrafts	-	-
Loans from DHSC	787	794
Lease liabilities	1,231	1,339
Total current borrowings	**2,018**	**2,133**
Non-current		
Loans from DHSC	379	1,156
Lease liabilities	536	130
Total non-current borrowings	**915**	**1,286**

Note 34.2 Reconciliation of liabilities arising from financing activities (Group)
Note- all Group items relate to the Trust

Group - 2024/25	Loans from DHSC	Lease liabilities	Total
	£000	£000	£000
Carrying value at 1 April 2024	**1,950**	**1,469**	**3,419**
Cash movements:			
Financing cash flows - payments and receipts of principal	(778)	(513)	**(1,291)**
Financing cash flows - payments of interest	(49)	(93)	**(142)**
Non-cash movements:			
Additions	-	811	**811**
Application of effective interest rate	43	93	**136**
Carrying value at 31 March 2025	**1,166**	**1,767**	**2,933**

Group - 2023/24	Loans from DHSC	Lease liabilities	Total
	£000	£000	£000
Carrying value at 1 April 2023	**2,734**	**316**	**3,050**
Prior period adjustment	-	-	**-**
Carrying value at 1 April 2023 - restated	**2,734**	**316**	**3,050**
Cash movements:			
Financing cash flows - payments and receipts of principal	(778)	(42)	**(820)**
Financing cash flows - payments of interest	(71)	-	**(71)**
Non-cash movements:			
Additions	-	1,195	**1,195**
Application of effective interest rate	65	-	**65**
Carrying value at 31 March 2024	**1,950**	**1,469**	**3,419**

Note 36.1 Provisions for liabilities and charges analysis (Group)
Note: Group provisions relate solely to the Trust

Group	Pensions: early departure costs	Pensions: injury benefits	Legal claims	Other	Charitable fund provisions	Total
	£000	£000	£000	£000	£000	£000
At 1 April 2024	**40**	**363**	**19**	**2,343**	**-**	**2,765**
Transfers by absorption	-	-	-	-	-	**-**
Change in the discount rate	-	-	-	(3)	-	**(3)**
Arising during the year	4	30	-	31	-	**65**
Utilised during the year	(7)	(27)	-	(1,258)	-	**(1,292)**
Reclassified to liabilities held in disposal groups	-	-	-	-	-	**-**
Reversed unused	-	-	-	(695)	-	**(695)**
Unwinding of discount	1	9	-	15	-	**25**
Movement in charitable fund provisions	-	-	-	-	-	**-**
At 31 March 2025	**38**	**375**	**19**	**433**	**-**	**865**
Expected timing of cash flows:						
- not later than one year;	6	27	9	8	-	**50**
- later than one year and not later than five years;	26	107	10	84	-	**227**
- later than five years.	6	241	-	341	-	**588**
Total	**38**	**375**	**19**	**433**	**-**	**865**

The provisions for pensions represent the discounted value of annual payments made to the NHS Pensions Agency calculated on an actuarial basis
Legal claims are relating to third party and employer's liabilities. Where the case falls within the remit of of the risk pooling schemes run by NHS Resolution (formerly NHS Litigation authority), the Trust's liability is limited to an excess of £3,000 or £10,000 per case with the remainder born by the scheme. The provision is shown net of any reimbursement due from NHS Resolution.

Note 36.3 Clinical negligence liabilities

At 31 March 2025, £2,058k was included in provisions of NHS Resolution in respect of clinical negligence liabilities of Queen Victoria Hospital NHS Foundation Trust (31 March 2024: £1,146k).
Pending confirmation

Note 37 Contingent assets and liabilities
These Group totals all relate to the Trust

	Group	
	31 March 2025	**31 March 2024**
	£000	**£000**
Value of contingent liabilities		
NHS Resolution legal claims	(1)	(2)
Other	(95)	(99)
Gross value of contingent liabilities	**(96)**	**(101)**
Amounts recoverable against liabilities	-	-
Net value of contingent liabilities	**(96)**	**(101)**
Net value of contingent assets	**-**	**-**

Note 38 Contractual capital commitments
These Group totals all relate to the Trust

	Group	
	31 March 2025	**31 March 2024**
	£000	**£000**
Property, plant and equipment	-	170
Intangible assets	88	-
Total	**88**	**170**

Note 43.2 Carrying values of financial assets (Group)

Carrying values of financial assets as at 31 March 2025	Held at amortised cost	Total book value
	£000	£000
Trade and other receivables excluding non financial assets	7,752	**7,752**
Other investments / financial assets	-	**-**
Cash and cash equivalents	12,941	**12,941**
Consolidated NHS Charitable fund financial assets	3,241	**3,241**
Total at 31 March 2025	**23,934**	**23,934**

Carrying values of financial assets as at 31 March 2024	Held at amortised cost	Total book value
	£000	£000
Trade and other receivables excluding non financial assets	7,185	**7,185**
Other investments / financial assets	-	**-**
Cash and cash equivalents	12,787	**12,787**
Consolidated NHS Charitable fund financial assets	3,320	**3,320**
Total at 31 March 2024	**23,292**	**23,292**

Note 43.3 Carrying values of financial assets (Trust)

Carrying values of financial assets as at 31 March 2025	Held at amortised cost	Total book value
	£000	£000
Trade and other receivables excluding non financial assets	7,752	**7,752**
Other investments / financial assets	-	**-**
Cash and cash equivalents	12,941	**12,941**
Total at 31 March 2025	**20,693**	**20,693**

Carrying values of financial assets as at 31 March 2024	Held at amortised cost	Total book value
	£000	£000
Trade and other receivables excluding non financial assets	7,185	**7,185**
Other investments / financial assets	-	**-**
Cash and cash equivalents	12,787	**12,787**
Total at 31 March 2024	**19,972**	**19,972**

Note 43.4 Carrying values of financial liabilities (Group)

Carrying values of financial liabilities as at 31 March 2025	Held at amortised cost	Total book value
	£000	£000
Loans from the Department of Health and Social Care	1,166	**1,166**
Obligations under leases	1,767	**1,767**
Trade and other payables excluding non financial liabilities	16,825	**16,825**
Total at 31 March 2025	**19,758**	**19,758**

Carrying values of financial liabilities as at 31 March 2024	Held at amortised cost	Total book value
	£000	£000
Loans from the Department of Health and Social Care	1,950	**1,950**
Obligations under leases	1,469	**1,469**
Trade and other payables excluding non financial liabilities	18,094	**18,094**
Consolidated NHS charitable fund financial liabilities	-	**-**
Total at 31 March 2024	**21,513**	**21,513**

Note 43.5 Carrying values of financial liabilities (Trust)

Carrying values of financial liabilities as at 31 March 2025	Held at amortised cost	Total book value
	£000	£000
Loans from the Department of Health and Social Care	1,166	**1,166**
Obligations under leases	1,767	**1,767**
Trade and other payables excluding non financial liabilities	16,825	**16,825**
Total at 31 March 2025	**19,758**	**19,758**

Carrying values of financial liabilities as at 31 March 2024	Held at amortised cost	Total book value
	£000	£000
Loans from the Department of Health and Social Care	1,950	**1,950**
Obligations under leases	1,469	**1,469**
Trade and other payables excluding non financial liabilities	18,094	**18,094**
Total at 31 March 2024	**21,513**	**21,513**

Note 43.7 Maturity of financial liabilities

The following maturity profile of financial liabilities is based on the contractual undiscounted cash flows. This differs to the amounts recognised in the statement of financial position which are discounted to present value.

	Group & Trust	
	31 March 2025	31 March 2024
	£000	£000
In one year or less	18,860	20,260
In more than one year but not more than five years	920	1,319
In more than five years	-	-
Total	**19,780**	**21,579**

Note 44 Losses and special payments

These Group totals all relate to the Trust

	2024/25	
Group and trust	**Total number of cases**	**Total value of cases**
	Number	**£000**
Losses		
Cash losses	-	-
Fruitless payments and constructive losses	1	9
Bad debts and claims abandoned	107	122
Stores losses and damage to property	-	-
Total losses	**108**	**131**
Special payments		
Compensation under court order or legally binding arbitration award	-	-
Extra-contractual payments	-	-
Ex-gratia payments	-	-
Special severance payments	-	-
Extra-statutory and extra-regulatory payments	-	-
Total special payments	**-**	**-**
Total losses and special payments	**108**	**131**

Compensation payments received

Note 46 Related parties
No board members or members of the key management staff or parties related to them undertook any transactions with Queen Victoria Hospital NHS Foundation Trust during 2024/25, (2023/24 none).

The Department of Health and Social Care is the parent department, other public sector bodies included within the Whole of Government Accounts are also deemed to be related parties. The Trust has financial transactions with many such bodies, the most significant being:

The Department of Health and Social Care
Other NHS providers
ICBs and NHS England
Other health bodies
Other Government departments
Local authorities
HM Revenue & Customs
NHS Pension Scheme
Welsh and Scottish Health Bodies
NHS Blood and Transplant

6. Appendices

6.1 Board of Director's register

Name, title and appointment	Board of Directors register and attendance record 2024/25					
	Board of Directors	**Audit and risk committee**	**Nomination and remuneration committee (not incl. extraordinary meetings)**	**Quality and safety committee**	**Finance and performance committee**	**Strategic development committee**
Jon Bell Interim Chief Finance Officer	2 of 2	N/A	N/A	N/A	2 of 2	N/A
Tania Cubison Chief Medical Officer	2 of 3	N/A	N/A	2 of 3	1 of 1	N/A
Vivek Chaudhri Associate Non-Executive Director	1 of 1	N/A	N/A	N/A	N/A	N/A
Jane Dickson Interim Chief Nursing Officer / Interim Deputy Chief Executive	1 of 2	N/A	N/A	3 of 3	3 of 3	N/A
Paul Dillon-Robinson Non-Executive Director	6 of 6	4 of 4	4 of 4	6 of 6	N/A	N/A
Helen Edmunds Chief People Officer	6 of 6	N/A	N/A	N/A	5 of 6	N/A
Jo Emmanuel Non-Executive Director	1 of 1	N/A	1 of 1	N/A	N/A	N/A

Name, title and appointment	Board of Directors register and attendance record 2024/25					
	Board of Directors	**Audit and risk committee**	**Nomination and remuneration committee (not incl. extraordinary meetings)**	**Quality and safety committee**	**Finance and performance committee**	**Strategic development committee**
Tamara Everington Chief Medical Officer	3 of 3	N/A	N/A	3 of 3	1 of 1	N/A
Russell Hobby Non-Executive Director	6 of 6	3 of 4	3 of 4	N/A	6 of 6	N/A
Abigail Jago Chief Strategy Officer / Acting Chief Executive Officer	6 of 6	N/A	N/A	N/A	1 of 1	7 of 7
James Lowell Chief Executive Officer	4 of 5	N/A	N/A	N/A	4 of 5	5 of 7
Karen Norman Non-Executive Director	6 of 6	N/A	3 of 4	4 of 6	N/A	7 of 7
Peter O'Donnell Non-Executive Director	6 of 6	2 of 4	4 of 4	N/A	6 of 6	N/A
Shaun O'Leary Non-Executive Director	6 of 6	N/A	3 of 4	6 of 6	N/A	6 of 7

Name, title and appointment	Board of Directors register and attendance record 2024/25					
	Board of Directors	**Audit and risk committee**	**Nomination and remuneration committee (not incl. extraordinary meetings)**	**Quality and safety committee**	**Finance and performance committee**	**Strategic development committee**
Clare Pirie Director of Communications and Corporate Affairs	N/A	N/A	N/A	N/A	N/A	N/A
Nicky Reeves Chief Nursing Officer	2 of 2	N/A	N/A	1 of 2	1 of 1	N/A
Aleema Shivji Associate Non-Executive Director	1 of 1	N/A	N/A	N/A	N/A	N/A
Jackie Smith Trust Chair	6 of 6	N/A	4 of 4	N/A	4 of 6	6 of 7
Edmund Tabay Chief Nursing Officer	2 of 2	N/A	N/A	1 of 1	1 of 1	N/A
Kirsten Timmins Chief Operating Officer	6 of 6	N/A	N/A	5 of 6	6 of 6	N/A
Maria Wheeler Chief Finance Officer	2 of 4	N/A	N/A	N/A	2 of 4	N/A

6.2 Council of Governor's register

Name	Constituency	Status of current term	Start term	End term
Jo Davis	Staff		01/07/2023	22/11/2024
Julie Holden	Stakeholder		06/01/2023	13/09/2024
Julia Searle	Public		01/07/2023	29/10/2026
Margo Taskiran	Public		01/07/2023	13/07/2024
Louise Thompson	Public		01/07/2023	15/07/2024
Chris Barham	Public	Re-elected 2nd term	01/07/2023	30/06/2026
Niamh Gavin	Staff	Elected 1st term	01/07/2023	30/06/2026
Janet Hall	Public	Elected 1st term	01/07/2023	30/06/2026
Denise Holland	Public	Elected 1st term	01/07/2023	30/06/2026
Bob Lanzer	Stakeholder	Appointed 1st term	15/04/2022	30/04/2025
Chris Parrish	Staff	Elected 1st term	01/07/2023	30/06/2026
Ken Sim	Public	Re-elected 2nd term	01/07/2023	30/06/2026
Linda Skinner	Stakeholder	Appointed 1st term	01/04/2023	30/04/2026
Roger Smith	Public	Re-elected 2nd term	01/07/2023	30/06/2026
Jonathan Squire	Public	Elected 1st term	01/07/2023	30/06/2026
Antony Fulford-Smith	Public	Elected 1st term	05/08/2024	04/08/2027
Richard Green	Public	Elected 1st term	05/08/2024	04/08/2027
John Harold	Public	Elected 1st term	05/08/2024	04/08/2027
David Porter	Public	Elected 1st term	05/08/2024	04/08/2027
Julie Mockford	Stakeholder	Appointed 1st term	07/10/2024	06/10/2027
Colin Fry	Public	Elected 1st term	09/12/2024	08/12/2027
Michele Augousti	Public	Elected 1st term	09/12/2024	08/12/2027
Charlie Robinson	Public	Elected 1st term	09/12/2024	08/12/2027
Liz James	Public	Elected 1st term	09/12/2024	08/12/2027
Felicity Hatch	Public	Elected 1st term	09/12/2024	08/12/2027
Rodabe Rudin	Public	Elected 1st term	09/12/2024	08/12/2027
Jennifer Tite	Public	Elected 1st term	09/12/2024	08/12/2027
Graham True	Staff	Elected 1st term	11/03/2025	30/06/2026

6.3 Director's biographies 2024/25

Jon Bell, Interim Chief Finance Officer (voting)

Jon's career in healthcare finance spans over three decades, including 16 years as the Chief Finance Officer in acute, commissioning and community healthcare organisations in London. He also has experience of working in healthcare systems overseas where he ran a transformation programme management office and was also a management consultant and board advisor.

His most recent role before joining QVH was as Chief Finance Officer of Hillingdon Hospitals NHS Foundation Trust. Jon is also a Trustee of the Association of Coloproctologists of Great Britain and Ireland.

Tania Cubison, Chief Medical Officer (voting)

Tania Cubison is a military plastic surgeon who first joined Queen Victoria Hospital as an SHO in 1996, progressing to consultant, before her appointment as Medical Director in January 2022. Tania was a Lieutenant Colonel in the Royal Army Medical Corps and one of a small number of regular army plastic surgeons who had an operational role and occasionally be deployed overseas. Tania underwent specialist registrar training in East Grinstead and 116 Newcastle-upon-Tyne, and was awarded the McGregor Gold medal for the FRCS (Plast) examination in 2006. She completed her training with a specialist burn fellowship at St Andrew's Burn Centre, Chelmsford and visits to burn centres in the USA.

Tania specialises in lower limb trauma reconstruction and microsurgery, particularly the surgical management of amputees. Tania was the safeguarding lead for the Trust and is very involved in looking at human factors and the influence on patient's safety of team building and communication. She is an active member of the British Burns Association and is currently the chair of the Senate for the Emergency Management of Severe Burns in the UK, as well as sitting on the Committee for the Trauma Interface Group. Tania is also a member of the Specialist Advisory Committee in Plastic Surgery, responsible for the training of the national trainees and has responsibility for less than full-time training, military trainees and also provides external support to the Yorkshire Deanery.

Vivek Chaudhri, Associate Non-Executive Director (non-voting)

Vivek Chaudhri joined the Board in January 2025. Vivek has over 30 years' experience in digital and technology transformation roles in Fortune 500 companies, including global leadership positions in the Life Sciences sector at Eli Lilly, Pfizer and Boehringer Ingelheim.

He is the Co-founder of the Global AI Leaders Network (GAIL), an organization dedicated to helping companies strategically and ethically navigate AI opportunities. Vivek also serves as a board advisor to AI companies, including ParallelDots and Aforza.

Jane Dickson, Interim Deputy Chief Executive (voting)

Jane Dickson became Interim Deputy Chief Executive in March 2025 having joined Queen Victoria Hospital NHS Foundation Trust initially as Interim Chief Nursing Officer in June 2024. She previously worked at Board level as Chief Nurse at East Kent Hospitals, and prior to that

at Surrey and Sussex Healthcare NHS Trust. Jane has held a number of senior posts in nursing and roles.

Earlier in her nursing career Jane specialised in intensive care nursing, and has spent a significant portion of her working in the highly regulated environment of NHS Blood and Transplant, leading organ donation services and latterly blood donation. Improving services and access to services, whilst at the same time supporting the teams who deliver that care has been at the heart of her career with people always at the centre of her approach. To support her own development Jane studied Health Care ethics at Kings College and has also completed an MSc in leadership.

Paul Dillon-Robinson, Non-Executive Director (voting)

Paul joined the Board in October 2019. Paul, from Buxted near Uckfield, is a Chartered Accountant who spent 17 years working in the NHS as a Head of Internal Audit, for a range of organisations in the Kent, Sussex and Surrey area. He then spent nine years as Director of Internal Audit for the House of Commons. Paul currently combines tutoring, training and consultancy work with non-executive and charity roles. At QVH, Paul chairs the Audit and Risk Committee and is a member of the Quality and Safety Committee.

Helen Edmunds, Chief People Officer (non-voting)

Helen joined Queen Victoria Hospital in March 2024 as Chief People Officer. Prior to joining the Trust Helen was Director of People Strategy at NHS Kent and Medway, with strategic leadership for the breadth of workforce development across the Kent and Medway integrated care system. This included provider Trusts, community, primary care training hubs, social care and voluntary sector.

Since joining the NHS in 1999, Helen has held senior leadership roles in ambulance, provider Trust, system and region across the people portfolio, including Head of Leadership and Organisational Development for the South East Leadership Academy and Deputy Director of Workforce Transformation for NHS England in the South West Region. Helen is an experienced system leader, delivering people and culture change programmes in several system and regional roles, bringing system partners together to deliver workforce programmes, supporting improved patient outcomes. Helen is passionate about people development, their wellbeing and cultural development as an enabler to improved service delivery.

Jo Emmanuel, Non-Executive Director (voting)

Jo Emmanuel joined the Board in January 2025 as clinical Non-Executive Director. Jo is a consultant psychiatrist who has worked for over 30 years within the NHS in both community and in-patient settings. She was Medical Director within Central North West London NHS Foundation Trust until 2021 when she moved to St Leonard’s on Sea where she has recently become a school governor. Jo has a particular interest in Clinical Ethics and co-founded the first Clinical Ethics Committee in Mental Health in the UK which she continues to co-chair.

Jo is also an experienced medical trainer and a trained coach and continues to utilise these skills in ongoing consultancy and career development work.

Tamara Everington, Chief Medical Officer (voting)

Prior to joining QVH in October 2024, Tamara was Associate Medical Director for Change and Chief Clinical Information Officer leading integrated improvement and transformation at Hampshire Hospitals NHS Foundation Trust, having previously been lead for clinical governance. Before this she held senior leadership roles at Salisbury NHS Foundation Trust and helped establish the Southern Haemophilia Network.

A consultant haematologist, Tamara has previously worked in both primary and intensive care environments in the South of England and Australia. She completed her PhD exploring cellular signalling pathways and their role in Cancer at University College London (UCLH) whilst working at UCLH and Great Ormond Street Hospitals. Tamara sees research and innovation delivered in partnership as key to ensuring the UK remains at the cutting edge of healthcare science and has delivered a range of research programmes aimed at understanding and improving patient experience and outcomes.

Ensuring that colleagues are personally supported in delivering high quality responsive care is fundamental to Tamara's approach. As a trainee she volunteered with the British Medical Association's 'doctors in difficulty' programme and also led the British Society for Haematology Annual Scientific Meeting through Covid, using novel approaches to increase broad appeal and outreach to the global community. Growing up as the youngest in a multicultural family, Tamara has a deep appreciation for shared learning and celebration.

Russell Hobby, Non-Executive Director (voting)

Russell joined the Board in July 2023. Russell is Chief Executive Officer of the social mobility charity Teach First. He joined in September 2017, building on more than 15 years developing and promoting leadership in the education system. Prior to Teach First, Russell was General Secretary of the National Association of Head Teachers (NAHT), the largest trade union for school leaders, and before that worked as a management consultant.

At QVH Russell is a member of the Audit and Risk Committee and the Finance and Performance Committee. He also serves as a trustee of Fair Education Alliance and Teach for All UK Charity Board. He is also part of the Education Committee of the Royal Society. Russell was awarded a CBE in the New Year Honours List 2022 and holds an honorary doctorate from Bath Spa University.

Abigail Jago, Chief Strategy Officer and Acting Chief Executive Officer (voting)

Abigail Jago became Acting Chief Executive in February 2025, having been Chief Strategy Officer since February 2023. Since joining the NHS in 2000, Abigail has managed services across multiple sites and has led change programmes in both an acute setting and with multiple partners across health and social care systems including one of the national Vanguard programmes.

Abigail has held a number of strategic and operational senior roles including at East Sussex Healthcare NHS Trust and Barts Health NHS Trust. Abigail is passionate about the NHS and the delivery of partnerships and system wide improvement.

Karen Norman, Non-Executive Director (voting)

Karen joined the board in April 2019. She is the Senior Independent Director, Chairs the Charity committee, and is a member of both the Quality and Safety Committee and the Strategic Development Committee. Karen has worked in healthcare for 45 years in both the public and private sectors in the UK, Australia, New Zealand and Gibraltar. She has 20 years' experience as an Executive Director at board level, as Gibraltar's Chief Nursing Officer, and was Director of Nursing and Clinical Governance at Brighton and Sussex University Hospitals NHS Trust from 1993-2004. She has also worked as a management consultant for Crosby Associates, an American quality management company.

Karen11 currently serves as Visiting Professor to the Doctorate in Management Programme at the University of Hertfordshire, and is also a Visiting Professor at the School of Nursing, Allied and Public Health Faculty of Health, Science, Social Care and Education at Kingston University, London. As co-author of three healthcare textbooks, she has shared her learning and contributed to the nursing profession through publications and presentations at conferences worldwide.

Peter O'Donnell, Non-Executive Director (voting)

Peter joined the Board in July 2023. In April 2021, Peter retired as an Executive Vice President of Unum, a Fortune 500 company and CEO of its UK business and Chairman of Unum Poland. Peter has over 30 years' experience in Financial services and worked as in a variety of senior finance roles at Prudential, RSA and Aviva.

Peter has a Bachelor of Commerce Degree from University College Dublin, is a fellow of CIMA and has significant experience of both international and the UK markets. He lives in Westerham, Kent and is a Director of Nottingham Building Society and One Family Friendly Society. Peter was previously a Trustee of Cardiac Risk in the Young.

Shaun O'Leary, Non-Executive Director (voting)

Shaun joined the Board in July 2023 and is currently Chair of St Wilfrid's Hospice. He is former joint chief executive of St Christopher's Hospice and prior to that was chief executive of St Catherine's Hospice. Shaun has over 30 years' experience working in the health and social care charity sector, including 25 years at senior management level. Shaun is Chair of the QVH Quality and Safety Committee and a member of the Charity Committee.

Clare Pirie, Director of Communications & Corporate Affairs (non-voting)

Clare joined QVH in 2016 and has worked in the NHS since 2000 at large teaching trusts in Sussex and London as well as for national and local NHS commissioning organisations. Clare's background is in communications. The ability to explain clearly, listen to and understand the concerns of key stakeholders, test how key decisions may be articulated and perceived are important for the effectiveness and success of an organisation

Nicky Reeves, Chief Nursing Officer (voting)

Nicky Reeves was appointed Chief Nurse in February 2022 having been Interim Director of Nursing and Quality since November 2020. Prior to that Nicky held the Deputy Director of Nursing post at QVH for five years. She trained at the Hammersmith Hospital and has 40 years

of nursing experience, in a range of senior posts both at QVH but also in Trusts around Surrey and Kent. Nicky has always had a specialist interest in surgical nursing and started her QVH career 15 years ago as the Burns Centre Manager. Nicky has worked at senior management level leading and managing services as well as having extensive operational nursing experience.

Aleema Shivji, Associate Non-Executive Director (non-voting)

Aleema Shivji joined the Board in January 2025. Aleema is a systems-level changemaker invested in building an inclusive and just world. She has almost 25 years of strategic and operational experience in the public and not-for-profit sectors in the UK and around the world. A seasoned senior leader, Aleema was most recently the Chief Impact Officer and Interim CEO at Oxfam GB. Significant prior roles include Executive Director of Impact and Investment at Comic Relief, and 15 years at Humanity & Inclusion, including as their UK Chief Executive.

Her non-executive experience includes the University of Sussex, Association of Charitable Foundations Funder Collaborative Hub, the BBC and the Start Network. Originally a physiotherapist, Aleema also holds a Masters in International Relations (Conflict, Security and Development) from the University of Sussex (2012).

Jackie Smith, Trust Chair (voting)

Jackie Smith joined Queen Victoria Hospital as its Chair in July 2022. Jackie has over 30 years of experience in regulation and law and has been in public service all of her working life. She spent 12 years in the Crown Prosecution Service before taking up a post at the General Medical Council regulating doctors. She moved from there to the Nursing and Midwifery Council (NMC) in August 2010 as the Director of Fitness to Practise. In June 2012, Jackie became the Chief Executive of the NMC leading the organisation for more than six very successful years. Jackie left the NMC at the end of July 2018 and took up a role as a Non-Executive Director at Camden and Islington NHS Foundation Trust before becoming its Chair in February 2020. She continued as Chair, also taking on the role of Chair at Barnet, Enfield and Haringey Mental Health Trust

Edmund Tabay, Chief Nursing Officer (voting)

Edmund Tabay joined the Trust as Chief Nursing Officer in January 2025. He qualified as a registered nurse in the Philippines and began his NHS career in 2001. Prior to joining QVH, Edmund held the position of Hospital Director of Nursing at the Princess Royal Hospital, University Hospitals Sussex. Before this, he served as Deputy Chief Nurse at The Queen Elizabeth Hospital King’s Lynn and Buckinghamshire Healthcare Trust.

Edmund is passionate about multi-professional team working and values the importance of working collaboratively with patients and their families to enhance their experience. He is equally committed to ensuring that staff are supported with the right skills to deliver the best possible care. With extensive experience in acute, large and complex organisations, as well as integrated Trust, Edmund brings a wealth of knowledge to QVH. Edmund completed his postgraduate studies in Advanced Health Care Practice at Oxford Brookes University, further strengthening his expertise in clinical excellence and leadership.

Kirsten Timmins, Chief Operating Officer (voting)

Kirsten joined the Trust in March 2024 as Chief Operating Officer. Kirsten brings over 20 years' experience in performance management and improvement across the public sector. She spent 13 years at the National Audit Office working with Parliament, The United Nations, Ministry of Defence, and International Development to influence policy, improve services, and increase transparency of government expenditure. In 2016 she joined NHS England and Improvement working with Trust Boards and Executive Teams across South East England to improve leadership, governance and performance against the constitutional standards. In 2021 she joined South London and Maudsley NHS Foundation as the Deputy Chief Operating Officer where she has been instrumental in building relationships across the health and care system and with the Metropolitan Police Service.

Maria Wheeler, Chief Finance Officer (voting)

Maria Wheeler was appointed Chief Finance Officer in July 2023. Maria Joined the NHS in 2001, qualifying as an accountant in 2004. She spent her first nine years at East and North Herts NHS Trust, before undertaking a wide range of senior roles within the NHS, including Chief Finance Officer at West Norfolk Clinical Commissioning Group, Thurrock Clinical Commissioning Group, more recently as Executive Director of Finance and Estates at Hertfordshire Partnership University NHS Foundation. Maria is passionate about the inclusion agenda, plays an active role in staff networks across the East of England Region. She currently Chairs the LGBTQ+ network for the East of England and recently been asked to chair the National One Finance LGBTQ+ network. She believes we need to build an environment where everyone can feel comfortable coming to work as their true selves.

Queen Victoria Hospital is a specialist NHS hospital providing life-changing reconstructive surgery, burns care and rehabilitation services, primarily in the South of England.

We are a centre of excellence, with an international reputation for pioneering complex surgical techniques and treatments.

Our world-leading surgeons perform routine reconstructive surgery for the people of East Grinstead and surrounding areas, specifically for hands, eyes, skin and teeth, and are supported by therapy teams who are highly trained in the management of complex and high-risk trauma, disease and disfigurement.

The hospital also provides a minor injuries unit, expert rehabilitation services and a sleep service. Everything we do is informed by our passion for providing the highest quality care, the best clinical outcomes and a safe and positive patient experience. You can find out more at qvh.nhs.uk

Queen Victoria Hospital
NHS Foundation Trust
Holtye Road
East Grinstead
West Sussex RH19 3DZ

T : 01342 414000
E : info@qvh.nhs.uk
W: www.qvh.nhs.uk