Queen Victoria Hospital
NHS Foundation Trust

QUEEN VICTORIA HOSPITAL
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Annual Report and Accounts 2025/26

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1. Introduction

Chair's introduction

It is a privilege to introduce Queen Victoria Hospital NHS Foundation Trust's Annual Report and Accounts for 2025/26.

I joined QVH as Interim Chair in January 2026 and have been struck by the professionalism, expertise and compassion of colleagues across the organisation. This report reflects a Trust that has continued to deliver high-quality specialist care and essential local services in a demanding NHS environment also taking important, deliberate steps to strengthen its foundations for the future.

From a governance perspective, March 2026 marked an important milestone, with confirmation that the additional licence conditions imposed in 2021 had been removed. This provides assurance of the progress made in leadership effectiveness, oversight arrangements and our ability to demonstrate strong governance.

Looking ahead, the Board has remained focused on long-term sustainability. Like many specialist providers, QVH faces a complex combination of rising demand, capacity constraints and financial challenge. During the year, following a robust appraisal process that included clinical, staff, patient and stakeholder input, the Board agreed, with the support of the Council of Governors, to progress a strategic partnership with Royal Surrey NHS Foundation Trust and Ashford and St Peter's Hospitals NHS Foundation Trust (RSFT/ASPH) group.

QVH has a strong history of collaboration, already working closely with partners in Kent, Surrey, Sussex and beyond, which this will build upon. We are now in a period of shared planning, analysis and assurance across all three organisations, to help us align expectations and timescales so we are all clear on how the partnership will deliver benefits for patients, colleagues and the communities we serve.

I would like to offer my sincere thanks to everyone who has contributed to QVH this year. In particular, I want to thank our staff for the care they provide every day, our volunteers and supporters for the time and kindness they give, and our patients whose feedback is vital in helping us continually improve the care we provide.

I also want to thank our Council of Governors for representing the interests of our members and the public, and for the constructive challenge and support they provide in holding our Non-Executive Directors to account for the performance of the Board.

I hope you find this Annual Report and Accounts informative and that you will join us as we look ahead with confidence, building on QVH's unique strengths and working together to secure a sustainable and positive future for the patients we serve.

Angela McNab
Interim Trust Chair
25 June 2026

2. 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 2025/26.

Statement from the Chief Executive Officer

Looking back, 2025/26 has been a year of sustained pressure and meaningful progress for Queen Victoria Hospital NHS Foundation Trust. At a time when expectations across the NHS to improve access, increase productivity and deliver sustainable services remain high, our focus has been on providing high-quality, compassionate care for patients, while strengthening the capacity and ways of working needed for the future.

I would like to begin by thanking colleagues in every role. The care delivered at QVH reflects exceptional skill, professionalism and compassion, sustained through a year of continued demand and constraint. I am proud of what our teams have achieved for patients, and of the way colleagues have continued to support one another, as well as those we care for.

Delivering for patients

Cancer services remain central to QVH's purpose and identity. In the national Cancer Patient Experience Survey, QVH achieved top national scores in several areas, including involvement in care decisions and access to support from ward staff, with overall cancer care rated above the national average. These results matter because they reflect how patients feel about their care at some of the most difficult moments in their lives.

Performance against the Faster Diagnosis Standard was consistently strong throughout the year and improved further in the final quarter. However, delivery of the 31-day and 62-day treatment standards was challenged at times. Increased urgent suspected cancer referrals, pathway complexity and capacity constraints all contributed. In response, targeted actions were implemented, including additional activity and strengthened teledermatology pathways, which will continue into 2026/27.

Across elective care, performance improved during much of the year, although delivery in the final quarter was more challenging. The focus moving forward is on improving theatre and outpatient productivity so that waiting times can be reduced and more timely care provided for patients.

For local services, the Minor Injuries Unit continued to provide reliable access, with more than 98% of patients seen, treated, discharged or transferred within four hours.

Building capacity and improving flow

One of the most significant developments this year was the start of construction of the dedicated Community Diagnostic Centre building, supported by £8.4m of national investment. It will play a key role in strengthening diagnostic capacity and future performance, helping to reduce the time patients wait for essential tests that inform diagnosis and treatment.

Diagnostic performance also recovered over the year following early challenges linked to CT equipment. Alongside this, the continued embedding of The QVH Way and an integrated

quality and performance framework has helped teams to focus improvement efforts where they have the greatest impact for patients.

Our people and our culture

The NHS Staff Survey results for 2025 show that colleagues continue to recognise QVH's strong commitment to patients: 90% would recommend care to family and friends, and 82% agree that patient care is the organisation's top priority. However, colleagues have also been clear about where pressures are being felt most strongly, particularly around workload, advocacy and aspects of speaking up.

While it is important to recognise that these results sit within the wider NHS context and reflect the impact of sustained operational pressure and financial challenge, this feedback has been carefully considered. Priorities for 2026/27 will focus on strengthening inclusion, supporting wellbeing and building psychological safety, with targeted action to improve staff voice and everyday experience at work.

Sustainability and partnership

QVH continues to operate in a challenging financial environment. Long-term sustainability will require productivity improvements, disciplined financial management and strategic change.

During the year, the Board agreed to progress a proposed strategic partnership with Royal Surrey NHS Foundation Trust and Ashford and St Peter's Hospitals NHS Foundation Trust (RSFT/ASPH) group. This will support the long-term resilience of specialist services, while enabling continued collaboration with a wide range of NHS partners for the benefit of patients across the region.

Looking ahead

As QVH moves into 2026/27, it does so having laid strong foundations through the first year of the *QVH Strategy 2025–2030*. Over the past 12 months, a number of key programmes have been delivered that support safer care for patients, improved productivity and long-term sustainability. This includes the go-live of Archie, the new Electronic Patient Record, with ongoing optimisation; strengthening improvement capability through The QVH Way and expanded continuous improvement training; and investing in staff through leadership development and work to embed the behavioural framework.

Important enablers of sustainable services have also progressed, including delivery of the cost improvement programme and a range of estates, infrastructure and equipment improvements, alongside the continued development of more collaborative ways of working.

Priorities for 2026/27 are clear: improving productivity and access; strengthening cancer pathway performance; improving staff experience; delivering sustainable services; and progressing partnership planning openly and collaboratively. This is underpinned by research, innovation and a commitment to continuous improvement.

At the heart of this report are the patients who place their trust in QVH. That responsibility will continue to shape decisions and improvement in the years ahead.

Abigail Jago
Acting Chief Executive Officer
25 June 2026

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 and 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 works within a number of multidisciplinary teams across the region.

In 2025/26, 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 core NHS principles: that care should be universal, comprehensive and free at the point of need. The Trust is licensed by the independent regulator, NHS England, to provide these services. Its 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 the corporate trustee of 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 the control, 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

QVH faces ongoing challenges in balancing the delivery of high-quality patient care with rising demand, increasing complexity of healthcare needs and the continued national requirement to increase productivity and efficiency. Strategic and transformational change, both within the Trust and across the wider health and care system, will play an important role in addressing operational and financial risks.

The Trust continues to face significant operational and strategic challenges, most notably in relation to waiting lists, workforce and resources, and the wider financial environment. Developing and maintaining collaborative relationships with partner organisations is critical to its future sustainability.

Following a robust appraisal process involving clinical, staff, patient and stakeholder input, the Board approved the decision to progress a strategic partnership option to support the long-term sustainability and resilience of its specialist services.

The Trust's nine strategic risks to achieving its key strategic objectives, which form the Board Assurance Framework, have remained the principal risks for the organisation during 2025/26. These are set out in more detail in 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 2026/27 as: delivering outstanding care; innovation and improvement; being an excellent employer; delivering sustainable services; and increasing and strengthening collaboration with partners for the benefit of patients.

Going concern disclosure

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

Performance analysis

Measuring performance

During 2025/26, the Trust has an integrated quality and performance reporting framework to support the flow of performance information from directorate to Board level across key strategic objectives and national performance indicators. Quality and performance review meetings are held monthly with each directorate, and the integrated quality and performance report is reviewed by the Trust Board and its Quality and Safety and Finance and Performance Committees.

Risks to the Trust achieving its key strategic objectives are set out in the Board Assurance Framework, alongside mitigating actions.

The Trust's continuous improvement methodology, 'The QVH Way', was launched during 2024/25 and continues to be embedded across the organisation. Teams use improvement huddles to review performance and identify future areas for improvement.

Operational performance

During 2025/26, the Trust continued to deliver high-quality, safe and compassionate care while operating under sustained demand and workforce pressures common across the NHS. The Trust maintained its strong reputation for excellent patient experience, supported by major digital improvements and infrastructure investment that will further strengthen access standards performance in future years.

Elective waiting times

Throughout 2025/26, the Trust continued to focus on reducing the length of time patients wait for treatment. Performance improved over the course of the year, with 18-week RTT performance increasing by 3%, from 58.9% in Month 1 to 61.85% in Month 12. In addition, the proportion of patients receiving a first appointment within 18 weeks improved by 7% during the year.

Delivery in Quarter 4 was more challenging, and the Trust did not meet its year-end targets for RTT 18 weeks, 52 weeks and 65 weeks. In response, the Trust is focusing on improving theatre and outpatient productivity, strengthening senior oversight of the patient tracking list, and increasing the use of digital technology to support a stretching RTT recovery trajectory in 2026/27.

The Trust continues to prioritise reducing long waits. The proportion of patients waiting over 52 weeks reduced from 2.2% of the overall waiting list to 1.1% during the year, with the total number of patients waiting over 52 weeks falling from 397 in April 2025 to 226 in March 2026. QVH remains committed to achieving and maintaining a position where no more than 1% of patients wait longer than 52 weeks in 2026/27.

Reducing the number of patients waiting over 65 weeks and 52 weeks remains a key operational focus for the Trust.

Urgent and Emergency Care (UEC) performance

QVH provides a Minor Injuries Unit (MIU) service rather than a Type 1 Emergency Department. During 2025/26, performance remained strong, with more than 96% of MIU patients seen, treated, discharged or transferred within the four-hour standard throughout the year.

	Target	Quarter 1	Quarter 2	Quarter 3	Quarter 4
4 hour standard	Constitutional standard 95%	96.4%	98.2%	99.6%	98.7%

Figures shown are month end for each quarter

Elective Care performance

	Quarter 1	Quarter 2	Quarter 3	Quarter 4
Referral to treatment (RTT) within 18 weeks (92% standard)	62.4%	64.5%	60.9%	61.8%
Proportion of patients having a first appointment in 18 weeks	75.8%	76.4%	73.4%	76%
Total patients waiting longer than 65 weeks	45	67	53	31
Total patients waiting longer than 52 weeks/overall proportion of the waiting list	388/ 2.2%	387/ 2.0%	266/ 1.3%	226/ 1.1%
Total waiting list size	17,869	19,776	20,186	20,841

Figures shown are month end for each quarter.

Cancer

During 2025/26, the Trust continued to see increased demand across cancer services, with a significant increase in urgent suspected cancer referrals compared with the previous year. This increase in demand, alongside pathway complexity and capacity constraints, has presented challenges in the delivery of cancer waiting time standards.

Performance against the 62-day treatment standard was particularly challenged during the year, although year-end performance of 81.6% exceeded the Trust plan. The 31-day treatment standard also remained below the national target, primarily due to consultant and theatre capacity pressures.

Despite these challenges, the Trust maintained strong performance in a number of key areas. The Faster Diagnosis Standard was consistently achieved throughout the year, exceeding the national target of 80% with delivery of 83.4% by year end, with further improvement seen in Quarter 4.

Patient experience continues to be a significant strength. In the 2025 National Cancer Patient Experience Survey, QVH achieved top national scores in several areas, including involvement

in care decisions (97% compared to 71% nationally) and access to help from ward staff (97% compared to 74% nationally). Overall cancer care at QVH was rated 9.05 out of 10, above the national average of 8.94.

A range of improvement actions have been implemented in response to performance challenges. These include additional weekend activity to support timely treatment, strengthening the teledermatology pathway to improve triage and support timely onward referral, and continued partnership working with the Surrey and Sussex Cancer Alliance and the Kent and Medway Cancer Alliance to review pathways using a continuous improvement approach. During 2025/26, the Trust continued to see increased demand across cancer services, with a 15% increase in urgent suspected cancer referrals compared with the previous year. This increase in demand, alongside pathway complexity and capacity constraints, has presented challenges in the delivery of cancer waiting time standards.

Cancer performance

	Target	Quarter 1	Quarter 2	Quarter 3	Quarter 4
First definitive treatment within 62 days	Constitutional standard 85%	81.7%	81.8%	73.2%	81.6%
Faster diagnosis standard	Constitutional standard/national target 80%	81.4%	77.5%	81.8%	83.4%

Figures shown are month end for each quarter

Diagnostic waiting times

During 2025/26, the Trust made significant progress in strengthening diagnostic capacity, with construction commencing on a new Community Diagnostic Centre on the East Grinstead site, supported by £8.4m of national investment. The centre is due to open in 2026/27 and represents a major improvement initiative for future performance.

Diagnostic performance improved over the course of the year following disruption earlier in the year due to the failure of CT equipment. By Month 12, performance had recovered to 89%

	Target	Quarter 1	Quarter 2	Quarter 3	Quarter 4
Diagnostic 6 week wait performance	Constitutional standard 99%	73.4%%	88.9%	88.5%	88.9%

Figures shown are month end for each quarter

Financial performance

During 2025/26, due to the balance of the Charity accounts, the Trust continues to report a consolidated group position. The accounts are appended at the end of this report.

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

Performance metrics

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

	Plan £000	Actual £000
Reported financial performance	**0**	**11**

During 2025/26, the Trust planned and delivered a break-even position after technical adjustments.

Prior to any adjustments, the 2025/26 accounts report a surplus of £1.54m. After adjustments for impairments, donations and additional deficit support funding, the Trust achieved an £11k surplus. This is calculated and shown in the table above (with prior year comparative).

These adjustments include additional deficit support funding of £1.6m, which was received following the national reallocation of funds to organisations that delivered their financial plans.

Adjusted Financial Performance	**2025/26 £000**	**2024/25 £000**
Trust position before adjustments - Surplus/(Deficit)	1,540	24
Adjustments		
(Revaluation) / Impairment of Land & Buildings		(238)
Impact of Donations and Donated Assets	109	230
Adjusted Financial Position / Control Total	**1,649**	**16**
Funding Adjustment		
Less additional non-recurrent deficit support funding	(1,638)	-
Adjusted Financial Position / Control Total (less additional DSF)	**11**	**16**

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 Statement of Comprehensive Income	**2025/26 £000**	**2024/25 £000**
Operating income from patient care activities	122,725	112,837
Other operating income	5,818	4,696
Operating expenses	(124,362)	(115,527)
Operating Surplus / Deficit	**4,181**	**2,006**
Net Finance Costs	(2,157)	(1,933)
Group position before adjustments - Surplus/(Deficit)	**2,024**	**73**

Group income

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

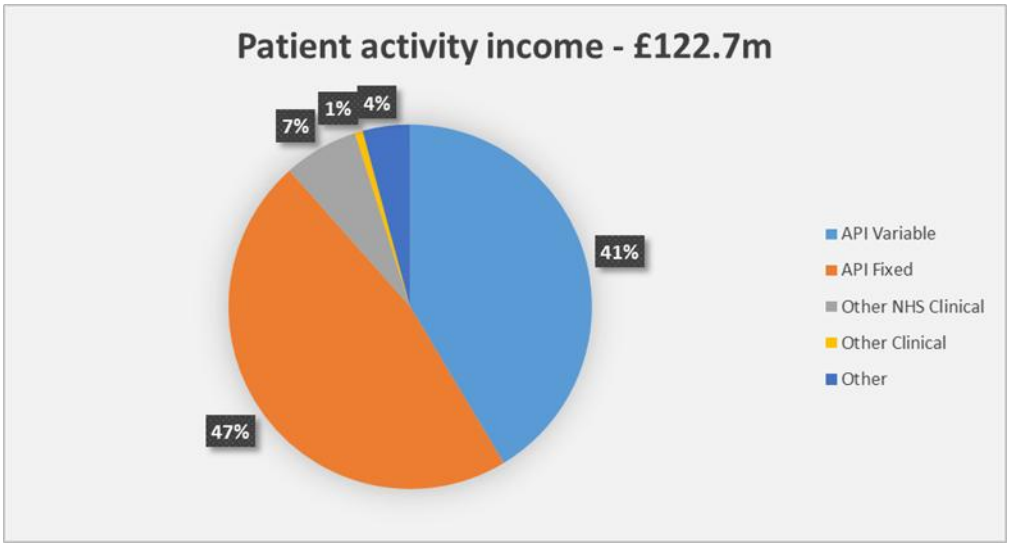
- Patient activity income from NHS commissioners for providing services to patients. The chart below shows the relative proportions.
    - Aligned payment & incentives (API) applies to almost all provider commissioner relationships.
    - API - variable covers elective, day case, outpatient and diagnostic activity that have prices based on actual activity.

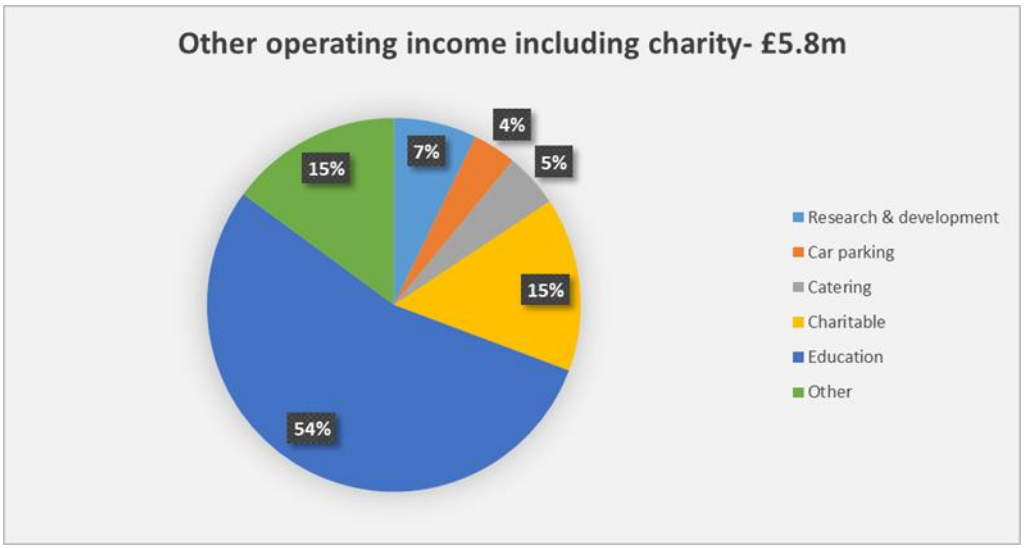
- API – fixed covers payments for activity but is for a set value and does not change with the level of activity undertaken.
- Elective patients are those whose treatment is planned in advance, such as day case or inpatient operations.
- Non-elective are generally those needing urgent care which has not been planned in advance.
- 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 or car parking.

  Note that other Income for 2025/26 is prepared on a Group basis and includes the QVH Charity.

Figure one: 2025/26 Income (group)





Group expenditure

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

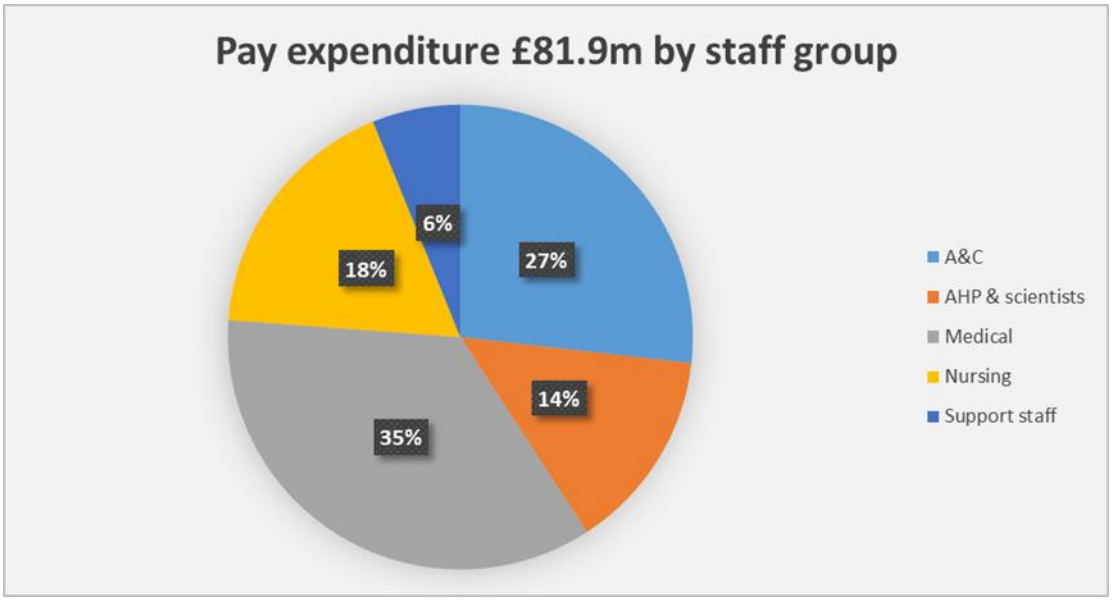
- Pay Expenditure
- Non-Pay Expenditure.

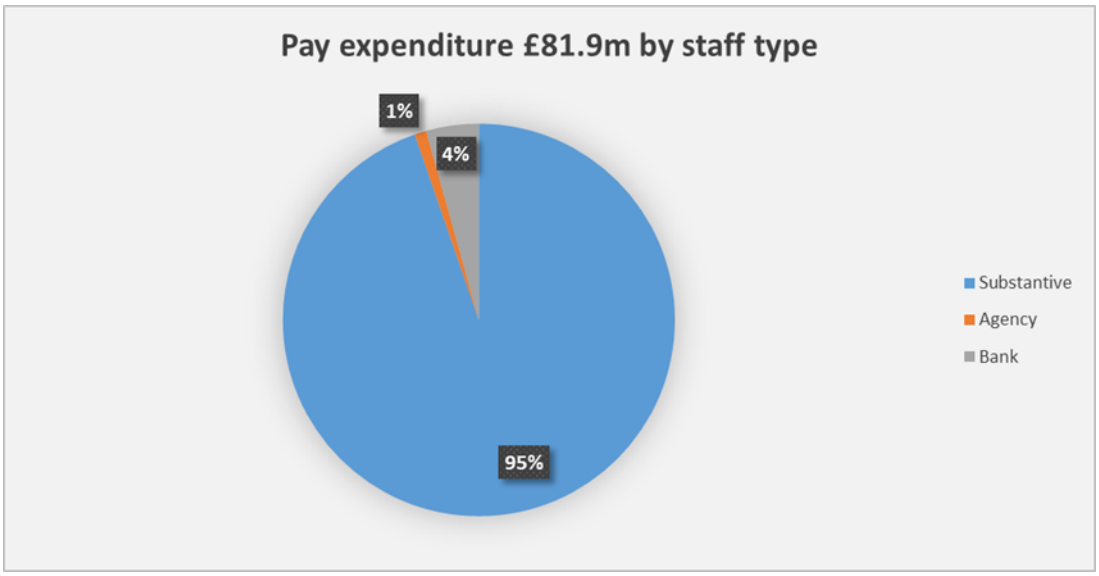
These are summarised in the following paragraphs and charts.

Group pay expenditure

The Trust spent £81.9m on staff to provide patient services in 2025/26. This covers all staff groups but does not include the staff costs within capital projects which were £2.3m. The breakdown of pay expenditure into staff groups is shown in the charts below.

Figure two: 2025/26 Pay expenditure (group)



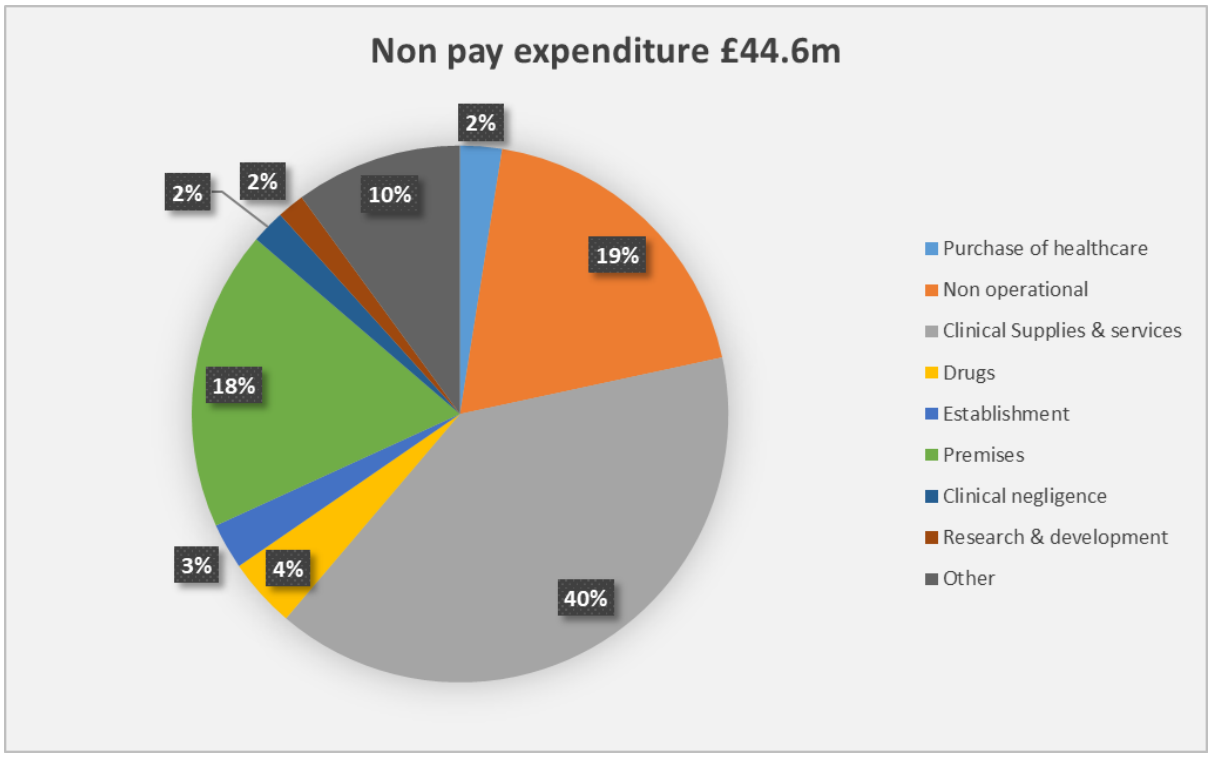


***** *Key*
A&C - Admin and Clerical
AHP - Allied Health Professional

Group non-pay expenditure

The Trust spent £44.6m on non-pay items in 2025/26 and this is illustrated by category in the chart below.

Figure three: 2025/26 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 at 31 March 2026 by professionally qualified, Royal Institute of Chartered Surveyors (RICS) registered, valuers Newmark Gerald Eve LLP. The 2024/25 valuation was undertaken via a full valuation with the 2025/26 valuation through a desktop basis. For 2025/26 the valuer, in arriving at the 31 March 2026 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 as at 31 March 2025.
- The valuer considered the costs of significant capital improvements completed since the last valuation on 31 March 2025.

Capital Expenditure

The Trust invested £4.45m of internally generated resources on capital assets (see below for breakdown) together with £12.19m funded from external sources. The externally funded schemes include the Electronic Patient Record (EPR) programme and Community Diagnostic Centre programme. In addition the Trust secured additional funding of £1.30m for diagnostics and £4.25m of critical infrastructure funding to support the essential works across the Trust estate. The Trust also spent £1.45m under IFRS16 right of use assets

which covered leases on the Trust's boiler and MRI. Total capital expenditure was £18.09m within the financial year.

The QVH Charity does not incur any capital expenditure, therefore all capital expenditure is attributable to the Trust. The charity donated £37k which the Trust used to purchase capital equipment. The land sale proceeds were used in 2025/26 to support the implementation of the new EPR system.

Capital investment Scheme	£m
Internal CRL	
IT hardware	0.08
Medical devices and equipment	0.06
Building and Maintenance	1.33
EPR	2.98
	4.45
Funded Capital	
EPR	0.76
CDC	5.87
Critical Infrastructure	4.25
Digital Histopathology / Diagnostics	1.30
	12.19
IFRS16 Right of use asset	
Temporary Boiler	0.98
Temporary MRI	0.47
Total Capital Investment	**18.09**

Financial risk

In 2026/27, the Trust faces several financial risks. These include:

- **Delivering required efficiency savings:** The Trust is required to deliver a £7.5m efficiency saving in order to deliver a breakeven position which follows 2025/26, where £7.5m was also required and delivered. There is a risk that QVH cannot identify sufficient efficiencies to fully address the financial challenge, that they cannot be delivered recurrently which would deteriorate 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 further in 2026/27. QVH is a small Trust and is required to produce statutory reports and to run core functions, similar to all NHS trusts. The small scale of the organisation makes the corporate cost reduction highly challenging, which may put the breakeven position at risk or lead to increased regulatory oversight.
- **Clinical income risk:** The Trust has contracts with commissioners which contain a significant proportion of 'block' income, and this presents a risk where activity levels run above those which are funded.
- **Operational capacity:** The Trust is aiming to improve its constitutional standards as per NHS requirements and has set targets for itself that see year-on-year improvement. Any further ask of the Trust would be difficult to deliver, and the cost of activity may be greater than the income available, especially with limited funds within the ICBs, which would provide additional challenges to the Trust.

- **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 the risks.
- **Cyber:** There are growing risks to all organisations resulting from cyber threats, managing the changes and supporting the national teams. The Trust links in with national teams, but increased threats come with increased costs to manage them, and this has the potential to require additional in-year management to maintain the Trust financial position.
- **Implementation of Patient Administration System:** The Trust is in the process of implementing a new PAS system. This is going to take significant resource to implement but will also 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.
- **Community Diagnostic Centre (CDC):** The Trust is nearing completion of the new CDC building. Any issues that arise that delay the completion of the build could impact the activity plans for the organisation and provide challenges to the Trust in delivering the income plan and constitutional standards.

Environment and sustainability

Climate change is impacting the health of patients and communities in Sussex, particularly more vulnerable populations. The Trust's challenge is to ensure it can continue to deliver its vision to "be a centre of excellence that rebuilds lives and supports communities for a healthier future" in the context of a changing climate.

The Trust's approach is informed by the emerging NHS 10-year Plan, including its focus on increasing the use of digitally enabled care and reducing demand through prevention. These elements are central to the Trust's approach to delivering Net Zero Carbon and are aligned to its strategic objectives. Delivery will be challenging but is expected to reduce environmental impact and support improvements in health outcomes for patients and the wider community.

The Trust's Green Plan 2026 sets out its commitment to addressing sustainability in three key areas, in line with the Health and Social Care Act 2022:

1. **Mitigation:** Achieving Net Zero Carbon by 2040 for direct emissions and by 2045 for indirect emissions.
2. **Adaptation:** Adapting services and infrastructure to the current and projected impacts of climate change across Sussex.
3. **Wider environmental impacts:** Reducing impacts on air pollution, biodiversity, water and waste, in line with the Environment Act 2021.

As part of this approach, the Trust is aligning with the recommendations of the Task Force on Climate-related Financial Disclosures, strengthening its approach to identifying, managing and reporting climate-related risks. Sustainability is embedded within the Trust's strategy and annual planning processes to support service innovation, improve health outcomes, support efficient use of resources, and reduce environmental impact.

Key areas of progress support the environment and sustainability in 2025/26 are:

- **Reduced emissions from anaesthetic gases:** Including the decommissioning of the piped nitrous oxide system, contributing to a 73% reduction in related emissions since 2019/20.

- **Energy efficiency through LED lighting:** Installation of LED lighting has reduced lighting energy demand by approximately 70%, lowering carbon emissions and improving the working environment.
- **Increased use of reusable clinical equipment:** Replacement of single-use anaesthetic trays with reusable alternatives, saving an estimated 2.2 tonnes of CO_2e and 188,000 litres of water annually.
- **Sustainable procurement practices:** Introduction of a Supplier Code of Conduct and incorporation of sustainability clauses into procurement contracts from July 2025.
- **Expansion of virtual care models**: Approximately 25% of outpatient appointments are now delivered virtually, improving access for patients and reducing travel-related emissions.
- **Development of a hub-and-spoke care model:** Expansion of diagnostic and elective care across 13 outreach sites, enabling more care to be delivered closer to patients' homes. This has reduced travel-related emissions, improved patient experience and alleviated pressure on the main hospital site.
- **Digital innovation to streamline care pathways:** Implementation of the Bleepa platform within the Community Diagnostic Centre to support the breathlessness pathway. This enabled secure multidisciplinary working between primary and secondary care, reduced reliance on face-to-face appointments, and achieved a 63% reduction in waiting times, with 90% of patients managed without an in-person specialist appointment. This approach was recognised nationally at the HSJ Partnership Awards 2025.
- **Strengthened strategic approach to sustainability:** Publication of a refreshed Trust Green Plan in partnership with Care Without Carbon (CWC), aligned with the Sussex system-wide strategy Together to Zero. This collaborative approach has enabled QVH to maximise the impact of limited resources, share expertise and learning, and deliver joint initiatives at scale, while strengthening its contribution to system-wide sustainability ambitions and demonstrating sector leadership.

Task force on climate-related Financial Disclosures (TCFD)

NHS England's NHS Foundation Trust Annual Reporting Manual adopts a phased approach to incorporating TCFD-recommended disclosures as part of sustainability reporting requirements, following HM Treasury's TCFD-aligned guidance for public sector annual reports. These disclosures are interpreted for the public sector by HM Treasury. Local NHS bodies are not required to disclose Scope 1, 2 and 3 greenhouse gas emissions, as these are calculated nationally by NHS England.

These disclosures cover the governance, risk management, and metrics and targets pillars for 2025/26 and are set out below.

The Trust recognises that climate change is a significant global challenge, with implications including warmer, wetter winters, hotter, drier summers, more variable rainfall and more severe storms. Rising sea levels and extreme weather events, such as flooding and heatwaves, increase risks to buildings and infrastructure.

The Trust Board, through the Finance and Performance Committee, oversees commitments relating to environmental sustainability and climate-related issues, as set out in the Trust's Green Plan. This commits the Trust to becoming a more sustainable healthcare provider and achieving net zero carbon by 2040. The Care Without Carbon framework sets out three key aims: reducing environmental impact, improving wellbeing, and investing in the future, which form the Trust's metrics for managing climate-related issues. The Green Plan will be updated

during 2026. The Board also considers climate-related issues in organisational planning and performance monitoring, including in the development of the *QVH Strategy 2025-30*.

A management-led Estates and Facilities sub-group of the Executive Leadership Team is responsible for day-to-day oversight of climate-related responsibilities.

Information on the Trust's approach to managing risks, including climate-related risks, is set out in the Annual Governance Statement within this Annual Report.

Health inequalities

Throughout the year, the Trust continued to work with partners across the wider health and care system to support delivery of the QVH Health Inequalities Strategy 2025–30 and to improve understanding of inequalities in access, experience and outcomes for patients.

Average patient ethnicity data completeness improved from 79.8% in 2024/25 to 83.9% in 2025/26, representing a 4.1 percentage point increase. This improvement was supported through targeted activity across clinical services and patient pathways. Elements of this work were also shared with Sussex system partners and will continue as a priority in 2026/27.

During 2025/26, the Trust developed a Health Inequalities Dashboard to support analysis of variation in Did Not Attend (DNA) rates, cancellations and waiting times by age, ethnicity, gender and indices of multiple deprivation (IMD) decile. The dashboard has improved visibility of variation across patient groups and supported early analysis of inequalities in access to care.

The Trust maintained strong performance in cancer staging data completeness, consistently achieving top quartile performance throughout 2025/26. Cancer staging data was also shared with primary care partners to support earlier identification of patients at risk of late presentation, particularly within head and neck cancer pathways.

During the year, the Trust contributed to Sussex-wide co-production of ethnicity data collection training resources and commenced development of a Trust-specific health inequalities learning resource to support workforce capability and awareness. Work also progressed to improve identification and recording of patients' communication and accessibility needs in line with the Accessible Information Standard.

Equality of service delivery

The Trust's Health Inequalities Programme forms part of its statutory duty to reduce inequalities in access, experience and outcomes, as set out in the NHS Constitution and the NHS Long Term Plan. The programme is aligned with the *QVH Strategy 2025–2030*, the QVH Health Inequalities Strategy, the Core20PLUS5 framework and the Sussex Integrated Care Strategy, ensuring that local delivery contributes to wider system objectives for prevention, inclusion and equitable care.

QVH continues to deliver its long-term commitment to tackling inequalities in access, experience and outcomes for patients and staff. The 2025/26 Health Inequalities Programme remains aligned with national and system frameworks, focusing on key priority areas including ethnicity data collection, variation in long-waiters, Did Not Attend and cancellation rates (including Was Not Brought in paediatrics), cancer staging and late presentation, workforce awareness, and compliance with the Accessible Information Standard.

During 2025/26, the Trust used its Health Inequalities Dashboard to support initial exploration of variation in long-waiters by age, ethnicity and deprivation. This represents an important step towards more systematic monitoring of potential unwarranted variation in waiting times.

Early analysis suggests that long-waiters are disproportionately concentrated among working-age adults and patients in more deprived IMD deciles, with a significant proportion of pathways recorded as 'ethnicity not known or not assigned'. Analysis also indicates higher DNA rates among some ethnic groups and patients from more deprived IMD deciles, as well as where ethnicity is not recorded. This analysis remains at an early stage and reflects both the developing maturity of the dashboard and the need for continued improvement in data completeness and quality.

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 in the Trust's Standards of Business Conduct Policy. The Trust maintains a register of gifts, hospitality and sponsorship received, and staff are required to declare any potential conflicts of interest.

The Trust has a counter fraud, bribery and corruption response plan which follows the NHS Counter Fraud Authority (NHSCFA) strategic guidance. The work plan and resource allocation are aligned to the objectives of this strategy and to locally identified risks. The Trust has undertaken 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 methodology and is recorded and managed in accordance with the organisation's risk management policy. Risks are included on the appropriate risk registers. Measures to mitigate identified risks are incorporated into an organisational work plan, with progress monitored at a senior level within the organisation and results reported to the Audit and Risk Committee. The plan is reviewed, evaluated and updated as required, and levels of staff awareness are monitored. Board-level evaluation of the effectiveness of counter fraud, bribery and corruption work is undertaken, and where recommendations have been made by NHSCFA, the Trust reports on how these have been addressed. Counter fraud, bribery and corruption arrangements have been assessed both internally and independently and rated as green.

Where there is concern regarding possible slavery or human trafficking of a patient, appropriate action is taken in line with the Trust's safeguarding procedures, including seeing the patient alone and using an independent translator. Where concerns remain, a referral would be made to the police. No cases of slavery or human trafficking were identified during 2025/26. The Trust's Modern Slavery Statement is available on its website.

The Trust works with partner organisations to promote the safety, health and wellbeing 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 2025/26 financial year affecting the Trust.

Overseas operations

The Trust has no overseas operations.

3. The Accountability Report

Directors' report

In 2025/26, the following individuals served as directors of Queen Victoria Hospital NHS Foundation Trust.

Name	Position
Jon Bell	Interim Chief Finance Officer (voting) until 08/05/2025
Liz Blackburn	Acting Chief Nursing Officer (voting) from 01/12/2025
Vivek Chaudhri	Associate Non-Executive Director (non-voting)
Jane Dickson	Interim Deputy Chief Executive Officer (non-voting) until 01/04/2026
Paul Dillon-Robinson	Non-Executive Director (non-voting) until 30/09/2025
Helen Edmunds	Chief People Officer (non-voting)
Jagjit Dosanjh-Elton	Non-Executive Director (voting) from 01/10/2025
Jo Emmanuel	Non-Executive Director (voting)
Tamara Everington	Chief Medical Officer (voting)
Russell Hobby	Non-Executive Director (voting)
Abigail Jago	Acting Chief Executive Officer (voting) Chief Strategy Officer (non-voting)
James Lowell*	Chief Executive Officer (until 10 August 2025)
Simon Marshall	Interim Chief Finance Officer (voting) from 09/05/2025
Angela McNab	Interim Trust Chair (voting) from 19/01/2026
Karen Norman	Non-Executive Director (voting) until 07/04/2025
Peter O'Donnell	Non-Executive Director (voting)
Shaun O'Leary	Non-Executive Director (voting)
Aleema Shivji	Associate Non-Executive Director (non-voting)
Jackie Smith	Trust Chair (voting) until 16/01/2026
Edmund Tabay	Chief Nursing Officer (voting) until 30/11/2025
Kirsten Timmins	Chief Operating Officer (voting)

**From 10 February 2025 to 10 August 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 2025/26 are provided in appendix three 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 http://www.qvh.nhs.uk/about-us/board-of-directors/meetings-in-public/. The Trust's decision makers declaration of interest register is available on the website via this link www.qvh.nhs.uk/wp-content/uploads/2026/05/DOI-Register-2025-2026-FINAL.pdf.

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 2025/26 (2024/25 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 2025/26 is shown below:

Better Payment Practice Code	2025/26	2025/26	2024/25	2024/25
	Number	£k	Number	£k
Total non-NHS trade invoices paid	19,576	71,260	20,885	70,257
Total non-NHS trade invoices paid within target	18,181	64,640	18,885	63,563
Percentage of non-NHS trade invoices paid within target	**92.87%**	**90.71%**	**90.40%**	**90.50%**
Total NHS trade invoices paid	971	3,800	889	4,755
Total NHS trade invoices paid within target	810	3,266	697	3,742
Percentage of NHS trade invoices paid within target	**83.42%**	**85.95%**	**78.40%**	**78.70%**
Percentage of All trade invoices paid within target (%)	**92.43%**	**90.47%**	**89.90%**	**89.70%**

Interest liability

The Trust did not incur any interest charges for late payment of invoices during 2025/26 (2024/25 nil).

NHS England well-led framework

As good practice, the Trust uses the NHS England well-led framework to ensure that it is well-led when considering organisational performance, internal controls, the Board Assurance Framework and the governance of quality. The Trust aims to maintain an inclusive and positive culture of continuous learning and improvement, based on meeting the needs of people who use services and the wider community, with this approach consistently shared across leaders and staff. The leadership team continues to support staff proactively and to work collaboratively with partners to deliver care that is safe, integrated, person-centred and sustainable, and to reduce inequalities.

The Trust's approach is informed by the well-led framework and supports its assessment of organisational performance, the effectiveness of internal controls and the Board Assurance Framework, and the identification of areas for further improvement in the governance of quality.

During the year, the Trust has continued to progress delivery of its Patient and Public Engagement Strategy, supporting its ambitions to improve patient experience and strengthen meaningful public involvement.

The Trust has continued to strengthen its alignment with the well-led framework during 2025/26, building on previous progress. The QVH Way, the Trust's continuous improvement methodology, has been further embedded across the organisation, supporting improvements in governance of quality, operational effectiveness and staff engagement.

The Annual Governance Statement for 2025/26 concludes that no significant internal control issues have been identified during the year. Issues identified in 2024/25 relating to weaknesses in governance arrangements have been addressed through the implementation of actions set out in the prior year Annual Governance Statement, which have strengthened the internal control environment.

The Trust has reviewed disclosures within the Annual Governance Statement, this Annual Report and relevant external reports and has identified no material inconsistencies. Where areas for improvement have been identified, appropriate action plans have been developed and are monitored through established governance processes.

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 www.qvh.nhs.uk/about-us/board-of-directors/meetings-in-public/

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 Care Quality Commission Adult Inpatient Survey 2024 (published September 2025), Queen Victoria Hospital again achieved the highest overall patient experience score in the country, with patients rating their care 9.4 out of 10 compared to a national average of 8.2.

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 25	May 25	Jun 25	Jul25	Aug 25	Sep 25	Oct 25	Nov 25	Dec 25	Jan 26	Feb26	Mar26
No. of patient safety incidents with moderate harm	0	0	0	0	1	0	0	0	2	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)	2	0	2	1	1	1	0	0	0	0	0	1

*(*Denotes- moderate harm caused elsewhere)*

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

1. Audit planning and clinical effectiveness
2. Quality outcome measures
3. Learning from Outcomes and Patient Experience
4. Patient information and Accessibility.

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. During 2025/26, QVH reported one case of hospital-acquired Clostridium difficile (C. diff), which was deemed unavoidable. There was one case of Pseudomonas aeruginosa bacteraemia and one case of E. coli bacteraemia. There were no hospital-attributable MRSA, MSSA or Klebsiella bacteraemia during the year.

The Trust takes complaints very seriously, recognising them as a vital source of learning from patient experience, and continues to improve its complaints management processes. During 2025/26, the Trust received 88 formal complaints, an increase of 20% from 73 in the previous financial year. In the same period, 339 Patient Advice and Liaison Service (PALS) requests were received, representing a 21% increase compared to the previous year.

Stakeholder relations

During 2025/26, the Trust maintained relationships with staff, volunteers, Foundation Trust members, governors, patient representatives and local partners through a programme of focused engagement activity.

As part of work to consider strategic partnership opportunities, alongside reaffirming commitment to the *QVH Strategy 2025–2030*, the Trust held a series of in-person and virtual workshops. These sessions enabled staff and volunteers to share their views and help shape thinking. Additional engagement sessions were held with external stakeholders, including Foundation Trust members, the Council of Governors and patient groups, to support detailed discussion of opportunities, considerations and concerns. Feedback from this engagement informed the Trust's thinking and supported the Board's decision to progress a strategic partnership with the Royal Surrey NHS Foundation Trust and Ashford and St Peter's Hospitals NHS Foundation Trust group. It has also informed the ongoing communications and engagement approach to support clear and consistent updates.

The Trust also undertook local engagement in relation to the Community Diagnostic Centre building project. This included information and Q&A sessions attended by local council representatives, voluntary and community sector partners, patient participation groups, governors, former patients and local residents. Further engagement activity is planned as this work continues.

Fees and charges (income generation)

During 2025/26 the Trust incurred no external consultancy costs considered material to the accounts (2024/25 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

During 2025/26, the Senior Salaries Review Body (SSRB) recommended a 3.25% increase in consolidated pay for very senior managers (VSMs), backdated to 1 April 2025. This recommendation was accepted by the Government and subsequently confirmed by NHS England in June 2025.

Following receipt of this guidance, the Trust's Nomination and Remuneration Committee met in July 2025 and reviewed the salaries of Executive Directors in line with the national recommendation. The Committee approved the backdated 3.25% uplift in VSM salaries, together with the application of a minimum baseline rate of pay set at 5% above the top of Agenda for Change Band 9.

During the year, there were no other significant decisions relating to senior manager remuneration, nor any substantial changes to the remuneration framework.

The Committee remained assured that executive pay was aligned with appropriate benchmark data for VSM salaries.

Angela McNab
Interim Trust Chair
25 June 2026

Senior managers' remuneration policy

The salary and pension entitlements of very senior managers (VSMs) are set out in the section below, which includes information subject to audit. The Trust's approach to remuneration continues to be influenced by national policy, benchmarking and local market factors. The majority of staff receive pay awards determined by the Department of Health and Social Care in accordance with national terms and conditions, including Agenda for Change and the relevant pay review bodies for doctors and dentists.

The Trust does not intend to introduce separate arrangements for performance-related pay or bonuses unless further guidance is issued by NHS England.

All very senior manager pay arrangements are subject to approval by the Nomination and Remuneration Committee of the Board of Directors.

In making new appointments, the Committee is cognisant of the Trust's data relating to the gender pay gap, the Workforce Race Equality Standard and the Workforce Disability Equality Standard, which are summarised in the Trust's annual equality and diversity report. When vacancies arise, the Trust encourages applications from all communities.

In agreeing and reviewing VSM pay, the Nomination and Remuneration Committee has regard to the 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 set out above.

The members of the Nomination and Remuneration Committee have agreed a set of principles in relation to setting, agreeing and reviewing VSM pay.

For new VSM appointments, the Chief People Officer reviews benchmarking data and considers market intelligence on salaries offered for comparable roles, taking into account supply and demand at the time. The review of existing VSM pay takes place annually, with timing dependent on the publication of relevant guidance by NHS England. In doing so, the Committee also takes account of:

- the outcome of annual appraisal conducted by the Chief Executive Officer (or by the Chair in the case of the Chief Executive Officer);
- the level of the national pay award for the Agenda for Change workforce;
- any exceptional circumstances or market conditions highlighted by the Chief Executive Officer; and
- updated benchmarking information and guidance.

The effectiveness and performance of VSMs is assessed through an annual appraisal process linked to the Trust's five key strategic objectives. From this, a set of individual objectives is developed for each VSM. Progress and achievement against these objectives are reviewed during the year by the Chief Executive Officer (or by the Chair in the case of the Chief Executive Officer).

The Trust's key strategic objectives also underpin the Board Assurance Framework, which is reviewed regularly by the Board and its committees.

The table below provides a description of the components of the remuneration package for senior managers.

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 arise where it is appropriate to recruit individuals on fixed-term contracts or through an employment agency to deliver specific, time-limited projects. This approach supports effective control of staffing resources and provides flexibility where appropriate to the role.

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

During 2025/26, the Executive Leadership Team continued to oversee pay and vacancy controls for all roles through established weekly review 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 nonexecutive Board members. Throughout this annual report, such persons are referred to as 'senior managers'.

During the year three senior managers were paid more than £150,000. The Trust took steps to ensure this salary was reasonable, including the nomination and remuneration committee reviewing benchmarking data.

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 within the context of national guidance on remuneration for very senior managers, which has maintained pay uplifts at or below those provided to staff on Agenda for Change terms and conditions. The Trust does not operate a separate remuneration policy for senior managers. The Trust's approach to remuneration continues to be influenced by national policy, benchmarking and local market factors.

The Nomination and Remuneration Committee, together with the governor-led Appointments Committee, recognises that diversity and inclusion are critical to the continued effectiveness of the Board and is committed to promoting diversity within its composition. Prior to any appointment to the Executive Leadership Team, the Nomination and Remuneration Committee evaluates the balance of skills, knowledge, experience and diversity of the team. In light of this evaluation, the Committee reviews the role description and the capabilities required for the appointment and ensures that recruitment processes are designed to attract the best candidates, including through open advertising and, where appropriate, the use of external advisers. The Committee also ensures that appointments to the Board of Directors are subject to a formal, rigorous and transparent process.

During 2025/26, Board-level recruitment was supported by external recruitment agencies, including taking active steps to attract a diverse range of candidates. The agencies selected demonstrated that diversity and inclusion, across all protected characteristics, were embedded within their recruitment processes, alongside other requirements.

The Trust's Recruitment and Selection Policy requires interview panels to be appropriately diverse for posts at 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
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	10 August 2025	Permanent	6 Months
Liz Blackburn	Acting Chief Nursing Officer (voting)	24 February 2025		Interim	3 Months
Kirsten Timmins	Chief Operating Officer (voting)	4 March 2024		Permanent	3 Months
Simon Marshall	Interim Chief Finance Officer (voting)	25 April 2025	31 May 2025	interim	3 Months
Tamara Everington	Chief Medical Officer (voting)	1 October 2024		Permanent	3 Months
Edmund Tabay	Chief Nursing Officer (voting)	13 January 2025	31 March 2026	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 31 March 2026	Interim Interim	NA

**From 10 February 2025 to 10 August 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 4 times formally during 2025/26 and held 4 extraordinary meetings.

When appropriate, the Committee was materially assisted in its decision making during 2025/26 by the Chief People Officer, and/or the Chief Executive Officer.

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

SALARY AND PENSION ENTITLEMENTS OF VERY SENIOR MANAGERS

A) Remuneration table 2025/26

Remuneration Table 2025/26			2025/26 Salary and fees (in bands of £5,000)	2025/26 Taxable benefits (total to the nearest £100)	2025/26 Annual performance-related bonuses (in bands of £5,000)	2025/26 Long-term performance-related bonuses (in bands of £5,000)	2025/26 All pension-related benefits (in bands of £2,500) **	2025/26 Other remuneration	2025/26 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		115 - 120	-	- -	- -	5.0 - 7.5	- - -	**120 - 125**
Jago A	Acting Chief Executive Officer		165 - 170	-	- -	- -	210.0 - 212.5	- - -	**375 - 380**
Everington T	Chief Medical Officer		200 - 205	-	- -	- -	85.0 - 87.5	- - -	**285 - 290**
Dillon-Robinson P	Non-Executive Director	left 30/09/2025	5 - 10	-	- -	- -	- - -	- - -	**5 - 10**
Bell J	Interim Chief Finance Officer	left 08/05/2025	15 - 20	-	- -	- -	- - -	- - -	**15 - 20**
Marshall S	Interim Chief Finance Officer	from 25/04/2025	160 - 165	-	- -	- -	42.5 - 45.0	- - -	**200 - 205**
Lowell J	Chief Executive	Secondment from 10/02/2025/Left 10/08/2025	65 - 70	-	- -	- -	25.0 - 27.5	- - -	**90 - 95**
Timmins K	Chief Operating Officer		140 - 145	-	- -	- -	35.0 - 37.5	- - -	**175 - 180**
Chaudhri V	Associate Non-Executive Director		5 - 10	-	- -	- -	- - -	- - -	**5 - 10**
Norman K	Non-Executive Director	left 07/04/2025	0 - 5	-	- -	- -	- - -	- -	**0 - 5**
Dickson J	Interim Deputy Chief Executive	left 31/03/2026	115 - 120	-	- -	- -	- - -	- - -	**115 - 120**
Blackburn E	Interim Chief nurse	from 01/12/2025	30 - 35	-	- -	- -	27.5 - 30.0	- - -	**60 - 65**
Tabay E	Chief Nurse	Secondment from 01/12/2025	130 - 135	-	- -	- -	90.0 - 92.5	- - -	**220 - 225**
Smith J	Chair	left 16/01/2026	40 - 45	-	- -	- -	- - -	- - -	**40 - 45**
McNab A	Interim Chair	from 19/01/2026	10 - 15	-	- -	- -	- - -	- - -	**10 - 15**
Dosanjh-Elton J	Non-Executive Director	from 01/10/2025	5 - 10	-	- -	- -	- - -	- - -	**5 - 10**
Shivji A	Associate Non-Executive Director		5 - 10	-	- -	- -	- - -	- - -	**5 - 10**
Emmanuel J	Non-Executive Director		15 - 20	-	- -	- -	- - -	- - -	**10 - 15**
Hobby R	Non-Executive Director		15 - 20	-	- -	- -	- - -	- - -	**10 - 15**
O'Donnell P	Non-Executive Director		15 - 20	-	- -	- -	- - -	- - -	**10 - 15**
O'Leary S	Non-Executive Director		15 - 20	-	- -	- -	- - -	- - -	**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 - Lowel J, Norman K, Smith J, Bell J, Dillon-Robinson P

SALARY AND PENSION ENTITLEMENTS OF VERY SENIOR MANAGERS

A) Remuneration table 2024/25

Remuneration Table 2024/25			2024/25 Salary and fees (in bands of £5,000)	2024/25 Taxable benefits (total to the nearest £100)	2024/25 Annual performance-related bonuses (in bands of £5,000)	2024/25 Long-term performance-related bonuses (in bands of £5,000)	2024/25 All pension-related benefits (in bands of £2,500) **	2024/25 Other remuneration	2024/25 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 Interim 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	left 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 to 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 - left	left 31/12/2024	155 - 160	-	- - -	- -	- - -	- - -	**155 - 160**
Lowell J	Chief Executive		175 - 180	-	- - -	- -	282.5 - 285.0	- - -	**455 - 460**
Timmins K	Director of Operations		135 - 140	-	- - -	- -	35.0 - 37.5	- -	**170 - 175**
Pirie C	Director of communications & CA - left	left 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	from 15/07/2024 until 12/01/2025 from 04/03/2025	75 - 80	-	- - -	- -	- - -	- - -	**75 - 80**
Reeves N	Chief nurse - retired	left 31/08/2024	50 - 55	-	- - -	- -	- - -	- - -	**50 - 55**
Tabay E	Chief Nurse	From 13/01/2025	25 - 30	-	- - -	- -	12.5 - 15.0	- - -	**40 - 45**
Smith J	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 2025/26

			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 2026 (bands of £5,000)	Lump sum at pension age related to accrued pension at 31 March 2026 (bands of £5,000)	Cash equivalent transfer value at 01-April-25	Real increase in cash equivalent transfer value	Cash equivalent transfer value at 31-Mar-26
			£'000	£'000	£'000	£'000	£'000	£'000	£'000
Edmunds	**H**	**Chief People Officer**	0-2.5	0-2.5	30-35	0-5	524	5	553
Jago	**A**	**Interim Chief Executive Officer**	10-12.5	20-22.5	50-55	120-125	826	203	1064
Lowell*	**J**	**Chief Executive Officer**	0-2.5	0-2.5	65-70	160-165	1331	22	1382
Blackburn	**E**	**Interim Chief Nursing Officer from 01/12/25**	0-2.5	2.5-5	20-25	50-55	377	24	494
Timmins	**K**	**Chief Operating Officer**	2.5-5	0-2.5	10-15	0-5	111	19	149
Marshall	**S**	**Interim Chief Financial Officer from 25/04/25**	2.5-5	0-2.5	50-55	125-130	1120	46	1211
Everington	**T**	**Chief Medical Officer**	5-7.5	0-2.5	80-85	205-210	1826	97	1977
Tabay	**E**	**Chief Nursing Officer - on secondment from 01/12/25**	5-7.5	5-7.5	30-35	65-70	547	84	657

*Please note J Lowell 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 2024 was 1.7%, therefore, an increase of 1.7% is applied to pensions and CETV at April 2025. Applying this inflation adjustment to the 31 March 2025 value has in some cases resulted in an adjusted value which exceeds the 31 March 2025 value.

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) £'000	Real increase in pension lump sum at pension age (bands of £2,500) £'000	Total accrued pension at pension age at 31 March 2025 (bands of £5,000) £'000	Lump sum at pension age related to accrued pension at 31 March 2025 (bands of £5,000) £'000	Cash equivalent transfer value at 01-April-24 £'000	Real increase in cash equivalent transfer value £'000	Cash equivalent transfer value at 31-Mar-25 £'000
Edmunds	H	Chief People Officer from 11/03/2024	2.5-5	0-2.5	30-35	0-5	419	62	524
Jago	A	Director of strategy & partnerships	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 & CA - left	0-2.5	0-2.5	35-40	90-95	727	0	78
Reeves	N	Chief nurse - left	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	Medical Director	5-7.5	7.5-10	75-80	200-205	1532	84	1826
Tabay	E	Chief nurse	0-2.5	0-2.5	25-30	60-65	443	12	547
Wheeler	M	Chief finance officer - left	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.

Disclosures relating to specific pay and remuneration matters

There are no additional disclosures relating to specific pay and remuneration matters.

Director expenses

No directors were receiving expenses.

Governor expenses

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

1 April 2025-31 March 2026		
Total number of Governors in office	Number of Governors receiving expenses in 2025/26	Aggregate sum of expenses paid in 2025/26 (rounded to the nearest £00)
24 served for all or part of 2025/26	0	£0

Payments for loss of office

No payments for loss in office have been made.

Payments to past senior managers

No payments to past senior managers have been made.

Fair pay disclosure

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

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

The banded remuneration of the highest-paid director in the organisation in 2025/26 was £200k–£205k (2024/25: £190k–£195k). This represents an increase of 5% between years (2024/25: 15%), primarily reflecting the annual pay uplift, which resulted in a modest increase in remuneration compared to the prior year. These figures are based on annualised full-time equivalent pay and benefits.

For employees of the Trust as a whole, remuneration in 2025/26 ranged from £22k to £253k (2024/25: £23k to £258k). The percentage increase in average employee remuneration (calculated as total remuneration for all employees on an annualised basis divided by the full-time equivalent number of employees) was 2% (2024/25: 6%). In 2025/26, 10 employees received remuneration in excess of the highest-paid director (2024/25: 8).

The remuneration of employees at the 25th percentile, median and 75th percentile is set out below. The pay ratio illustrates the relationship between the total pay and benefits of the highest-paid director (excluding pension benefits) and each of these points within the remuneration range of the Trust's workforce.

Percentile Information			
Figures for 2025/26			
	25th Percentile	Median	75th Percentile
Salary and Allowances - All Staff - £k	29.5	40.8	58.5
Salary and Allowances - Highest Paid Director - £k	202.5	202.5	202.5
Salary and Allowances - Ratio	6.9	5.0	3.5
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

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Abigail Jago
Acting Chief Executive Officer
25 June 2026

Staff report

Staff numbers

Staff Group	2025/26 Total No.	2025/26 Permanent No.	2025/26 Other No.	2024/25 Total No.
Medical and dental	183	183		178
Ambulance staff	-			-
Administration and estates	379	340	39	360
Healthcare assistants and other support staff	172	161	11	134
Nursing, midwifery and health visiting staff	222	196	26	256
Nursing, midwifery and health visiting learners	-			
Scientific, therapeutic and technical staff	71	65	6	78
Healthcare science staff	125	120	5	123
Social care staff	-			
Other	-			
Total average numbers	**1,152**	**1,065**	**87**	**1,129**
Of which:				
Number of employees (WTE) engaged on capital projects	**26**	**7**	**19**	**-**

Staff costs

Staff Costs	2025/26 Total £000.	2025/26 Permanent £000	2025/26 Other £000	2024/25 Total £000.
Salaries and wages	61,194	61,194	-	58,108
Social security costs	8,094	8,094	-	6,247
Apprenticeship levy	289	289	-	271
Pension cost - employer contributions to NHS pension scheme	7,448	7,448	-	6,813
Pension cost - employer contributions paid by NHSE on provider's behalf	4,870	4,870	-	4,414
Pension cost - other	-	-	-	18
Other post employment benefits	-	-	-	
Other employment benefits	-	-	-	
Termination benefits	-	-	-	
Temporary staff - external bank	-	-	-	
Temporary staff - agency/contract staff	2,240	-	2,240	3,761
NHS charitable funds staff	-	-	-	
TOTAL GROSS STAFF COSTS	**84,135**	**81,895**	**2,240**	**79,632**
Of which:				
Costs capitalised as part of assets	**2,253**	**758**	**1,495**	**1,472**

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

2025/26 data

	Chief executive	Executive directors	Non-executive directors	Other senior managers	All other employees	Total
Female	1	4	4	0	957	966
Male	0	2	4	0	318	324
Total						**1290**

Sickness and absence data

2025 Data

Total full time equivalent staff years available	Total days lost	Average number of days of sickness absence per full time equivalent employee
1063	15,734	9.1

Information on staff turnover

2025/26 data

12 Month Rolling Turnover rate												
	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Turnover Rate FTE (12m)	11.18 %	10.73 %	10.16 %	10.24 %	10.46 %	10.61 %	10.98 %	10.88 %	10.50 %	10.71 %	10.83 %	11.01 %

Staff policies and actions applied during the financial year

Policy	Date	Comments
Alcohol, Drug and Substance Misuse	26/02/2024	Updated introduction and aims of policy sections Addition of Definitions section, legislation section and procedure
Retirement	24/03/2025	Full rewrite on new template and change to retirement policy, and not just flexible retirement. Clarity over requirements for all types of retirement, and addition of partial retirement
Raising Concerns (Whistleblowing)	24/03/2025	General update and move to new template Minor updates following Local Counter Fraud team recommendations
Managing Appeals	24/03/2025	General update and move to new template Additional scope added
Leavers	24/03/2025	General update and move to new template
Sexual Safety	24/03/2025	New policy
Managing Wellbeing and Stress at Work	28/07/2025	New policy (replaced Management of Stress at Work policy)
Managing Sickness	28/07/2025	Full policy rewrite and move to new template Change in terminology for long term absence Change to bank work terms following absence Addition of reasonable adjustments section
Employment Break	11/08/2025	General update and move to new template
Managing Performance	11/08/2025	General update and move to new template
Menopause and Hormonal Change in the Workplace Guidance	24/09/2025	Move to new template and rewrite of previous menopause guidance Inclusion of hormonal change

Unpaid Parental Leave	29/09/2025	General update and move to new template Separated ER and Workforce teams responsibilities Clarified terminology on UPL entitlement Replaced information about UPL advising on EDRA assessment and written notice to the employee
Equality, Diversity and Inclusion	06/10/2025	General update and move to new template Added definitions for each protected characteristic, added reducing inequalities section, added reporting concerns section, added reasonable adjustments section and added EIA section
Family Leave	23/02/2026	Merge of maternity, adoption and shared parental leave policy with paternity leave policy. Policy rename and update on new template Addition of information on Neonatal care leave and paternity leave day one right
MHPS	06/10/2025	Reviewed and updated in line with current practices Digital data and confidentiality reinforced

On an annual basis, the Trust undertakes an assessment of its workforce against the national requirements of the Workforce Disability Equality Standard (WDES). This enables the Trust to monitor its performance and progress across a range of centrally reported metrics. The results are published on the Trust's website and provide insight into performance in areas including recruitment, access to training, and opportunities for career development.

Staff survey

The NHS staff survey is conducted annually. From 2021/22 the survey questions align to the seven elements of the NHS 'People Promise', retaining two previous themes of engagement and morale. 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 2025/26 survey among trust staff was 56% (2024/25: 58%). In 2025, the Trust employed a mixed-mode survey to ensure all staff could access it. A communications and engagement strategy ensured 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 the communications team and departmental leads to encourage staff to complete the survey.

Scores for each indicator, together with those of the survey benchmarking group (Acute Specialist), are presented below:

Indicators ('People Promise' elements & themes)	**2025/26**		**2024/25**		**2023/24**	
	Trust score	Benchmarking group score	Trust score	Benchmarking group score	Trust score	Benchmarking group score
People Promise:						
We are compassionate and inclusive	7.60	7.61	7.75	7.65	7.83	7.64
We are recognised and rewarded	6.03	6.11	6.26	6.20	6.31	6.13
We each have a voice that counts	6.71	6.87	6.95	6.95	7.11	6.93
We are safe and healthy	6.27	6.40	6.51	6.48	6.48	6.41
We are always learning	5.67	5.79	5.89	5.87	6.06	5.79
We work flexibly	6.43	6.42	6.63	6.50	6.59	6.41
We are a team	6.85	6.92	7.03	6.95	7.01	6.93
Staff engagement	7.08	7.20	7.38	7.31	7.49	7.29
Morale	5.93	6.15	6.21	6.25	6.31	6.14
Response Rates	56.0%	50%	57.6%	55.0%	58.8%	54.5%

The 2025 NHS Staff Survey results for QVH show an overall decline across all People Promise (PP) elements and the themes of staff engagement and morale compared to 2024 results. However, QVH remains comparable with the average scores of other Specialist Trusts (13 providers) and is above the national average scores.

There are areas where QVH continues to be above average within the 13 specialist trust group, including:

- Higher-than-average scores for inclusion, equality, staff safety and development
- A top-quartile result for recommending our care to family and friends
- A consistently strong response rate, reflecting the willingness of staff to speak up and engage.

The 2025 staff survey results continue to demonstrate that QVH has a strong focus on patients and the care they receive:

- 90% of colleagues would recommend the care QVH provides to family and friends. This is above the specialist trust average and reflects the ongoing commitment of QVH teams to delivering high-quality patient care
- 82% said that patient care is the organisation's top priority.

QVH saw improvements in several important areas, including:

- A significant reduction in colleagues with a long-term condition feeling pressured to work when unwell
- More colleagues feeling able to report harassment, bullying or abuse, with important progress in several areas. This is an important indicator that psychological safety is strengthening and a more supportive workplace is being created

- Fewer incidents of physical violence, harassment or abuse from patients or the public
- Fewer colleagues experiencing discrimination from managers or colleagues
- Ethnically diverse groups continue to report stronger engagement and overall scores.

Key areas of focus for improvement include:

- Key indicators relating to advocacy, workload and speaking up have fallen in 2025, in particular recommending QVH as a place to work. However, this score remains comparable with other specialist trusts and above the national average
- Although some aspects of speaking up have improved, it is recognised that further work is required in this area
- Staff declaring long-term conditions reported lower scores for involvement, motivation and morale.

In light of the current climate and the findings of the staff survey, QVH will focus on a number of key priorities throughout 2026/2027. These include strengthening diversity and inclusion, with a particular focus on the experiences of staff who have declared a disability. A programme of focus groups will be undertaken to better understand lived experience and identify improvements to working arrangements. In addition, Oliver McGowan Tier 2 training is being rolled out across QVH from April 2026 to support awareness and inclusion.

Supporting staff wellbeing and addressing workload pressures will remain a priority, with continued focus on improving workplace experience and staff morale. Alongside this, the Cultural Transformation Steering Group (CTSG) will lead work to strengthen psychological safety and staff voice, with a particular focus on speaking up and the experiences of colleagues with long-term conditions or illness.

QVH will also continue its commitment to supporting the Armed Forces community. In April 2026, an application was submitted for Silver Defence Employer Recognition, and work is ongoing with the Veterans' Covenant Healthcare Alliance (VCHA) to embed Armed Forces awareness training within Trust induction and wider learning programmes. The Trust is also working towards Veteran Aware reaccreditation by the end of the year.

The Trust remains committed to the national Step into Health programme, a partnership between the NHS, Walking with the Wounded and the Royal Foundation, which connects NHS employers with talented individuals from the Armed Forces community and supports access to careers in the NHS.

Expenditure on consultancy

During 2025/26 the Trust incurred no external consultancy costs (2024/25 Nil).

Off-payroll engagements

During 2025/26 there were no off-payroll engagements (2024/25 Nil).

Exit packages

A total of 2 contractual exit packages were undertaken by the Trust in 2025/26.

Exit package cost band	Number of compulsory redundancies	Number of other departures agreed	Total number of exit packages by cost band
<£10,000			
£10,000 – £25,000		2	2
£25,001 – £50,000		1	1
£50,001 – £100,000			
£100,000 – £150,000			
£150,001 – £200,000			
Total number of exit packages by type		3	3
Total resource cost	£0	£52,829	£52,829

	Agreement Number	**Total Value of Agreements £000**
Voluntary Redundancies including early retirement	0	
Mutual agreed resignations (MARS)	0	
Early Retirements in the efficiency of the service	0	
Contractual payments in lieu of notice	2	38
Exit payments following Employment Tribunals or court orders	0	
Non-contractual payments requiring HMT approval	1	15
Total	3	53
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 2025 can be found here by clicking this link
http://www.qvh.nhs.uk/about-us/publications-policies/equality-schemes-and-data/

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. No governor elections were held during the year. At the time of writing, there are five public governor vacancies. A number of public governors and all staff governors are coming to the end of terms at the end of June 2026. Elections will be held to fill these roles during 2026/27. All QVH governors are appointed for a term of three years and will serve a maximum of three terms. A full register of members of the Council of Governors during 2025/26 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 and collaboration plans.

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 members 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 Non-executive director who joined the Board in October 2025 for a term of three years upon recommendation from the Appointments Committee. The Council of Governors also appointed an interim Trust Chair for the period January to September 2026, until a shared Chair is in post as part of the strategic partnership work.

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 related 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. The Trust received confirmation that the additional licence conditions have been removed in March 2026.

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 remains strong 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
http://www.qvh.nhs.uk/about-us/council-of-governors/

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 Trust's 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 2025/26, QVH had the following Board sub-committees:

- The Audit and Risk Committee
- The Nomination and Remuneration Committee
- The Strategy and Culture 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 www.qvh.nhs.uk/about-us/board-of-directors/

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 appendix 1.

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 a strategic partnership to secure a sustainable future for the Trust's services. Following a robust process to identify potential partners, in December 2025, Queen Victoria Hospital NHS Foundation Trust (QVH) selected the Royal Surrey NHS Foundation Trust and Ashford and St Peter's Hospitals NHS Foundation Trust (RSFT/ASPH) group with which to establish a future strategic partnership.

The Trust continues to be an active member of the NHS Surrey and Sussex Committee in Common and Provider Collaborative.

The Trust has applied the principles of the Code of governance for NHS provider trusts on a ‘comply or explain’ basis during 2025/26. 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 2025/26 is the framework for assessing health systems including providers. It promotes transparency, improvement, and helps identify potential support or intervention needs. NHS organisations are allocated to one of five 'segments'.

Segmentation indicates performance and whether improvement is required, from high-performing across all domains (segment 1) to low performance across a range of domains (segment 4). An organisation assessed as segment 4 combined with a low capability to improve is allocated to segment 5.

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

a) Its segment derived from scored metrics under five performance domains (being access to services, effectiveness and experience of care, patient safety, people and workforce, and finance and productivity)
b) considering financial override which may limit a segment to be no better than 3
c) contextual metrics which are not scored (for example those under sixth domain of improving health and reducing inequality) and
d) capability assessments which consider the organisation's leadership and governance.

QVH is in segment 3 as at March 2026. Current segmentation information for NHS trusts and foundation trusts is published on the NHS England website: https://www.england.nhs.uk/nhs-oversight-framework/segmentation-and-league-tables/. The Trust is included on the acute trust dashboard.

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 for each financial year a statement of accounts in the form and on the basis required by those Directions. The accounts are prepared on an accruals basis and must give a true and fair view of the state of affairs of Queen Victoria Hospital NHS Foundation Trust and of its income and expenditure, other items of comprehensive income and cash flows for the financial year.

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

- observe the Accounts Direction issued by NHS England, including the relevant accounting and disclosure requirements, and apply suitable accounting policies on a consistent basis
- make judgements and estimates on a reasonable basis
- state whether applicable accounting standards as set out in the *NHS Foundation Trust Annual Reporting Manual* (and the *Department of Health and Social Care Group Accounting Manual*) have been followed, and disclose and explain any material departures in the financial statements
- ensure that the use of public funds complies with the relevant legislation, delegated authorities and guidance
- confirm that the annual report and accounts, taken as a whole, is fair, balanced and understandable and provides the information necessary for patients, regulators and stakeholders to assess the NHS foundation trust's performance, business model and strategy 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 at any time the financial position of the NHS foundation trust and to enable them to ensure that the accounts comply with requirements outlined in the above mentioned Act. The Accounting Officer is also responsible for safeguarding the assets of the NHS foundation trust and hence for taking reasonable steps for the prevention and detection of fraud and other irregularities.

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

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

Abigail Jago
Acting Chief Executive Officer
25 June 2026

Annual governance statement

Scope of responsibility

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

The purpose of the system of internal control

The system of internal control is designed to manage risk to a reasonable level rather than to eliminate all risk of failure to achieve policies, aims and objectives; it can therefore only provide reasonable and not absolute assurance of effectiveness. The system of internal control is based on an ongoing process designed to identify and prioritise the risks to the achievement of the policies, aims and objectives of Queen Victoria Hospital NHS Foundation Trust, to evaluate the likelihood of those risks being realised and the impact should they be realised, and to manage them efficiently, effectively and economically. The system of internal control has been in place in Queen Victoria Hospital NHS Foundation Trust for the year ended 31 March 2026 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 key 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 2024/25, we revised our operational and management governance arrangements and these have since been kept under regular review. An Executive Committee for Quality and Risk is in place 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 the executive leadership team and 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 was updated during 2025/26 to align with the Trust's revised key strategic objectives and the environment within which the Trust is operating within, aligns with national guidance and reflects assurance on our high level strategic risks that are deemed the most significant.

During 2025/26, our internal auditors undertook a review of our Board Assurance Framework and risk management arrangements. The audit provided reasonable assurance, confirming that risk management processes are clearly defined and established, supported by a comprehensive framework and effective governance arrangements. A small number of improvement actions were identified to support further development.

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

The Trust has a comprehensive Risk Management Framework in place and I own this 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. The Trust now has a Risk Management Specialist in post to support directorates, business units and the executive team with application of the framework and a programme of training is being developed for the end of 2025/26 and into 2026/27.

Each corporate and clinical directorate has a local risk register, and the directorate leadership teams 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 our Executive Leadership Team. The entirety of the local risk registers are also presented to the Executive Committee for Quality and Risk at regular intervals throughout the year. Executive performance review meetings with clinical directorates are in place to provide challenge and 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 and there is an internal Clinical Learning Forum in place.

The risk and control framework

Risk management framework

Risk management is guided by the Trust's Risk Management Framework. The process starts with the systematic 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 corporate and 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 periodically 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 as well as action plans to mitigate the risks. These risks were reviewed during 2025/26. The highest scoring strategic risks during the period are related to:

- The Trust's financial position
- The Trust's ageing estate
- The Trust's long term sustainability
- Leadership capacity.

Key controls, assurance and actions on these risks include:

Controls	Assurance	Actions
• Cost improvement plans and quality impact assessments • The development of a strategic partnership to address sustainability challenges • Key strategic objectives • Governing documents including policies • Internal control processes • Key people in roles • Staff training and guidance	• Oversight from the Board sub-committees • Integrated quality and performance reporting • Internal and external audit • PLACE & PAM assessments, third party estate condition surveys, assessments. And testing regimes. • Reviews and reporting of serious incidents.	• Continued development of strategic partnership and implementation • Engagement plan • Continued identification of cost improvement programmes • Development of medium term financial plan • Exploration of opportunities for shared corporate services and key roles

The responsibilities and accountabilities of the Board members and sub-committees of the Board are well defined within the governing documents including Standing Orders and terms of

reference. 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 workforce 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 performance reviews.
- Provider engagement meetings are held with the Care Quality Commission to ensure compliance with regulatory standards and compassionate care.
- The Trust has an information governance group which meets regularly and provides assurance reporting for appropriate oversight by the Executive leadership team and relevant Board sub-committee.
- Equality impact assessments are integrated into core business. Each new or revised policy requires an equality impact assessment to be completed to ensure the Trust meets legislative requirements and does not discriminate against protected characteristic groups. The equality impact assessment is completed by the manager writing the policy and signed off by their line manager prior to approval by the relevant ratifying group.
- The Council of Governors receive quarterly updates from the Non-executive director Chairs of the Quality and safety, Finance and performance, Audit and risk and Strategy and culture 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.

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's additional licence conditions were removed by NHS England.

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***	The Council of Governor Appointments Committee is responsible for setting the Chair and non-executive director (NED) remuneration. All NEDs receive the same

structure (published by NHS England Dec 2019).	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.

The Trust's compliance with the Code of governance for NHS provider trusts has significantly improved since the new code came into place.

Quality governance

The Trust's quality governance framework is built upon the principles described within the eight domains of NHS England's well-led framework and the five quality domains outlined by the CQC. All aspects of quality are overseen by the executive sub-committee for quality which provides assurance to the Executive committee for quality and risk. The Quality and safety committee has oversight at Board level. 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 and how the risks 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 2025-26, 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 Cyber Assessment Framework and aligned data security protection toolkit sets out the standard for data security. 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 approaching the national data guardian standards and that all actions within the improvement plan have been completed. 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.

The Trust gained an 'approaching standards' grade for the submission during the period, and at the time of writing this statement, all actions within the improvement plan have been completed.

Well led

Foundation trust Boards are required to undertake an external review of governance and leadership every three to 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 largely concluded, 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.

The Trust will undertake its next external review of governance and leadership during 2026/27, the findings of which will be outlined in the 2026/27 Annual governance statement.

Assurance statements

Compliance with the Developing Workforce Safeguards 25 recommendations

The Trust has a People Strategy aligned with the Trust's overall *QVH Strategy 2025–2030*. 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 oversight is in place. Key performance metrics related to the Trust's workforce are monitored by the Finance and Performance Committee and the Board through integrated quality and performance reporting.

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, recognising that this can be challenging due to the ageing fabric of the Trust's estate. The Trust has revised its Green Plan during 2025/26 and this is available on the Trust's website http://www.qvh.nhs.uk/about-us/green-plan/

Review of economy, efficiency and effectiveness of the use of resources

The Trust ended the 2025/26 financial year with a breakeven position after adjusting for additional deficit support funding, however, this position was achieved using non-recurrent benefits and the Trust has an underlying deficit position which was reduced from 2024/25.

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 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 in the governance arrangements were identified during 2024/25 as set out within the previous Annual governance statement. These weaknesses have been addressed during quarter 4 of 2024/25 and into 2025/26, with the completion of the action plan.

The Trust has a challenging Cost improvement programme for 2026/27 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 Reporting (IQPR).

The Trust recognises the need to ensure that its services are sustainable for the future. During 2025/26, the Trust Board agreed to move forwards with a partnership with the Royal Surrey NHS Foundation Trust and Ashford and St Peter's Hospitals NHS Foundation Trust (RSFT/ASPH) group, including a shared Chair and Chief executive officer.

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 there were no reportable confidentiality breaches.

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. The Trust has established an 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. There is a need to increase the resource for the Trust's business intelligence function to strengthen the organisation's reporting capability.

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 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, Care Quality Commission, NHS Resolution and audit, as well as ensuring internal quality measures are regularly tested and standards are met.

During 2024/25, 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 continued review has provided assurance that there have been no breaches of the Trust's governing documents since quarter four of 2024/25 and during 2025/26. This demonstrates that the actions completed to strengthen the Trust's internal control environment and compliance have been effective. During 2025/26, an internal audit was completed in this area and concluded reasonable

assurance. The internal auditors observed considerable progress and strengthening of controls compared to when work was previously conducted in this area.

The Trust's internal audit programme provides a mechanism for assessing the effectiveness of the organisation's control environment.

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**
Compliance	Reasonable assurance	0	1	2	3
Data quality and performance- faster diagnosis standard	Reasonable assurance	0	2	1	3
Incident management	Reasonable assurance	0	3	1	4
Substantive medical and dental job planning	Partial assurance	1	8	1	10
Cyber Assessment Framework (DSPT)	Partial assurance	1	9	0	10
Financial management	Reasonable assurance	0	3	2	5
Key financial controls – accounts payable	Reasonable assurance	0	1	4	5
Board Assurance Framework & Risk management	Reasonable assurance	0	1	3	4

The 2025/26 internal audit programme concluded that, overall, there is a generally sound system of internal control, designed to meet the Trust's objectives and controls are generally applied consistently, although improvements are required in some areas. The majority of internal audit reviews resulted in reasonable assurance opinions. Two reviews received partial assurance opinions relating to the Cyber Assessment Framework (DSPT) and Substantive Medical and Dental Job Planning. The Trust has made good progress in implementing management actions arising from these reviews, with all high priority actions completed and ongoing work to evidence completion of a small number of remaining medium priority actions.

The Trust has recognised the need for continued focus on medical and dental job planning and associated declarations by medical staff from quarter 4 of 2025/26 and into 2026/27.

The overall head of internal audit opinion for the period is that there is a generally sound system of internal control, designed to meet the organisation's objectives and controls are generally being applied consistently, although some improvements are required.

During the period, the Audit and Risk Committee has overseen the completion of management actions and improvements and strengthening of the control environment.

Conclusion

No significant internal control issues have been identified during 2025/26. Significant internal control issues identified in 2024/25 related to weaknesses in governance arrangements have been addressed through the implementation of the key actions described within the 2024/25 Annual governance statement which have strengthened the internal control environment. The Trust continues to operate with an underlying deficit position, however, there are now plans in place to support sustainability of the Trust's services for the future through strategic partnership.

Abigail Jago
Acting Chief Executive Officer
25 June 2026

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 2026, which comprise the Consolidated Statement of Comprehensive Income, the Statements of Financial Position, the Consolidated 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 2025 to 2026.

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 2026 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 2025 to 2026; 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 2025/26; 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 2025/26 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 page 43), 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 2025 to 2026.

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 it 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 are 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 2025 to 2026.

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 including evaluating the accuracy and occurrence of non-block contract and other income and the existence and valuation of associated receivables, and assessing the completeness of non-pay expenditure and 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 2026.

We have nothing to report in this respect.

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 is 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 2026 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.

As at the date of issue of our auditor's report, we have not submitted our Consolidated NHS Provider Accounts (CPA) Group Audit Return to the National Audit Office (NAO) for the year

ended 31 March 2026. In addition confirmation has not been received from the NAO that the Department of Health and Social Care (DHSC) Group Accounts audit for 2025-26 has been certified by the Comptroller and Auditor General.

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 2026.

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.

Rebecca Lister

Rebecca Lister, Key Audit Partner

for and on behalf of Azets Audit Services, Local Auditor

Edinburgh

26 June 2026

5. Annual accounts 2025/26

Foreword to the accounts

These accounts for the year ended 31 March 2026 have been prepared by Queen Victoria Hospital NHS Foundation Trust in accordance with paragraphs 24 and 25 of Schedule 7 to the NHS Act 2006 and are presented to Parliament pursuant to Schedule 7, paragraph 25 (4) (a) of the National Health Service Act 2006.

Abigail Jago
Acting Chief Executive Officer
25 June 2026

Consolidated Statement of Comprehensive Income

		Group	
		2025/26	2024/25
	Note	£000	£000
Operating income from patient care activities	3	122,725	112,837
Other operating income	4	5,818	4,696
Operating expenses	6,8	(124,362)	(115,527)
Operating surplus/(deficit) from continuing operations		**4,181**	**2,006**
Finance income	10	558	449
Finance expenses	11	(84)	(146)
PDC dividends payable		(2,631)	(2,236)
Net finance costs		**(2,157)**	**(1,933)**
Surplus / (deficit) for the year from continuing operations		**2,024**	**73**
Other comprehensive income			
Will not be reclassified to income and expenditure:			
Impairments	7	(3,568)	-
Revaluations	16,14.1	1,661	4,168
May be reclassified to income and expenditure when certain conditions are met:			
Foreign exchange gains / (losses) recognised directly in OCI		-	-
Total other comprehensive income for the period		**(1,907)**	**4,168**
Total comprehensive income / (expense) for the period		**117**	**4,241**
Surplus/ (deficit) for the period attributable to:			
Queen Victoria Hospital NHS Foundation Trust		2,024	73
Total		**2,024**	**73**
Total comprehensive income/ (expense) for the period attributable to:			
Queen Victoria Hospital NHS Foundation Trust		117	4,241
Total		**117**	**4,241**

Statements of Financial Position

		Group		Trust	
		31 March 2026	31 March 2025	31 March 2026	31 March 2025
	Note	£000	£000	£000	£000
Non-current assets					
Intangible assets	13	15,922	12,237	15,922	12,237
Property, plant and equipment	14	73,933	68,311	73,933	68,311
Right of use assets	16	4,077	3,573	4,077	3,573
Receivables	20	272	305	272	305
Other assets	22	-	-	-	-
Total non-current assets		**94,204**	**84,426**	**94,204**	**84,426**
Current assets					
Inventories	19	1,125	1,170	1,125	1,170
Receivables	20	7,577	9,413	7,577	9,413
Other assets	22	-	-	-	-
Non-current assets held for sale	23.1	-	-	-	-
Cash and cash equivalents	21	22,866	16,183	19,182	12,941
Total current assets		**31,568**	**26,766**	**27,884**	**23,524**
Current liabilities					
Trade and other payables	22	(23,130)	(20,539)	(23,092)	(20,459)
Borrowings	24	(1,505)	(2,018)	(1,505)	(2,018)
Other financial liabilities	25	-	-	-	-
Provisions	25	(48)	(50)	(48)	(50)
Other liabilities	23	(368)	(535)	(368)	(535)
Liabilities in disposal groups	23.2	-	-	-	-
Total current liabilities		**(25,051)**	**(23,142)**	**(25,013)**	**(23,062)**
Total assets less current liabilities		**100,721**	**88,050**	**97,075**	**84,888**
Non-current liabilities					
Trade and other payables	22	-	-	-	-
Borrowings	24	(1,282)	(915)	(1,282)	(915)
Other financial liabilities	25	-	-	-	-
Provisions	25	(814)	(815)	(814)	(815)
Other liabilities	23	-	-	-	-
Total non-current liabilities		**(2,096)**	**(1,730)**	**(2,096)**	**(1,730)**
Total assets employed		**98,625**	**86,320**	**94,979**	**83,158**
Financed by					
Public dividend capital		53,487	41,299	53,487	41,299
Revaluation reserve		22,532	24,439	22,532	24,439
Financial assets reserve		-	-		
Other reserves		-	-		
Merger reserve		-	-		
Income and expenditure reserve		18,960	17,420	18,960	17,420
Non-controlling Interest		-	-		
Charitable fund reserves	18	3,646	3,162		
Total taxpayers' equity		**98,625**	**86,320**	**94,979**	**83,158**

The notes on pages 69 to 112 form part of these accounts.

Name: Abigail Jago
Position: Acting Chief Executive Officer
Date: 25 June 2026

Consolidated Statement of Changes in Equity for the year ended 31 March 2026

Group	Public dividend capital £000	Revaluation reserve £000	Financial assets reserve £000	Other reserves £000	Merger reserve £000	Income and expenditure reserve £000	Charitable fund reserves £000	Non-controlling interest £000	Total £000
Taxpayers' and others' equity at 1 April 2025 - brought forward	**41,299**	**24,439**	**-**	**-**	**-**	**17,420**	**3,162**	**-**	**86,320**
Surplus/(deficit) for the year	-	-	-	-	-	1,540	484	-	**2,024**
Revaluations	-	1,661	-	-	-	-	-	-	**1,661**
Impairments	-	(3,568)	-	-	-	-	-	-	**(3,568)**
Public dividend capital received	12,188	-	-	-	-	-	-	-	**12,188**
Taxpayers' and others' equity at 31 March 2026	**53,487**	**22,532**	**-**	**-**	**-**	**18,960**	**3,646**	**-**	**98,625**

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

Group	Public dividend capital £000	Revaluation reserve £000	Financial assets reserve £000	Other reserves £000	Merger reserve £000	Income and expenditure reserve £000	Charitable fund reserves £000	Non-controlling interest £000	Total £000
Taxpayers' and others' equity at 1 April 2024 - brought forward	**31,655**	**20,271**	**-**	**-**	**-**	**17,396**	**3,113**	**-**	**72,435**
Prior period adjustment	-	-	-	-	-	-	-	-	**-**
Taxpayers' and others' equity at 1 April 2024 - restated	**31,655**	**20,271**	**-**	**-**	**-**	**17,396**	**3,113**	**-**	**72,435**
Surplus/(deficit) for the year	-	-	-	-	-	24	49	-	**73**
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**	**3,162**	**-**	**86,320**

Information on reserves

Public dividend capital
Public dividend capital (PDC) is a type of public sector equity finance based on the excess of assets over liabilities at the time of establishment of the predecessor NHS organisation. Additional PDC may also be issued to trusts by the Department of Health and Social Care. A charge, reflecting the cost of capital utilised by the trust, is payable to the Department of Health as the public dividend capital dividend.

Revaluation reserve
Increases in asset values arising from revaluations are recognised in the revaluation reserve, except where, and to the extent that, they reverse impairments previously recognised in operating expenses, in which case they are recognised in operating income. Subsequent downward movements in asset valuations are charged to the revaluation reserve to the extent that a previous gain was recognised unless the downward movement represents a clear consumption of economic benefit or a reduction in service potential.

Financial assets reserve
This reserve comprises changes in the fair value of financial assets measured at fair value through other comprehensive income. When these instruments are derecognised, cumulative gains or losses previously recognised as other comprehensive income or expenditure are recycled to income or expenditure, unless the assets are equity instruments measured at fair value through other comprehensive income as a result of irrevocable election at recognition.

Income and expenditure reserve
The balance of this reserve is the accumulated surpluses and deficits of the trust.

Charitable funds reserve
This reserve comprises the ring-fenced funds held by the NHS charitable funds consolidated within these financial statements. These reserves are classified as restricted or unrestricted; a breakdown is provided in note 18

Statements of Cash Flows

	Note	Group 2025/26 £000	Group 2024/25 £000	Trust 2025/26 £000	Trust 2024/25 £000
Cash flows from operating activities					
Operating surplus / (deficit)		4,181	2,006	3,781	2,027
Non-cash income and expense:					
Depreciation and amortisation	6.1	6,371	4,588	6,371	4,588
Net impairments	7	-	(238)	-	(238)
Income recognised in respect of capital donations	4	(37)	-	(37)	
(Increase) / decrease in receivables and other assets		1,869	(578)	1,869	(578)
(Increase) / decrease in inventories		45	49	45	49
Increase / (decrease) in payables and other liabilities		3,506	1,707	3,506	1,707
Increase / (decrease) in provisions		(14)	(1,909)	(14)	(1,909)
Movements in charitable fund working capital		(42)	(127)	-	
Other movements in operating cash flows		-	(1)	-	(1)
Net cash flows from / (used in) operating activities		**15,879**	**5,497**	**15,521**	**5,645**
Cash flows from investing activities					
Interest received		474	379	474	379
Purchase of intangible assets		(7,763)	(7,211)	(7,763)	(7,211)
Sales of intangible assets		-	-	-	-
Purchase of PPE and investment property		(10,049)	(7,121)	(10,049)	(7,121)
Sales of PPE and investment property		-	2,250	-	2,250
Net cash flows from charitable fund investing activities		84	70	-	-
Net cash flows from / (used in) investing activities		**(17,254)**	**(11,633)**	**(17,338)**	**(11,703)**
Cash flows from financing activities					
Public dividend capital received		12,188	9,644	12,188	9,644
Public dividend capital repaid		-	-	-	
Movement on loans from DHSC		(778)	(778)	(778)	(778)
Capital element of lease liability repayments		(809)	(513)	(809)	(513)
Interest on loans		(27)	(49)	(27)	(49)
Interest paid on lease liability repayments		(55)	(93)	(55)	(93)
PDC dividend (paid) / refunded		(2,461)	(1,999)	(2,461)	(1,999)
Net cash flows from / (used in) financing activities		**8,058**	**6,212**	**8,058**	**6,212**
Increase / (decrease) in cash and cash equivalents		**6,683**	**76**	**6,241**	**154**
Cash and cash equivalents at 1 April - brought forward		**16,183**	**16,107**	**12,941**	**12,787**
Prior period adjustments			-		
Cash and cash equivalents at 1 April - restated		**16,183**	**16,107**	**12,941**	**12,787**
Cash and cash equivalents transferred under absorption accounting	32	-	-		-
Unrealised gains / (losses) on foreign exchange		-	-		-
Cash and cash equivalents at 31 March	21	**22,866**	**16,183**	**19,182**	**12,941**

Notes to the Accounts

Note 1 Accounting policies and other information Note

1.1 Basis of preparation

The Department of Health and Social Care has directed that the financial statements of the Trust shall meet the accounting requirements of the Department of Health and Social Care Group Accounting Manual (GAM), which shall be agreed with HM Treasury. Consequently, the following financial statements have been prepared in accordance with the GAM 2025/26 issued by the Department of Health and Social Care. The accounting policies contained in the GAM follow International Financial Reporting Standards to the extent that they are meaningful and appropriate to the NHS, as determined by HM Treasury, which is advised by the Financial Reporting Advisory Board. Where the GAM permits a choice of accounting policy, the accounting policy that is judged to be most appropriate to the particular circumstances of the Trust for the purpose of giving a true and fair view has been selected. The particular policies adopted are described below. These have been applied consistently in dealing with items considered material in relation to the accounts.

Accounting convention

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

Note 1.2 Going concern

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

Note 1.3 Consolidation NHS

Charitable Funds

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

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 Expenditure on other goods and services

Discontinued operations occur where activities either cease without transfer to another entity, or transfer to an entity outside of the boundary of the Whole of Government Accounts, such as private or voluntary sectors. Such activities are accounted for in accordance with IFRS 5. Activities that are transferred to other bodies within the boundary of the Whole of Government Accounts are ‘machinery of government changes’ and treated as continuing operations.

Note 1.9 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 cost of at least £5,000, or
- collectively, a number of items have a cost of at least £5,000 and individually have cost of more than £250, where the assets are functionally interdependent, had broadly simultaneous purchase dates, are anticipated to have similar disposal dates and are under single managerial control.

Where a large asset, for example a building, includes a number of components with significantly different asset lives, eg, 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 value in existing use is defined as market value except where a building is so specialised in nature no active market exists from which to draw satisfactory transactional evidence. In this case a valuer will adopt a depreciated replacement cost (DRC) model on a modern equivalent asset (MEA) basis.

A DRC model estimates current value in existing use as the present value of the asset's remaining service potential, which is assumed to be at least equal to the cost of replacing that service potential. An MEA basis assumes that the asset will be replaced with a modern asset of equivalent capacity and 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.

Valuation guidance issued by the Royal Institute of Chartered Surveyors states that valuations are performed net of VAT where the VAT is recoverable by the entity. This basis has been applied to the trust's Private Finance Initiative (PFI) scheme where the construction is completed by a special purpose vehicle and the costs have recoverable VAT for the trust.

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	10

Note 1.10 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. From 1 April 2025, subsequent measurement of intangible assets is at cost less amortisation.

Prior to 1 April 2025, intangible assets were held under a revaluation approach reflecting current value in existing use. Revaluation gains and losses and impairments were treated in the same manner as for property, plant and equipment. On 1 April 2025, the carrying value of these assets was carried forward as 'deemed cost' and any related revaluation surpluses in the revaluation reserve were transferred to the I&E reserve.

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

Impairments

Where indicators of impairment exist, the recoverable amount is assessed as the higher of its fair value and the cost to replace the service capacity. Where this is lower than the carrying value an impairment is recognised in expenditure. The recoverable amount of intangible assets under construction is assessed annually, irrespective of indicators of impairment.

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	Max life
	Years	Years
Software licences	3	5

Note 1.11 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.

Note 1.12 Cash and cash equivalents

Cash is cash in hand and deposits with any financial institution repayable without penalty on notice of not more than 24 hours. Cash equivalents are investments that mature in 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 1.13 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 1.14 Leases

A lease is a contract or part of a contract that conveys the right to use an asset for a period of time in exchange for consideration. An adaptation of the relevant accounting standard by HM Treasury for the public sector means that for NHS bodies, this includes lease-like arrangements with other public sector entities that do not take the legal form of a contract. It also includes peppercorn leases where consideration paid is nil or nominal (significantly below market value) but in all other respects meet the definition of a lease. The trust does not apply lease accounting to new contracts for the use of intangible assets.

The Trust determines the term of the lease term with reference to the non-cancellable period and any options to extend or terminate the lease which the Trust is reasonably certain to exercise.

The Trust as 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 4.81% applied to new leases commencing in 2025 and 5.32% to new leases commencing in 2026.

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

Subsequent measurement

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

The Trust subsequently measures the lease liability by increasing the carrying amount for interest arising which is also charged to expenditure as a finance cost and reducing the carrying amount for lease payments made. The liability is also

remeasured for changes in assessments impacting the lease term, lease modifications or to reflect actual changes in lease payments. Such remeasurements are also reflected in the cost of the right of use asset. Where there is a change in the lease term or option to purchase the underlying asset, an updated discount rate is applied to the remaining lease payments.

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 1.15 Provisions

The Trust recognises a provision where it has a present legal or constructive obligation of uncertain timing or amount; for which it is probable that there will be a future outflow of cash or other resources; and a reliable estimate can be made of the amount. The amount recognised in the Statement of Financial Position is the best estimate of the resources required to settle the obligation. Where the effect of the time value of money is significant, the estimated risk-adjusted cash flows are discounted using HM Treasury's discount rates effective from 31 March 2026:

		Nominal rate	Prior year rate
Short-term	Up to 5 years	3.64%	4.03%
Medium-term	After 5 years up to 10 years	4.22%	4.07%
Long-term	After 10 years up to 40 years	5.32%	4.81%
Very long-term	Exceeding 40 years	5.07%	4.55%

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 2026:

	Inflation rate	Prior year rate
Year 1	2.5%	2.60%
Year 2	2.0%	2.30%
Into perpetuity	2.0%	2.00%

Early retirement provisions and injury benefit provisions both use the HM Treasury's post-employment benefits discount rate of 2.95% in real terms (prior year: 2.40%).

Clinical negligence costs

NHS Resolution operates a risk pooling scheme under which the trust pays an annual contribution to NHS Resolution, which, in return, settles all clinical negligence claims. Although NHS Resolution is administratively responsible for all clinical negligence cases, the legal liability remains with the Trust. The total value of clinical negligence provisions carried by NHS Resolution on behalf of the trust is disclosed at Note 25.2 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 1.16 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 26 where an inflow of economic benefits is probable.

Contingent liabilities are not recognised, but are disclosed in Note 26.

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 1.17 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 1.18 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 1.19 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 1.20 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 1.21 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 1.22 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 1.23 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 1.24 Early adoption of standards, amendments and interpretations

No new accounting standards or revisions to existing standards have been early adopted in 2025/26.

Note 1.25 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 2025/26 £52,926,000 (2024/25 £52,704,000)**

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 22.1.

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)	**2025/26**	**2024/25**
	£000	**£000**
Income from commissioners under API contracts - variable element*	50,800	-
Income from commissioners under API contracts - fixed element*	57,720	104,417
High cost drugs income from commissioners	280	-
Other NHS clinical income	8,170	2,153
Private patient income	29	32
National pay award central funding***		222
Additional pension contribution central funding**	4,870	4,414
Other clinical income	856	1,599
Total income from activities	**122,725**	**112,837**

*Aligned payment and incentive contracts are the main form of contracting between NHS providers and their commissioners. More information can be found in the 2025/26 NHS Payment Scheme documentation. 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 14.38% with the additional amount being paid over by NHS England on providers' behalf. The full cost of employer contributions (23.7%) and related NHS England funding (9.4%) have been recognised in these accounts.

***Additional funding was made available directly to providers by NHS England in 2024/25 for implementing the backdated element of pay awards where government offers were finalised after the end of the 2023/24 financial year. NHS Payment Scheme prices and API contracts are updated for the weighted uplift in in-year pay costs when awards are finalised.

Note 3.2 Income from patient care activities (by source)

	2025/26	**2024/25**
Income from patient care activities received from:	**£000**	**£000**
NHS England	13,361	18,127
Integrated care boards	106,333	90,926
Other NHS providers	2,158	2,153
Non-NHS: private patients	29	32
Non-NHS: overseas patients (chargeable to patient)	133	219
Injury cost recovery scheme	166	239
Non NHS: other	545	1,141
Total income from activities	**122,725**	**112,837**
Of which:		
Related to continuing operations	122,725	112,837
Related to discontinued operations	-	-

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

	2025/26	2024/25
	£000	£000
Income recognised this year	133	219
Cash payments received in-year	5	26
Amounts added to provision for impairment of receivables	133	201
Amounts written off in-year	-	68

Note 4 Other operating income (Group)

	2025/26			2024/25		
	Contract income	Non-contract income	Total	Contract income	Non-contract income	Total
	£000	£000	£000	£000	£000	£000
Research and development	418	-	**418**	472	-	**472**
Education and training	2,886	277	**3,163**	2,647	-	**2,647**
Non-patient care services to other bodies	437		**437**	-		**-**
Income in respect of employee benefits accounted on a gross basis	-		**-**	-		**-**
Receipt of capital grants and donations and peppercorn leases		37	**37**		-	**-**
Charitable and other contributions to expenditure		262	**262**		257	**257**
Charitable fund incoming resources		614	**614**		169	**169**
Other income	887	-	**887**	1,151	-	**1,151**
Total other operating income	**4,628**	**1,190**	**5,818**	**4,270**	**426**	**4,696**
Of which:						
Related to continuing operations			5,818			4,696
Related to discontinued operations			-			-

Note 5.1 Income from activities arising from commissioner requested services

The trust is required to analyse the level of income from activities that has arisen from commissioner requested and non-commissioner requested services. Commissioner requested services are defined in the provider licence and are services that commissioners believe would need to be protected in the event of provider failure. This information is provided in the table below:

	2025/26	2024/25
	£000	£000
Income from services designated as commissioner requested services	122,725	112,586
Income from services not designated as commissioner requested services	-	251
Total	**122,725**	**112,837**

Note 6.1 Operating expenses (Group)

	2025/26	2024/25
	£000	£000
Purchase of healthcare from NHS and DHSC bodies	26	-
Purchase of healthcare from non-NHS and non-DHSC bodies	1,097	1,018
Purchase of social care	-	-
Staff and executive directors costs	81,492	77,838
Remuneration of non-executive directors	162	143
Supplies and services - clinical (excluding drugs costs)	17,679	15,991
Supplies and services - general	1,261	1,203
Drug costs (drugs inventory consumed and purchase of non-inventory drugs)	1,870	1,633
Inventories written down	-	75
Consultancy costs	-	-
Establishment	1,233	1,491
Premises	8,080	5,707
Transport (including patient travel)	401	404
Depreciation on property, plant and equipment	4,893	3,695
Amortisation on intangible assets	1,478	893
Net impairments	-	(238)
Movement in credit loss allowance: contract receivables / contract assets	(67)	215
Change in provisions discount rate(s)	(2)	-
Fees payable to the external auditor		
audit services- statutory audit	147	136
other auditor remuneration (external auditor only)	-	-
Internal audit costs	91	57
Clinical negligence	904	892
Legal fees	207	638
Insurance (as a policy holder)	73	54
Research and development	422	273
Education and training	702	510
Redundancy	-	52
Car parking & security	361	369
Other services, eg external payroll	104	108
Other NHS charitable fund resources expended	208	190
Other	1,540	2,180
Total	**124,362**	**115,527**
Of which:		
Related to continuing operations	124,362	115,527
Related to discontinued operations	-	-

*Other includes professional fees for out-sourced services.

Note 6.2 Limitation on auditor's liability (Group)

The limitation on auditor's liability for external audit work is £1 million (2024/25: £1 million).

Note 7 Impairment of assets (Group)

	2025/26	2024/25
	£000	£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)
Impairments of charitable fund assets	-	-
Other	-	-
Total net impairments charged to operating surplus / deficit	**-**	**(238)**
Impairments charged to the revaluation reserve	3,568	-
Total net impairments	**3,568**	**(238)**

Note 8 Employee benefits (Group)

	2025/26 Total £000	2024/25 Total £000
Salaries and wages	61,194	58,108
Social security costs	8,094	6,247
Apprenticeship levy	289	271
Employer's contributions to NHS pensions	12,318	11,227
Pension cost - other	-	18
Other post employment benefits	-	-
Other employment benefits	-	-
Termination benefits	-	-
Temporary staff (including agency)	2,240	3,761
NHS charitable funds staff	-	-
Total gross staff costs	**84,135**	**79,632**
Recoveries in respect of seconded staff	-	-
Total staff costs	**84,135**	**79,632**
Of which		
Costs capitalised as part of assets	2,253	1,472

Note 8.1 Retirements due to ill-health (Group)

During 2025/26 there were 2 early retirements from the trust agreed on the grounds of ill-health (2 in the year ended 31 March 2025). The estimated additional pension liabilities of these ill-health retirements is £43k (£272k in 2024/25).

These estimated costs are calculated on an average basis and will be borne by the NHS Pension Scheme.

Note 9 Pension costs

Past and present employees are covered by the provisions of the NHS Pension Schemes. Details of the benefits payable and rules of the schemes can be found on the NHS Pensions website at www.nhsbsa.nhs.uk/pensions. Both the 1995/2008 and 2015 schemes are accounted for, and the scheme liability valued, as a single combined scheme. Both are unfunded defined benefit schemes that cover NHS employers, GP practices and other bodies, allowed under the direction of the Secretary of State for Health and Social Care in England and Wales. They are not designed to be run in a way that would enable NHS bodies to identify their share of the underlying scheme assets and liabilities. Therefore, each scheme is accounted for as if it were a defined contribution scheme: the cost to the NHS body of participating in each scheme is taken as equal to the contributions payable to that scheme for the accounting period.

In order that the defined benefit obligations recognised in the financial statements do not differ materially from those that would be determined at the reporting date by a formal actuarial valuation, the FReM requires that "the period between formal valuations shall be four years, with approximate assessments in intervening years". An outline of these follows:

a) Accounting valuation

A valuation of scheme liability is carried out annually by the scheme actuary (currently the Government Actuary's Department) as at the end of the reporting period. This utilises an actuarial assessment for the previous accounting period in conjunction with updated membership and financial data for the current reporting period, and is accepted as providing suitably robust figures for financial reporting purposes. The valuation of the scheme liability as at 31 March 2026, is based on valuation data as at 31 March 2023, updated to 31 March 2026 with summary global member and accounting data. In undertaking this actuarial assessment, the methodology prescribed in IAS 19, relevant FReM interpretations, and the discount rate prescribed by HM Treasury have also been used.

The latest assessment of the liabilities of the scheme is contained in the Statement by the Actuary, which forms part of the annual NHS Pension Scheme Annual Report and Accounts. These accounts can be viewed on the NHS Pensions website and are published annually. Copies can also be obtained from The Stationery Office.

b) Full actuarial (funding) valuation

The purpose of this valuation is to assess the level of liability in respect of the benefits due under the schemes (considering recent demographic experience), and to recommend the contribution rate payable by employers.

The latest actuarial valuation undertaken for the NHS Pension Scheme was completed as at 31 March 2020. The results of this valuation set the employer contribution rate payable from 1 April 2024 at 23.7% of pensionable pay. The core cost cap cost of the scheme was calculated to be outside of the 3% cost cap corridor as at 31 March 2020. However, when the wider economic situation was taken into account through the economic cost cap cost of the scheme, the cost cap corridor was not similarly breached. As a result, there was no impact on the member benefit structure or contribution rates.

The 2024 actuarial valuation is currently being prepared and will be published before new contribution rates are implemented from April 2027

Note 10 Finance income (Group)

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

	2025/26	2024/25
	£000	£000
Interest on bank accounts	474	379
NHS charitable fund investment income	84	70
Other finance income	-	-
Total finance income	**558**	**449**

Note 11.1 Finance expenditure (Group)

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

	2025/26	2024/25
	£000	£000
Interest expense:		
Interest on loans from the Department of Health and Social Care	18	43
Interest on lease obligations	55	93
Total interest expense	**73**	**136**
Unwinding of discount on provisions	11	10
Other finance costs	-	-
Total finance costs	**84**	**146**

Note 12 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 £1.6 million (2024/25 surplus £0.2million). The trust's total comprehensive income/(expense) for the period was a surplus of £3.7 million (204/25: £4.2 million).

Note 13.1 Intangible assets - 2025/26

Group	Software licences	Intangible assets under construction	Charitable fund intangible assets	Total
	£000	£000	£000	£000
Cost at 1 April 2025 - brought forward *	**5,734**	**10,172**	**-**	**15,906**
Transfers by absorption	-	-	-	**-**
Additions	-	5,163	-	**5,163**
Reclassifications	11,720	(11,720)	-	**-**
Transfers to / from assets held for sale	-	-	-	**-**
Disposals / derecognition	-	-	-	**-**
Cost at 31 March 2026	**17,454**	**3,615**	**-**	**21,069**
Amortisation at 1 April 2025 - brought forward	**3,669**	**-**	**-**	**3,669**
Transfers by absorption	-	-	-	**-**
Provided during the year	1,478	-	-	**1,478**
Impairments	-	-	-	**-**
Reversals of impairments	-	-	-	**-**
Reclassifications	-	-	-	**-**
Transfers to / from assets held for sale	-	-	-	**-**
Disposals / derecognition	-	-	-	**-**
Amortisation at 31 March 2026	**5,147**	**-**	**-**	**5,147**
Net book value at 31 March 2026	**12,307**	**3,615**	**-**	**15,922**
Net book value at 1 April 2025	**2,065**	**10,172**	**-**	**12,237**

* From 1 April 2025, the option to apply the revaluation model in IAS 38 to intangible assets has been withdrawn prospectively. Where assets were previously revalued, the carrying value at the transition date was carried forward as 'deemed cost'.

Note 13.2 Intangible assets - 2024/25

Group	Software licences	Intangible assets under construction	Charitable fund intangible assets	Total
	£000	£000	£000	£000
Valuation / gross cost at 1 April 2024 - as previously stated	**5,400**	**5,517**	**-**	**10,917**
Prior period adjustments	-	-	-	**-**
Valuation / gross cost at 1 April 2024 - restated	**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 - as previously stated	**2,776**	**-**	**-**	**2,776**
Prior period adjustments	-	-	-	**-**
Amortisation at 1 April 2024 - restated	**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 14.1 Property, plant and equipment - 2025/26

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 2025 - brought forward	**4,530**	**47,868**	**7,481**	**22,802**	**11,168**	**-**	**93,849**
Transfers by absorption	-	-	-	-	-	-	**-**
Additions	-	984	8,463	1,704	325	-	**11,476**
Impairments	(170)	(3,398)	-	-	-	-	**(3,568)**
Reversals of impairments	-	-	-	-	-	-	**-**
Revaluations	-	(22)	-	-	-	-	**(22)**
Reclassifications	-	1,084	(3,274)	1,866	324	-	**-**
Transfers to / from assets held for sale	-	-	-	-	-	-	**-**
Disposals / derecognition	-	-	-	-	-	-	**-**
Valuation/gross cost at 31 March 2026	**4,360**	**46,516**	**12,670**	**26,372**	**11,817**	**-**	**101,735**
Accumulated depreciation at 1 April 2025 - brought forward	**-**	**-**	**-**	**17,439**	**8,099**	**-**	**25,538**
Transfers by absorption	-	-	-	-	-	-	**-**
Provided during the year	-	1,599	-	1,167	1,097	-	**3,863**
Impairments	-	-	-	-	-	-	**-**
Reversals of impairments	-	-	-	-	-	-	**-**
Revaluations	-	(1,599)	-	-	-	-	**(1,599)**
Accumulated depreciation at 31 March 2026	**-**	**-**	**-**	**18,606**	**9,196**	**-**	**27,802**
Net book value at 31 March 2026	**4,360**	**46,516**	**12,670**	**7,766**	**2,621**	**-**	**73,933**
Net book value at 1 April 2025	**4,530**	**47,868**	**7,481**	**5,363**	**3,069**	**-**	**68,311**

Note 14.2 Property, plant and equipment - 2024/25

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 - as previously stated	**6,050**	**44,583**	**5,028**	**18,882**	**10,720**	**-**	**85,263**
Prior period adjustments	-	-	-	-	-	-	**-**
Valuation / gross cost at 1 April 2024 - restated	**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 - as previously stated	**-**	**-**	**-**	**16,719**	**7,099**	**-**	**23,818**
Prior period adjustments	-	-	-	-	-	-	**-**
Accumulated depreciation at 1 April 2024 - restated	**-**	**-**	**-**	**16,719**	**7,099**	**-**	**23,818**
Transfers by absorption	-	-	-	-	-	-	**-**
Provided during the year	-	1,505	-	720	1,000	-	**3,225**
Impairments	-	-	-	-	-	-	**-**
Reversals of impairments	-	(1,505)	-	-	-	-	**(1,505)**
Revaluations							
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 14.3 Property, plant and equipment financing - 31 March 2026

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	4,360	44,551	12,670	7,647	2,621	-	**71,849**
On-SoFP PFI contracts and other service concession arrangements	-	-	-	-	-	-	**-**
Off-SoFP PFI residual interests	-	-	-	-	-	-	**-**
Owned - donated/granted	-	1,965	-	119	-	-	**2,084**
NBV total at 31 March 2026	**4,360**	**46,516**	**12,670**	**7,766**	**2,621**	**-**	**73,933**

Note 14.4 Property, plant and equipment financing - 31 March 2025

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 15 Donations of property, plant and equipment

In 2025/26 The Queen Victoria NHS Trust Charitable Fund donated capital items with a combined value of £37,000.

Note 16 Revaluations of property, plant and equipment

Land and Buildings were revalued as at 31st March 2026 by professionally qualified, Royal Institute of Chartered Surveyors (RICS) registered, external valuers Gerald Eve LLP (see note 1.9). The valuation took account of changes in market values and work carried out by the Trust since the previous valuation as at 31 March 2025. 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 16.1 Right of use assets - 2025/26

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 2025 - brought forward	**2,295**	**2,301**	**4,596**	**-**
Transfers by absorption	-	-	**-**	-
Additions	-	1,492	**1,492**	-
Remeasurements of the lease liability	-	(42)	**(42)**	-
Movements in provisions for restoration / removal costs	-	-	**-**	-
Impairments	-	-	**-**	-
Reversal of impairments	-	-	**-**	-
Revaluations	20	-	**20**	-
Reclassifications	-	-	**-**	-
Disposals / derecognition	-	-	**-**	-
Valuation/gross cost at 31 March 2026	**2,315**	**3,751**	**6,066**	**-**
Accumulated depreciation at 1 April 2025 - brought forward	**308**	**715**	**1,023**	**-**
Transfers by absorption	-	-	**-**	-
Revaluations	(64)	-	**(64)**	
Provided during the year	64	966	**1,030**	-
Accumulated depreciation at 31 March 2026	**308**	**1,681**	**1,989**	**-**
Net book value at 31 March 2026	**2,007**	**2,070**	**4,077**	**-**
Net book value at 1 April 2025	**1,987**	**1,586**	**3,573**	**-**

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 16.2 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**	**-**
Prior period adjustments	-	-	**-**	-
Valuation / gross cost at 1 April 2024 - restated	**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**	**-**
Prior period adjustments	-	-	**-**	-
Accumulated depreciation at 1 April 2024 - restated	**244**	**309**	**553**	**-**
Transfers by absorption	-	-	**-**	-
Provided during the year	64	406	**470**	-
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 16.3 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 24.1.

	Group		Trust	
	2025/26	2024/25	2025/26	2024/25
	£000	£000	£000	£000
Carrying value at 1 April	**1,767**	**1,469**	**1,767**	1469
Prior period adjustments		-		-
Carrying value at 1 April - restated	**1,767**	**1,469**	**1,767**	**1,469**
Transfers by absorption	-	-	-	0
Lease additions	1,492	811	1,492	811
Lease liability remeasurements	(42)	-	(42)	0
Interest charge arising in year	55	93	55	93
Early terminations	-	-	-	0
Lease payments (cash outflows)	(864)	(606)	(864)	(606)
Other changes	-	-	-	0
Carrying value at 31 March	**2,408**	**1,767**	**2,408**	**1,767**

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.
Income generated from subleasing right of use assets is £0k and is included within revenue from operating leases in note 4.

Note 16.4 Maturity analysis of future lease payments at 31 March 2026

	Group		Trust	
	Total	Of which leased from DHSC group bodies:	Total	Of which leased from DHSC group bodies:
	31 March 2026	31 March 2026	31 March 2026	31 March 2026
	£000	£000	£000	£000
Undiscounted future lease payments payable in:				
- not later than one year;	1,126	-	1,126	
- later than one year and not later than five years;	1,282	-	1,282	
- later than five years.	-	-	-	
Total gross future lease payments	**2,408**	**-**	**2,408**	**-**
Finance charges allocated to future periods	-	-	-	
Net lease liabilities at 31 March 2026	**2,408**	**-**	**2,408**	**-**
Of which:				
Leased from other NHS providers		-		
Leased from other DHSC group bodies		-		

Note 16.5 Maturity analysis of future lease payments at 31 March 2025

	Group		Trust	
	Total	Of which leased from DHSC group bodies:	Total	Of which leased from DHSC group bodies:
	31 March 2025	31 March 2025	31 March 2025	31 March 2025
	£000	£000	£000	£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 finance lease liabilities at 31 March 2025	**1,767**	**-**	**1,767**	**-**
Of which:				
Leased from other NHS providers		-		
Leased from other DHSC group bodies		-		

Note 18 Analysis of charitable fund reserves

Charitable Fund, Registered Charity No. 1056120

	31 March 2026	31 March 2025
	£000	£000
Unrestricted funds:		
Unrestricted income funds	786	368
Revaluation reserve	-	-
Other reserves	-	-
Restricted funds:		
Endowment funds	-	-
Other restricted income funds	2,860	2,794
	3,646	**3,162**

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 19 Inventories

	Group	
	31 March 2026	31 March 2025
	£000	£000
Drugs	176	159
Work In progress	-	-
Consumables	949	1,011
Energy	-	-
Other	-	-
Charitable fund inventory	-	-
Total inventories	**1,125**	**1,170**
of which:		
Held at fair value less costs to sell	-	-

Inventories recognised in expenses for the year were £8,229k (2024/25: £5,005k). Write-down of inventories recognised as expenses for the year were £0k (2024/25: £75k).

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 20.1 Receivables

	Group	
	31 March 2026	31 March 2025
	£000	£000
Current		
Contract receivables	6,431	8,272
Contract assets	-	-
Capital receivables	-	-
Allowance for impaired contract receivables / assets	(766)	(833)
Allowance for other impaired receivables	-	-
Deposits and advances	-	-
Prepayments (non-PFI)	1,381	1,094
VAT receivable	495	804
Corporation and other taxes receivable	-	-
Other receivables	36	76
NHS charitable funds receivables	-	-
Total current receivables	**7,577**	**9,413**
Non-current		
Other receivables	272	305
NHS charitable funds receivables	-	-
Total non-current receivables	**272**	**305**
Of which receivable from NHS and DHSC group bodies:		
Current	4,169	5,662
Non-current	272	305

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 20.2 Allowances for credit losses - 2025/26

	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 2025 - brought forward	**833**	**-**	**833**	
Transfers by absorption	-	-	-	
New allowances arising	379	-	379	
Changes in existing allowances	-	-	-	
Reversals of allowances	(446)	-	(446)	
Utilisation of allowances (write offs)	-	-	-	
Changes arising following modification of contractual cash flows	-	-	-	
Foreign exchange and other changes	-	-	-	
Allowances as at 31 Mar 2026	**766**	**-**	**766**	**-**

Note 20.3 Allowances for credit losses - 2024/25

	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 2024 - as previously stated	**740**	**-**	**740**	
Prior period adjustments	-	-	-	
Allowances as at 1 Apr 2024 - restated	**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 20.4 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 2025/26 there are no arrangements where the Trust is a lessor

Note 21.1 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	
	2025/26	2024/25	2025/26	2024/25
	£000	£000	£000	£000
At 1 April	**16,183**	**16,107**	**12,941**	**12,787**
Prior period adjustments		-		-
At 1 April (restated)	**16,183**	**16,107**	**12,941**	**12,787**
Transfers by absorption	-	-		-
Net change in year	6,683	76	6,241	154
At 31 March	**22,866**	**16,183**	**19,182**	**12,941**
Broken down into:				
Cash at commercial banks and in hand	6,432	5,466	2,748	2,224
Cash with the Government Banking Service	16,434	10,717	16,434	10,717
Deposits with the National Loan Fund	-	-	-	-
Other current investments	-	-	-	-
Total cash and cash equivalents as in SoFP	**22,866**	**16,183**	**19,182**	**12,941**
Bank overdrafts (GBS and commercial banks)	-	-	-	-
Drawdown in committed facility	-	-	-	-
Total cash and cash equivalents as in SoCF	**22,866**	**16,183**	**19,182**	**12,941**

Note 21.2 Third party assets held by the trust

Queen Victoria Hospital NHS Foundation Trust held 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 22.1 Trade and other payables

	Group		Trust	
	31 March 2026	31 March 2025	31 March 2026	31 March 2025
	£000	£000	£000	£000
Current				
Trade payables	5,890	2,016	5,890	2,016
Capital payables	6,960	8,170	6,960	8,170
Accruals	6,487	7,045	6,487	7,045
Receipts in advance and payments on account	-	-	-	-
PFI lifecycle replacement received in advance	-	-	-	-
Social security costs	928	781	928	781
VAT payables	-	-	-	-
Other taxes payable	973	942	973	942
PDC dividend payable	535	365	535	365
Pension contributions payable	1,092	1,037	1,092	1,037
Other payables	227	103	227	103
NHS charitable funds: trade and other payables	38	80	-	
Total current trade and other payables	**23,130**	**20,539**	**23,092**	**20,459**
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	4,708	4,772	4708	4772
Non-current	-	-		

Note 22.2 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 2026 £000	31 March 2026 Number	31 March 2025 £000	31 March 2025 Number
- to buy out the liability for early retirements over 5 years	-		-	
- number of cases involved		-		-

Note 23 Other liabilities

	Group & Trust	
	31 March 2026	31 March 2025
	£000	£000
Current		
Deferred income: contract liabilities	368	535
Total other current liabilities	**368**	**535**
Non-current		
Deferred income: contract liabilities	-	-
Total other non-current liabilities	**-**	**-**

Note 24.1 Borrowings

	Group	
	31 March 2026	31 March 2025
	£000	£000
Current		
Bank overdrafts	-	-
Loans from DHSC	379	787
Other loans	-	-
Lease liabilities	1,126	1,231
Total current borrowings	**1,505**	**2,018**
Non-current		
Loans from DHSC	-	379
Lease liabilities	1,282	536
Total non-current borrowings	**1,282**	**915**

Note 24.2 Reconciliation of liabilities arising from financing activities (Group)

Group - 2025/26	Loans from DHSC	Lease liabilities	Total
	£000	£000	£000
Carrying value at 1 April 2025	**1,166**	**1,767**	**2,933**
Cash movements:			
Financing cash flows - payments and receipts of principal	(778)	(809)	**(1,587)**
Financing cash flows - payments of interest	(27)	(55)	**(82)**
Non-cash movements:			
Additions	-	1,492	**1,492**
Lease liability remeasurements	-	(42)	**(42)**
Remeasurement of PFI / other service concession liability resulting from change in index or rate			**-**
Application of effective interest rate	18	55	**73**
Carrying value at 31 March 2026	**379**	**2,408**	**2,787**

Group - 2024/25	Loans from DHSC	Lease liabilities	Total
	£000	£000	£000
Carrying value at 1 April 2024	**1,950**	**1,469**	**3,419**
Prior period adjustment	-	-	**-**
Carrying value at 1 April 2024 - restated	**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**
Remeasurement of PFI / other service concession liability resulting from change in index or rate			**-**
Application of effective interest rate	43	93	**136**
Carrying value at 31 March 2025	**1,166**	**1,767**	**2,933**

Note 25.1 Provisions for liabilities and charges analysis (Group)

Group	Pensions: early departure costs	Pensions: injury benefits	Legal claims	Other	Charitable fund provisions	Total
	£000	£000	£000	£000	£000	£000
At 1 April 2025	**38**	**375**	**19**	**433**	**-**	**865**
Transfers by absorption	-	-	-	-	-	**-**
Change in the discount rate	-	(2)	-	(21)	-	**(23)**
Arising during the year	-	9	42	(26)	-	**25**
Utilised during the year	-	(28)	-	(6)	-	**(34)**
Reclassified to liabilities held in disposal groups	-	-	-	-	-	**-**
Unwinding of discount	-	11	-	18	-	**29**
Movement in charitable fund provisions	-	-	-	-	-	**-**
At 31 March 2026	**38**	**365**	**61**	**398**	**-**	**862**
Expected timing of cash flows:	6	27	9	6	-	**48**
- not later than one year;	26	108	52	90	-	**276**
- later than one year and not later than five years;	6	230	-	302	-	**538**
- later than five years.	**38**	**365**	**61**	**398**	**-**	**862**
Total						

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 25.2 Clinical negligence liabilities

At 31 March 2026, £2,122k was included in provisions of NHS Resolution in respect of clinical negligence liabilities of Queen Victoria Hospital NHS Foundation Trust (31 March 2025: £2,058k).

Note 26 Contingent assets and liabilities

	Group	
	31 March 2026	31 March 2025
	£000	£000
Value of contingent liabilities		
NHS Resolution legal claims	(2)	(1)
Other	(112)	(95)
Gross value of contingent liabilities	**(114)**	**(96)**
Amounts recoverable against liabilities	-	-
Net value of contingent liabilities	**(114)**	**(96)**
Net value of contingent assets	**-**	**-**

Note 27 Contractual capital commitments

	Group	
	31 March 2026	31 March 2025
	£000	£000
Property, plant and equipment	5,510	-
Intangible assets	620	88
Total	**6,130**	**88**

Note 28 Carrying values of financial assets (Group)

Carrying values of financial assets as at 31 March 2026	Held at amortised cost	Total book value
	£000	£000
Trade and other receivables excluding non financial assets	5,943	**5,943**
Cash and cash equivalents	19,182	**19,182**
Consolidated NHS Charitable fund financial assets	3,684	**3,684**
Total at 31 March 2026	**28,809**	**28,809**

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**
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**

Note 28.1 Carrying values of financial assets (Trust)

Carrying values of financial assets as at 31 March 2026	Held at amortised cost	Total book value
	£000	£000
Trade and other receivables excluding non financial assets	5,943	**5,943**
Cash and cash equivalents	19,182	**19,182**
Total at 31 March 2026	**25,125**	**25,125**

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**
Cash and cash equivalents	12,941	**12,941**
Total at 31 March 2025	**20,693**	**20,693**

Note 28.2 Carrying values of financial liabilities (Group)

Carrying values of financial liabilities as at 31 March 2026	Held at amortised cost	Total book value
	£000	£000
Loans from the Department of Health and Social Care	379	**379**
Obligations under leases	2,408	**2,408**
Trade and other payables excluding non financial liabilities	19,170	**19,170**
Total at 31 March 2026	**21,957**	**21,957**

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**

Note 28.3 Carrying values of financial liabilities (Trust)

Carrying values of financial liabilities as at 31 March 2026	Held at amortised cost	Total book value
	£000	£000
Loans from the Department of Health and Social Care	379	**379**
Obligations under leases	2,408	**2,408**
Trade and other payables excluding non financial liabilities	19,170	**19,170**
Total at 31 March 2026	**21,957**	**21,957**

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**

Note 28.4 Maturity of financial liabilities

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 2026	31 March 2025
	£000	£000
In one year or less	20,678	18,860
In more than one year but not more than five years	1,282	920
In more than five years	-	-
Total	**21,960**	**19,780**

Note 29 Losses and special payments

	2025/26	
Group and trust	**Total number of cases**	**Total value of cases**
	Number	**£000**
Losses		
Cash losses	-	-
Fruitless payments and constructive losses	-	-
Bad debts and claims abandoned	-	-
Stores losses and damage to property	-	-
Total losses	**-**	**-**
Special payments		
Compensation under court order or legally binding arbitration award	-	-
Extra-contractual payments	-	-
Ex-gratia payments	-	-
Special severance payments	1	15
Extra-statutory and extra-regulatory payments	-	-
Total special payments	**1**	**15**
Total losses and special payments	**1**	**15**

Compensation payments received

Note 31 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 2025/26, (2024/25 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 2025/26 (includes extraordinary meetings)					
	Board of Directors	**Audit & risk committee**	**Nomination & remuneration committee**	**Quality & safety committee**	**Finance & performance committee**	**Strategy & culture committee**
Jon Bell **Interim** Chief Finance Officer	**2 of 2**	**NA**	**NA**	**NA**	**1 of 1**	**NA**
Liz Blackburn Acting Chief Nursing Officer	**4 of 4**	**NA**	**NA**	**3 of 3**	**1 of 4**	**NA**
Vivek Chaudhri Associate Non-Executive Director	**12 of 14**	**NA**	**NA**	**NA**	**NA**	**NA**
Jane Dickson Interim Deputy Chief Executive Officer	**9 of 14**	**NA**	**NA**	**NA**	**NA**	**NA**
Paul Dillon-Robinson Non-Executive Director	**8 of 8**	**2 of 2**	**4 of 5**	**4 of 4**	**NA**	**NA**
Helen Edmunds Chief People Officer	**14 of 14**	**NA**	**NA**	**NA**	**8 of 10**	**4 of 4**
Jagjit Dosanjh-Elton Non-Executive Director	**6 of 6**	**2 of 2**	**3 of 3**	**NA**	**3 of 3**	**NA**
Jo Emmanuel Non-Executive Director	**14 of 14**	**NA**	**4 of 7**	**6 of 7**	**NA**	**NA**
Tamara Everington Chief Medical Officer	**14 of 14**	**NA**	**NA**	**7 of 7**	**8 of 10**	**3 of 4**
Russell Hobby Non-Executive Director	**10 of 14**	**2 of 4**	**7 of 8**	**2 of 2**	**8 of 10**	**1 of 3**
Abigail Jago Acting Chief Executive Officer and Chief Strategy Officer	**14 of 14**	**NA**	**NA**	**NA**	**6 of 10**	**4 of 4**
Simon Marshall Interim Chief Finance Officer	**12 of 12**	**NA**	**NA**	**NA**	**9 of 9**	**NA**
Angela McNab Interim Trust Chair	**3 of 3**	**NA**	**1 of 1**	**NA**	**NA**	**1 of 1**
Karen Norman Non-Executive Director	**0 of 0**	**NA**	**1 of 1**	**NA**	**NA**	**NA**
Peter O'Donnell Non-Executive Director	**9 of 14**	**3 of 4**	**6 of 8**	**NA**	**10 of 10**	**1 of 1**
Shaun O'Leary Non-Executive Director	**11 of 14**	**NA**	**8 of 8**	**7 of 7**	**NA**	**4 of 4**
Aleema Shivji Associate Non-Executive Director	**10 of 6**	**NA**	**NA**	**NA**	**NA**	**NA**
Jackie Smith Trust Chair	**7 of 11**	**NA**	**6 of 7**	**NA**	**7 of 7**	**3 of 3**
Edmund Tabay Chief Nursing Officer	**7 of 10**	**NA**	**NA**	**3 of 5**	**3 of 6**	**NA**
Kirsten Timmins Chief Operating Officer	**10 of 11**	**NA**	**NA**	**6 of 7**	**10 of 10**	**NA**

6.2 Council of Governors' register

Name	Constituency	Status of current term	Start term	End term
Chris Parrish	Staff	Elected 1st term	01/07/2023	24/07/2025
Colin Fry	Public	Elected 1st term	09/12/2024	23/02/2026
Denise Holland	Public	Elected 1st term	01/07/2023	04/03/2026
Linda Skinner	Stakeholder	Appointed 1st term	01/04/2023	31/03/2026
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
Ken Sim	Public	Re-elected 2nd term	01/07/2023	30/06/2026
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
Graham True	Staff	Elected 1st term	11/03/2025	30/06/2026
Kokila Ramalingham	Staff	Elected 1st term	01/10/2025	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
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
Bob Lanzer	Stakeholder	Re-elected 2nd term	01/05/2025	30/04/2028

6.3 Directors' biographies 2025/26

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 Queen Victoria Hospital 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.

Liz Blackburn, Acting Chief Nursing Officer (voting)

After qualifying as a nurse in 2001, Liz gained experience in surgical nursing at St George's Hospital and critical care nursing at Guy's and St Thomas' Hospital. Liz moved to East Grinstead and joined the team at Queen Victoria Hospital in September 2005. Since then Liz has held a number of roles within our Critical Care Unit and Burns department, whilst also obtaining a postgraduate certificate in research.

Liz has a keen interest in clinical education and is passionate about providing high quality care and giving patients the best experience, as well as ensuring that staff feel valued and supported.

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 organisation 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 Officer (non-voting)

Jane Dickson became Interim Deputy Chief Executive in March 2025, having joined Queen Victoria Hospital 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 (non-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.

Jagjit Dosanjh-Elton, Non-Executive Director (voting)

Jagjit Dosanjh-Elton joined the Board in October 2025.

With over 25 years of experience in finance, Jagjit has built a distinguished career across the private and charitable sector. Jagjit currently operates on a portfolio basis, as a Chief Financial Officer and Non-Executive Director for several organisations. Previously Jagjit has held senior roles at The Economist and Gemserv Limited (now part of The Talan Group).

Jagjit holds a Bachelor of Science degree from Brunel University and an MBA from Warwick Business School. Her professional journey is defined not only by strategic leadership and financial expertise, but also by a deep commitment to advancing equity and inclusion. She is a passionate advocate for creating opportunities that foster representation and social mobility across business and society.

Jo Emmanuel, Non-Executive Director (voting)

Jo Emmanuel joined the Board in January 2025.

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)

Tamara Everington joined Queen Victoria Hospital as Chief Medical Officer in October 2024.

Prior to joining the Trust, 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 Hobby joined the Board in July 2023.

Russell is Chief Executive Officer of The Kemnal Academies Trust and was previously Chief Executive Officer of social mobility charity Teach First. 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.

Russell is a member of the Education Committee of the Royal Society. He is a Life peer in the House of Lords, taking his seat in February 2026.

Russell was awarded a CBE in the New Year Honours List 2022 and was presented with the honorary title of Doctor of Education from Bath Spa University in 2023.

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

Abigail Jago became Acting Chief Executive Officer in January 2025, having been Chief Strategy Officer since February 2023.

Since joining the NHS in 2000, she 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.

Simon Marshall, Interim Chief Finance Officer (voting) from 09/05/2025

Simon Marshall joined the Trust in May 2025 as Interim Chief Finance Officer.

Simon has over three decades of experience working in the healthcare sector, including 25 years in NHS Chief Finance Officer roles across London and Surrey. Prior to joining QVH he was Chief Finance Officer at Ashford and St Peters NHS Foundation Trust. Simon is also a fellow of the Chartered Institute of Public Finance and Accountancy.

Simon is passionate about business leadership and service transformation, whilst driving improvements to the quality of patient services.

Angela McNab, Interim Trust Chair (voting)

Angela McNab joined Queen Victoria Hospital as Interim Chair in January 2026.

Angela has a long-standing career in health and social care, spanning national policy, regulation and operational delivery. This includes extensive experience at chief executive-level, including for Camden and Islington NHS Foundation Trust and Kent and Medway NHS and Social Care Partnership Trust.

She has also worked as Director of Public Health, Delivery and Performance at the Department of Health and has worked as a non-executive in a range of organisations including social care and regulation.

Angela has a particular interest in developing positive and inclusive culture in organisations and in strategic leadership. She is a qualified executive coach. Angela is also a Non-Executive Director and the Vice Chair of NHS Kent and Medway ICB.

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.

Karen 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 O'Donnell 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 Non-Executive Director of Nottingham Building Society and Vice Chair and Senior Independent Director of the OneFamily Group. Peter was previously a Trustee of Cardiac Risk in the Young.

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

Shaun O'Leary joined the Board in July 2023.

Shaun 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.

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

Aleema Shivji joined the Board in January 2025.

Aleema is a systems-level change maker 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, she 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 Timmins joined the Trust in March 2024 as Chief Operating Officer.

Kirsten brings 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.

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

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