NHS

James Paget University Hospitals NHS Foundation Trust

ANNUAL REPORT AND ACCOUNTS 2023/24

James Paget University Hospitals NHS Foundation Trust

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

Contents

Foreword by the Chair and Chief Executive

Mark Friend, Chair

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I am delighted to introduce the James Paget's Annual Report and Accounts in my role as Chair of the Board of Directors and Council of Governors for the Trust.

When I joined the Trust in October 2023, I was struck by the compassion and care that staff at the James Paget demonstrate – both in clinical and non-clinical roles. In my experience of working at other NHS Foundation Trusts, these values are vital in helping to improve patients' experience and in attracting and retaining a happy, thriving workforce.

The James Paget Hospital faces significant challenges – as all NHS and social care organisations do – in meeting growing patient demand and complexity, but I have been hugely impressed by how our teams are delivering in these circumstances, and the support they have shown to each other throughout this period.

As we near completion of year one of our five-year strategy 'Building a Healthier Future Together', launched in May 2023, I return to our guiding strategic priorities of our Patients, our People, our Partners, and our Performance to reflect on the distance we have travelled over 2023-24.

For our Patients, we have continued to provide services during operationally challenging circumstances and have made every effort to provide care for those waiting longest for a procedure at our hospital. Through our commitment to Quality Improvement, aligned to our Patient Safety systems, we are actively making our services better, and collaborating with patients to understand their needs.

Our People have worked tirelessly through another difficult and unpredictable year, which is a source of immense pride for me and the rest of the Board. They are the foundation on which we provide care to our patients and communities, and we are developing infrastructure and support to improve the experience of working at the Trust, and to tackle the issues that matter to our employees and teams.

Throughout the past year we have strengthened and increased the range of our partnerships to tackle inequalities, support our people and add value to our services. I would like to take this opportunity to thank all our partners, including health and care system partners, local government, and the voluntary and charity sector. I look forward to finding new solutions and creating new opportunities together.

The rapid development of new buildings on our estate – additional diagnostic facilities and orthopaedic theatre spaces – will help improve the access and speed of the care we can provide and give our staff the best facilities with which to care for our patients.

The progress across these areas over the past 12 months provides encouragement towards our future – and our exciting, ambitious plans for a new hospital on our estate, scheduled for 2030. By working on the long-term plans for 'Future Paget' alongside delivering care today, we are ensuring that our staff, patients, and stakeholders can input into this once-in-a-generation opportunity.

Jo Segasby, Chief Executive

Jo Segasby, Chief Executive

Over the past year, the key theme of the James Paget's performance is 'Improving Together,' which is how we define the transformation we can see across our hospital and services, and how we are doing this in partnership with our staff, our patients and communities, and our fellow health and care system organisations.

Our hospital has faced significant challenges over 2023-24. We have seen increased demand for our services at the same time as we have focused on ensuring people who have been waiting longest for services can receive the procedure and care that they need.

We have also welcomed regulatory scrutiny of our maternity services over the past year, within the context of our long-term Maternity Improvement Plan, and in response to Care Quality Commission's inspection report of our services in 2022.

The outcomes of the inspection of maternity services told us the immediate steps we needed to take to improve the safety of our maternity services, and we have rapidly responded to these requirements as a Trust, with support from health and care system partners.

The additional findings we received from the report and the national staff survey results provided supplementary information for areas we know where we need to improve together across the hospital – in living and breathing our Trust values and behaviours, in developing a shared kindness and respect framework, and in dedicating time and resources to improve our leadership and team working.

These are priorities across all staff groups and are outlined in both our five-year strategy 'Building a Healthier Future Together' and our 'People Plan' launched last year. Alongside this, our 'Patient Experience and Engagement Plan' has been co-designed with patients to focus on how we will improve the experience patients have in accessing services at the James Paget, alongside continuing to roll out the Patient Safety Incident Response Framework initiative launched in 2023.

We have also seen significant change and improvement across our physical estate, with our new Concept Ward launching in May 2023, which has already won a number of awards for its innovative construction, and exemplar partnership working in delivering the vision of future care, accessible today at our hospital.

Coupled to this development is the Community Diagnostic Centre building scheduled to open on our main hospital site in summer 2024, this will provide additional diagnostic capacity on site, as well as an additional centre located at Northgate Hospital in Great Yarmouth, due to open in the autumn of 2024. This will provide communities in our area with improved access to diagnostic and assessment services, which will help provide earlier interventions, and the right care at the right time for our patients.

These additions to our hospital will strengthen the performance and quality of care we provide, as we continue to carefully plan our long-term estate development through our Future Paget programme.

We must also not lose focus on our financial performance and our financial sustainability, and our staff and teams have been outstanding in defining and delivering innovations and ideas to improve our efficiency as an organisation.

Our history and purpose

The James Paget Healthcare NHS Trust became the first Foundation Trust in Norfolk and Suffolk on 01 August 2006. This marked a significant milestone in the hospital's history, as it transitioned to a new governance model that offered greater autonomy and flexibility in managing its services. The hospital was renamed the James Paget University Hospitals NHS Foundation Trust, reflecting its expanded role in medical education and research. The hospital's history and purpose are deeply intertwined with its commitment to providing high-quality healthcare services to its local community.

The hospital employs over 4,000 staff members and provides services at the James Paget University Hospital in Gorleston, supplemented by services at the Newberry Centre Children's Clinic and other outreach clinics. The hospital serves a catchment population of 250,000, a figure expected to steadily increase, particularly among people aged over sixty-five.

The Trust prides itself on being a high-performing organisation that prioritises patient care. The hospital continually strives to improve clinical outcomes and patient experiences to meet the needs of its patients and local population. The hospital is deeply rooted in the local community and boasts a diverse, talented, and loyal workforce committed to embracing and delivering improvement and change.

Despite facing numerous challenges due to the changing landscape in the NHS and ongoing financial challenges, the hospital remains committed to its vision of continually improving quality and patient care. The hospital aims to provide services that are tightly integrated with primary, community, and social care, and to maximise its potential as a first-class centre for teaching and research, working in partnership across the Norfolk and Waveney Integrated Care System.

As a University Hospital, the James Paget Hospital trains over one-third of the medical students from the University of East Anglia and works collaboratively with the University of Suffolk. The hospital is proactive in managing its staffing and has made significant progress in developing new roles, nurturing its people, and focusing on a 'Grow Your Own' approach to ensure that it has the right staff to treat its patients.

The hospital has earned a strong national and international reputation for research and excellence in the quality of its training facilities. Since becoming a Foundation Trust in 2006, the hospital has developed many services for local people, the most recent of which is the new concept ward.

The public and staff are directly involved in decisions about the hospital's services, through its membership and the Council of Governors, who can influence the future of how services are provided. This democratic structure is a key feature of Foundation Trusts, ensuring that the hospital is accountable to the community it serves.

In conclusion, the James Paget University Hospitals NHS Foundation Trust is a regional anchor institution that provides essential healthcare services to its communities. Its history is marked by its transition to a Foundation Trust, and its purpose is defined by its commitment to patient care, education, and research. Despite the challenges it faces, the hospital remains dedicated to improving its services and meeting the needs of its patients and local community.

Performance

The Board of Directors maintains a five-year strategy which sets out four Strategic Priorities for the Trust. The Strategy runs from 2023-2028. The Strategic Priorities were developed and agreed through a process of wide consultation and engagement with stakeholders to ensure they are aligned to the needs of our community, patients, carers, staff, and our system partners. Each priority is supported with a series of ambitions which will be delivered over the term of the strategy.

The Priorities and underpinning ambitions are shown below.

- **Strategic Priority 1: Caring for Our Patients**
  1. Deliver the best and safest care for our patients
  2. Continuously improve patient experience
  3. Reduce health inequalities, ensuring equitable access for all
- **Strategic Priority 2: Supporting Our People**
  1. Promote an inclusive, fair, and safe workplace
  2. Develop compassionate and effective leadership
  3. Attract, engage, develop, and deploy our staff to deliver the best care for our patients
  4. Promote wellbeing opportunities to keep our staff healthy and well
- **Strategic Priority 3: Collaborating with Our partners**
  1. Collaborate to achieve seamless patient pathways both at place and system level
  2. Embrace our role as an anchor institution, working together for the best outcomes
  3. Be an effective partner to achieve both our ambitions and our partner's ambitions
- **Strategic Priority 4: Enhancing Our Performance**
  1. Make the best use of our physical and financial resources
  2. Lead the way towards achieving Net Zero Carbon
  3. Future-proof our services for the people we serve
  4. Improve services through digital transformation, research, and new models of care

The Strategy is delegated to the Chief Executive to achieve the outcomes expected. An annual delivery plan is agreed by Board each year to ensure the Priorities and Ambitions are delivered over the term of the strategy.

The Board keeps track of the status of its Strategic Priorities, the Ambitions, and underpinning annual delivery plan through the relevant Committees and the regular reporting which outlines the risks that could derail the Board's intentions and how they are mitigated. This report is known as a Board Assurance Framework Report and is closely scrutinised by the Board Committees at each meeting, prior to submission to the Board. This enables the Board to form an opinion as to whether additional actions or resource allocations are required to guarantee the desired outcomes.

Good progress was made across all objectives in the Year 1 Delivery Plan and some objectives have been carried over into Year 2 (2024/25). During 2024/25 a gap analysis will be developed to ensure that over the duration of the Strategy the annual delivery plans (through their stated objectives) will ensure progress as required across all ambitions in each of the four priority areas.

More detail on these risks and how they were managed is available in the Annual Governance Statement contained in the Financial Statements.

Activity and performance overview

Operational pressures for most of the year have proved challenging as we continued to make progress with the delivery of our priorities and objectives. The ongoing demand for urgent and emergency care services and industrial action placing pressure on all our services. We continued to maintain the important focus of the recovery of elective and cancer services and strive for continuous improvement in quality and safety.

Our Emergency Department (Urgent and Emergency Care – UEC) performance has been challenging all year with a resilience plan produced to support increase demand over winter. We successfully implemented a decision to admit unit to support patient flow within the emergency department and support ambulance handovers to improve ambulance response times in the community. A further improvement initiative in March 2024 saw 4-hour performance increase from 62% to 74%.

The number of patients with a right to discharge (non-criteria to reside) stabilised but at a much higher level than previously as a result of challenges with community and social care demand and capacity. We maintained a higher level of inpatient beds across both the hospital site and Carlton Court as well as increased use of virtual ward to address this challenge. The research initiative delivered through the hospital's new Concept Ward continued with the use of the ward over the winter for respiratory patients, including Covid-19 and Flu and monitoring of transmission of infections, as a result there were no outbreaks over winter on this ward.

Challenges are being seen across all acute hospitals in Norfolk and Waveney to reduce the number of patients who are medically fit and no longer require acute care. We continued to work locally through our Great Yarmouth and Waveney Place Board to address health inequalities and improve hospital flow as well as across the Norfolk and Waveney System on wider initiatives.

Our ability to reduce patient waiting times has been impacted by patient flow across the hospital. Despite this we eliminated patients waiting longer than 104 weeks and significantly reduced the number of patients waiting over 78 and 65 weeks. Targeted work will continue for a few specialities in 2024/25 such as Trauma and Orthopaedics, ENT, and Urology to eliminate patients waiting over 65 weeks in 2024/25.

Our cancer performance continues to fluctuate across a number of targets and the backlog of patients over 62 days had significant improvement towards the end of the year as actions to transform patient pathways took effect, e.g. one stop pathways in urology being expanded, Faecal Immunochemical Test

(FIT) negative pathway established. We know there is further improvement to be made and look forward to launching a tele dermatology service and one stop gynaecology pathway in 2024/25 to improve and sustain performance with the faster diagnosis standard.

The number of patients we treated over the last year is set out below, with comparisons to the two previous financial years. We overachieved our predicted activity levels for elective care and the numbers of patients accessing our urgent and emergency care services has significantly increased.

Activity	2021/22	2022/23	2023/24
Elective Inpatients	2,755	3,680	4,350
Day Cases	30,265	31,440	33,656
Non-Elective Inpatients	28,095	28,903	29,929
Outpatients	250,891	264,850	270,194
A&E (Emergency Department)	85,191	91,377	97,623

Performance reporting continues to improve with the integrated performance report that is used by the Board to enable the impact of performance to be assessed across quality and safety, operational, workforce, and financial indicators fully embedded across the organisation.

Performance continued to be monitored by the Board of Directors with detailed discussion at the Finance and Performance, Patient Safety and Quality and People and Culture Committees. The Performance Management Framework is updated on an annual basis and is approved by the Board. The objective of this framework is to ensure that information is available which enables the Board and other key staff to understand, monitor and assess the Trust's quality and performance, so that appropriate action can be taken when performance against set targets deteriorates.

The KPIs are in line with the 2023/24 planning guidance which focused on elective recovery and additional measures to monitor how the Emergency Department was functioning to support patients.

National NHS objectives 2023/24	Measure name (metric)	Threshold 2023/24	Actual 2023/24
Maximise elective activity and reduce long waits, taking full advantage of opportunities to transform the delivery of services	Elective activity levels at 2019/20 levels	105.91%	110.70%
Eliminate waits of over 65 weeks for elective care by March 2024 (except where patients choose to wait longer or in specific specialties)	Patients waiting more than 65 weeks to start consultant-led treatment	0	1,285
Meet the cancer faster diagnosis standard by March 2024 so that 75% of patients who have been urgently referred by their GP for suspected cancer are diagnosed or have cancer ruled out within 28 days	% meeting faster diagnosis standard	75%	72.5%
Continue to reduce the number of patients waiting over 62 days for Cancer referrals	People waiting longer than 62 days	96	71
Increase the percentage of patients that receive a diagnostic test within six weeks in line with the March 2025 ambition of 95%	Diagnostic activity levels at 2019/20 levels	95%	86.0%

National NHS objectives 2023/24	Measure name (metric)	Threshold 2023/24	Actual 2023/24
Improve A&E waiting times so that no less than 76% of patients are seen within 4 hours by March 2024 with further improvement in 2024/25	ED 4 Hour Waits	76%	74.1%
Reduce adult general and acute (G&A) bed occupancy to 92% or below	Adult General and Acute Bed Occupancy	92%	97.5%

Details of our service and quality improvements can be found within the Director's report at page 42 and within the Quality Account 2023/24 available on our website https://www.jpaget.nhs.uk/about-us/publications-reports/quality-report/

Whilst delivery of our quality priorities has already been mentioned, more detail is set out below on what we planned to achieve and an assessment of our performance.

There was one priority not achieved – to reduce incidence of category 2 pressure ulcers by 5% from revised 2022/23 baseline of 208 following tissue viability nurse specialist review and recategorisation. Therefore, our threshold for 5% reduction was 198 and we ended the year with 259. This will remain a focus during 24/25.

Patient Safety

a	We will implement the Patient Safety Incident Response Framework (PSIRF)	**Achieved**
b	We will reduce the risk of development of Category 2 pressure ulcers for patients whilst they are in hospital	**Not Achieved**
c	Demonstrate robust processes are in place to address the immediate and essential actions from the Maternity Improvement Plan.	**Achieved**

Clinical Effectiveness

a	To demonstrate effectiveness of multidisciplinary learning from deaths	**Achieved**
b	Improve timeliness of access	**Partially achieved**
c	To optimise the Trust's clinical guideline process	**Achieved**
d	To establish a robust process for participating in, and learning from, national clinical audits	**Achieved**

Patient Experience

a	Redesign of the Patient Advice and Liaison Service (PALS).	**Partially achieved**
b	Ensure we receive and act upon feedback from patients and their families on their experiences and feedback on their care and our services	**Achieved**

Working collaboratively to support patients

Health Inequalities

Addressing health inequalities is a priority in this Trust, across the health and care system and the NHS. Working together on the elective programme with the other Trusts seeks to ensure that patients are treated in turn, based on their clinical need. It also underpins the work we are doing as part of the Norfolk and Waveney Acute Hospitals Collaborative. More information on how we approach the provisions of the Equality Act to reduce health inequalities can be found in the Staff Report at page 66.

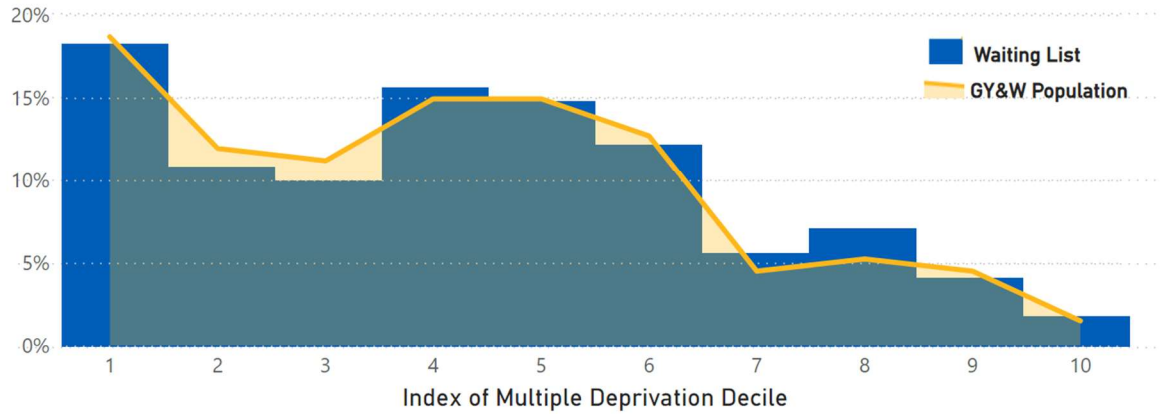
The following data outlines the James Paget's performance towards addressing health inequalities in the patient population served by the hospital. The data is sourced through the hospitals Information Services department, and nationally published data on deprivation, age, sex and ethnicity profiles for the Great Yarmouth and Waveney area.

The Trust uses the health inequalities data at its disposal to refocus approaches on how its services are provided. Our Health Inequalities Improvement Plan is aligned with the Norfolk and Waveney Health Inequalities Strategic Framework for Action. The Trust's Plan, informed by the NHS Providers self-assessment, has shown a strong foundation for building a comprehensive approach to addressing health inequalities. We have five workstreams focused on both patient care and workforce equalities. Health inequalities are integral to the Speciality Development Plans used across all clinical services, supported by a dedicated clinical lead. Metrics are being refined to measure the efficacy of our work on health inequalities, and how it supports both Great Yarmouth and Waveney Place plans, as well as the overarching system framework for health inequalities within the Integrated Care System. The Trust Board of Directors monitors the progress and outcomes through tailored reports on the implementation of our agreed 5-year Trust Strategy.

Health Inequalities 2023/24 - Waiting List Analysis

Information Services | NHS James Paget University Hospitals NHS Foundation Trust

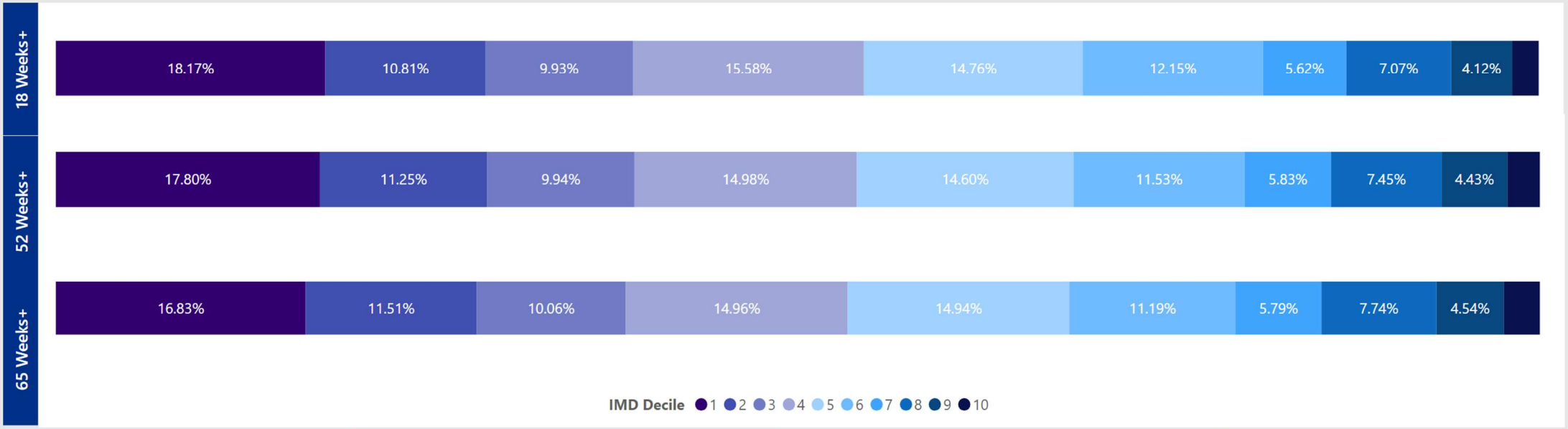
Waiting List Profile by IMD decile for patients waiting over 18 weeks



IMD	GY&W Population	Waiting List
1	18.66%	18.17%
2	11.94%	10.81%
3	11.19%	9.93%
4	14.93%	15.58%
5	14.93%	14.76%
6	12.69%	12.15%
7	4.48%	5.62%
8	5.22%	7.07%
9	4.48%	4.12%
10	1.49%	1.80%

Comparing the profile of patients waiting more than 18 weeks for treatment 2023/24 to the profile of the population of Great Yarmouth and Waveney by IMD decile indicates that the Trust is seeing a distribution of patients waiting that is closely reflective of the local population as a whole.

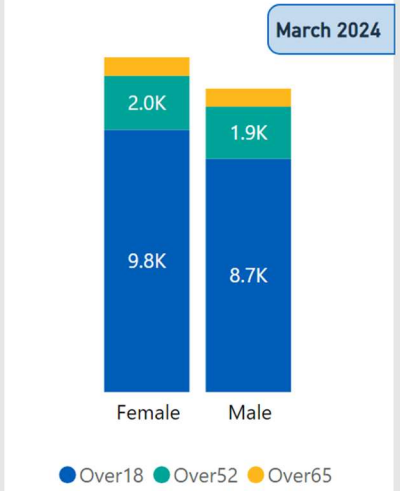
When comparing those waiting 18 or more weeks to those waiting 52 and 65 weeks or more respectively (see below) there are minor changes in the percentages waiting from each decile but overall this suggests that deprivation is not impacting on waiting times.

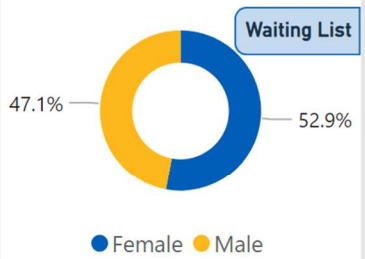


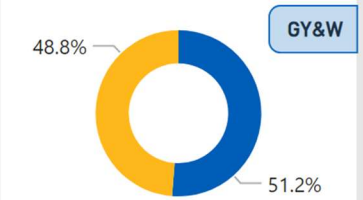
Health Inequalities 2023/24 - Waiting List Analysis

Information Services | NHS James Paget University Hospitals NHS Foundation Trust

Waiting List Profile by Sex and weeks waiting





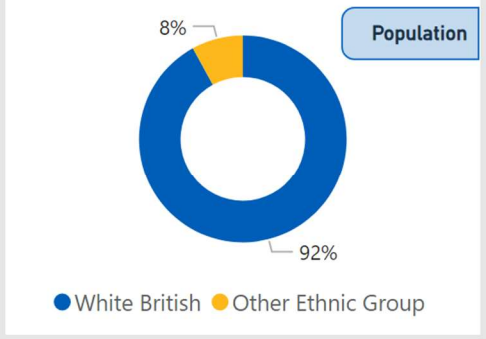


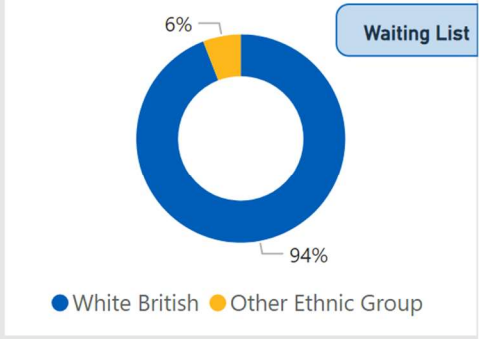
Comparing the sex distribution of the waiting list shows that there are more women than men waiting over 18 weeks for treatment, in line with the profile for the population of Great Yarmouth and Waveney (GY&W). The waiting list has grown from April 23 to March 24, but the ratio of male/female has not shifted significantly. Whilst not shown visually, the proportion of men and women waiting at the higher waits of 52 and 65 weeks is in line with the proportion at over 18 weeks, indicating that there is only a small increase in the percentage of men waiting in the longer wait brackets (49% to 47% for 18+ weeks).

With regards to ethnic groups, the population of GY&W is an outlier compared to the national picture when it comes to the high percentage (92%) of White - British residents. This profile is closely mirrored in the waiting list profile and there are no changes to the profile for longer waits.

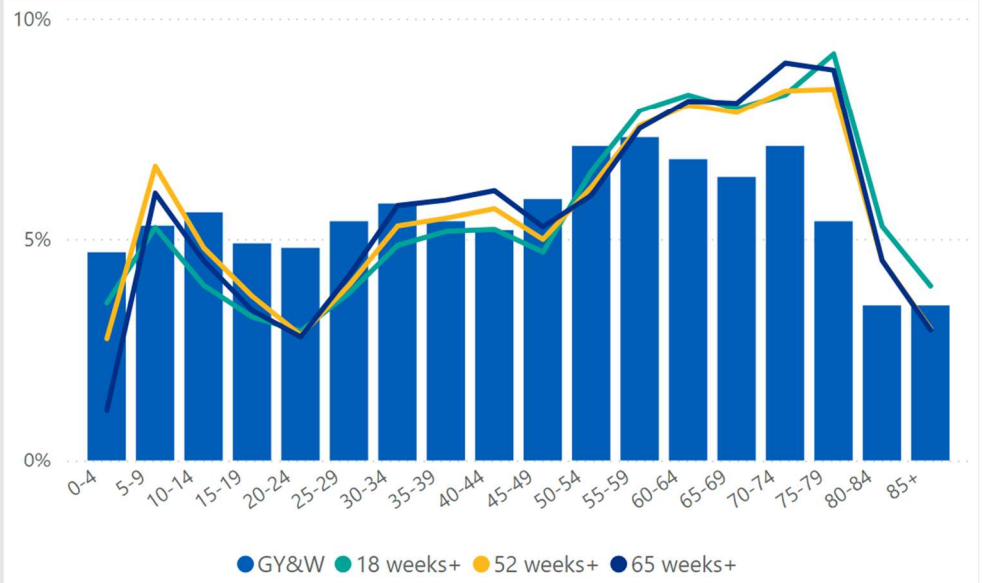
When comparing the age profile of the waiting list compared to the population of GY&W, there are some significant differences, with patients over 60 representing 43% of the list, whilst only making up 33% of the population. There are slight differences in the distribution for the long waiters, with children aged 5-9 increasing as a percentage of the overall longer waiters.

Waiting List Profile by Ethnicity and weeks waiting





Waiting List Profile by Age and weeks waiting

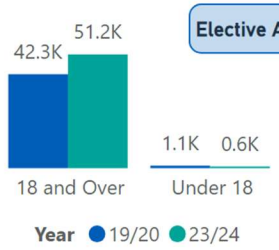


Health Inequalities 2023/24 - Elective Activity

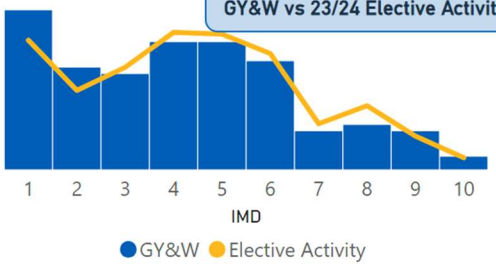
Information Services | NHS James Paget University Hospitals NHS Foundation Trust

Elective Activity Profile pre-pandemic compared to 2023/24 - overall activity and profile by decile - split by under/over 18

Elective Activity by age



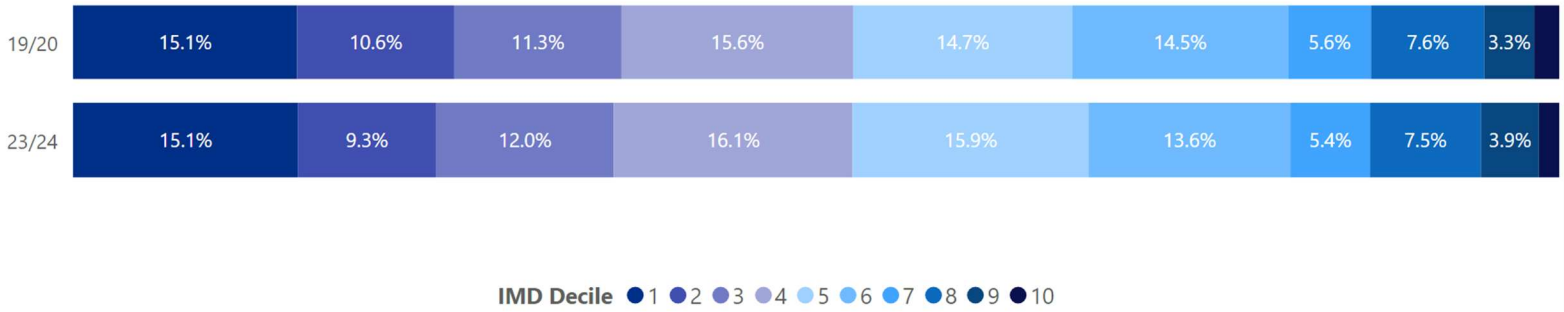
GY&W vs 23/24 Elective Activity



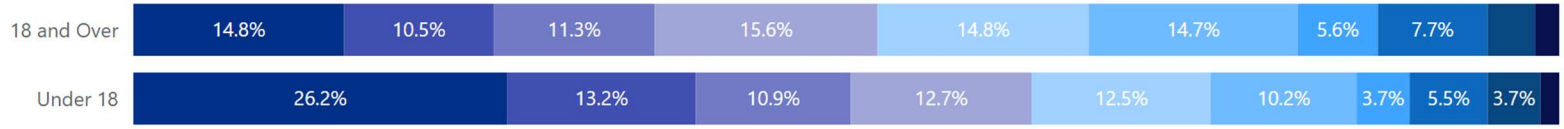
Elective Activity is higher overall in 2023/24 than pre-pandemic (2019/20) but there has not been a significant shift in the profile when looking at IMD groups (top right chart). The above profile suggests that there is an under-representation of the two lowest deciles in the activity profile compared to GY&W percentages.

The Under 18 profile to the right suggests that this is not the case for this smaller cohort - with the lower deciles over-represented, although the total number of under-18s is small and has reduced.

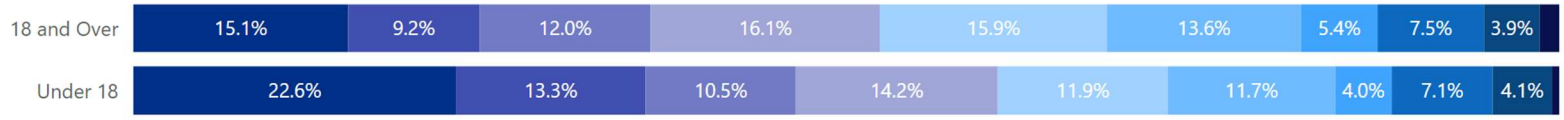
Pre-Pandemic vs 2023/24



2019/20



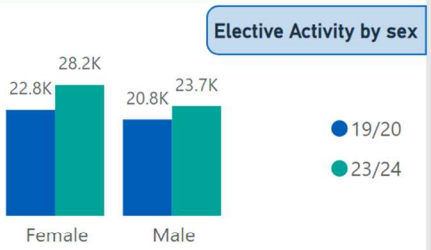
2023/24

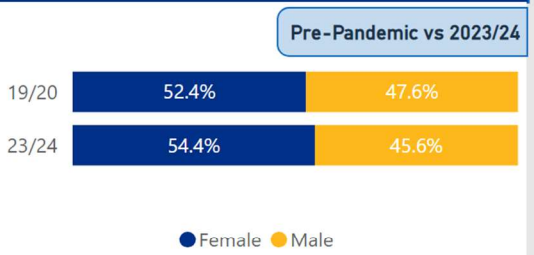


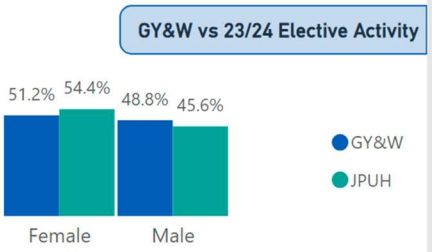
Health Inequalities 2023/24 - Elective Activity

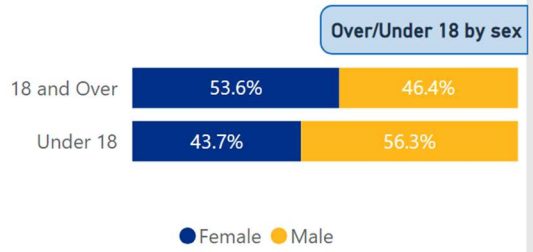
Information Services | NHS James Paget University Hospitals NHS Foundation Trust

Elective Activity Profile pre-pandemic compared to 2023/24 - Sex profile







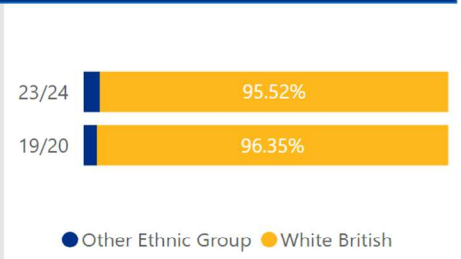


On the previous page, Elective Activity was shown to be higher in 2023/24 than pre-pandemic 2019/20 - when compared to the distribution of activity by sex, female activity has increased more than male, and this is also then reflected in a slight increase in the percentage of women undergoing elective activity in 2023/24. When split by over/under 18 however, there are more male patients than female. Women are also marginally over-represented when compared to the GY&W cohort.

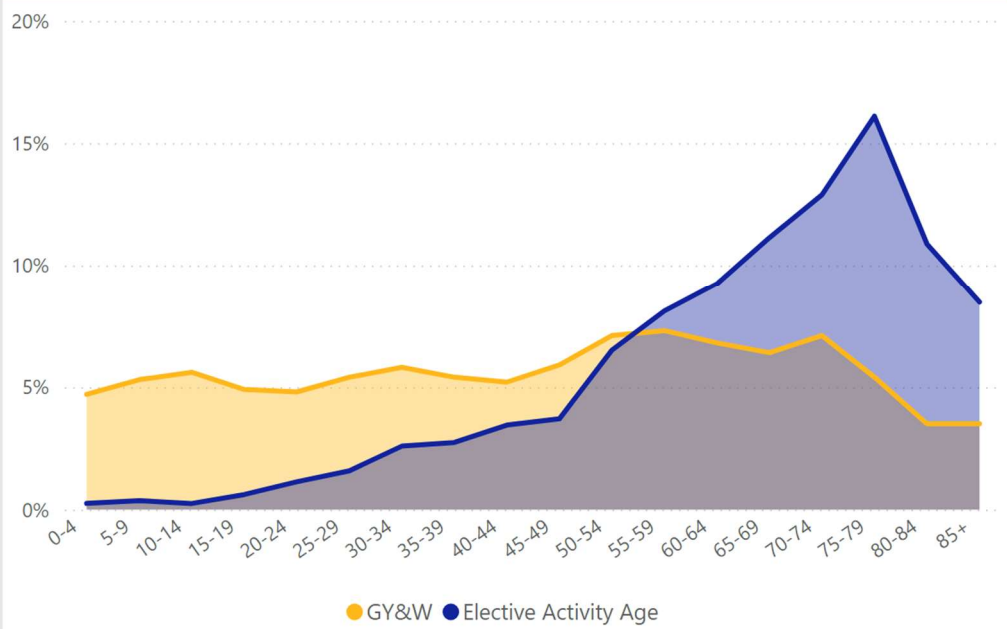
Ethnicity shows a largely consistent profile, with a marginal increase in the overall numbers from other ethnic groups alongside a larger increase in the numerically dominant white British grouping. Overall, the profile matches that for GY&W as a whole.

The chart to the right compares the profile of age bands across GY&W with the distribution of Elective Activity in 23/24. There is a marked difference in profile, reflective of the greater need for elective services in older cohorts.

Elective Activity Profile pre-pandemic compared to 2023/24 - Ethnicity profile



Elective Activity Age profile 2023/24



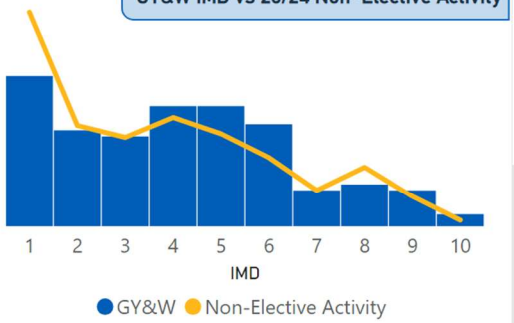
Health Inequalities 2023/24 - Children's Health

Information Services

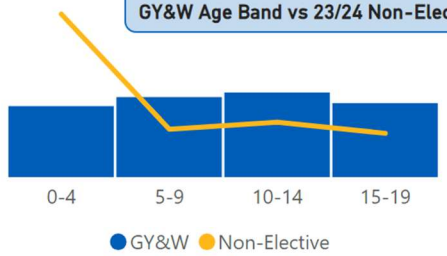
NHS James Paget University Hospitals NHS Foundation Trust

Non-Elective Activity Profile for under 18s

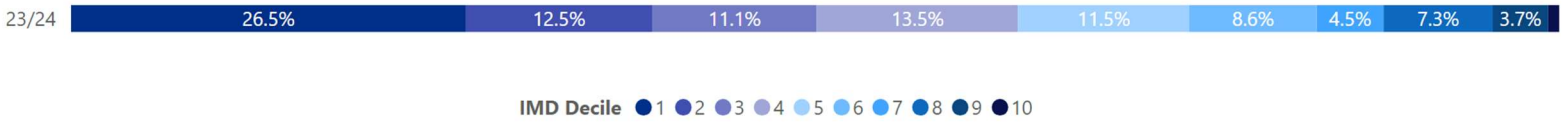
GY&W IMD vs 23/24 Non-Elective Activity



GY&W Age Band vs 23/24 Non-Elective



Non-Elective Activity split by Decile

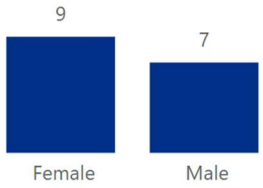


IMD Decile 1 2 3 4 5 6 7 8 9 10

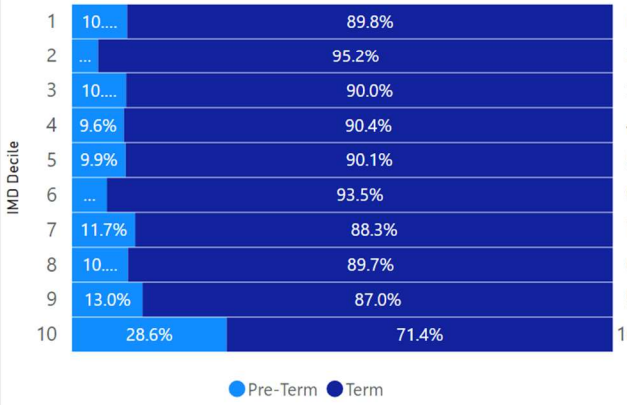
The metrics on this page concern children's health - to the left and above, the distribution of non-elective admissions for under 18 year olds in 23/24 by IMD decile. The data indicates that we see a disproportionate percentage of children admitted as emergency patients from the lowest decile and also the youngest age group of 0-4. The metric concerning tooth extractions for the under-10 age group does not contain enough patients for analysis, but does suggest that the Trust does not see a significant number of children for this procedure.

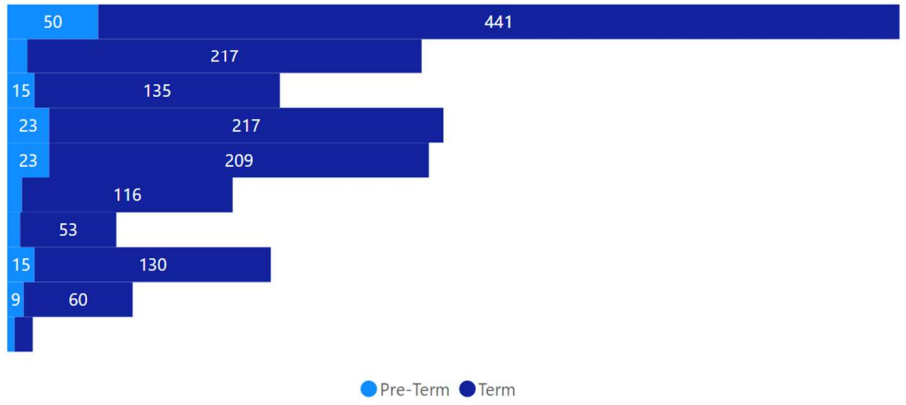
The charts below show the percentage of pre-term births for 23/24 - overall the Trust sees a higher percentage of pre-term births (9.4%) than the national average for England and Wales (7.6% in 2022) but the percentage by decile does not appear to be increased for any one group (the high % for decile 10 is related to the small number of births in this decile).

Tooth extractions for under 10s



Pre-term (<37 weeks gestation) births by IMD Decile - % of total and number

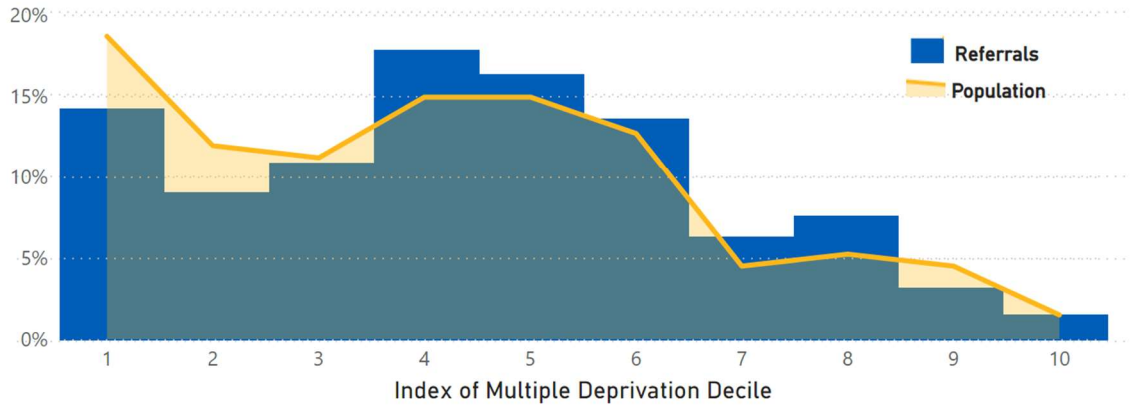




Health Inequalities 2023/24 - Cancer Referrals

Information Services | NHS James Paget University Hospitals NHS Foundation Trust

Referrals for Cancer Profile by IMD decile

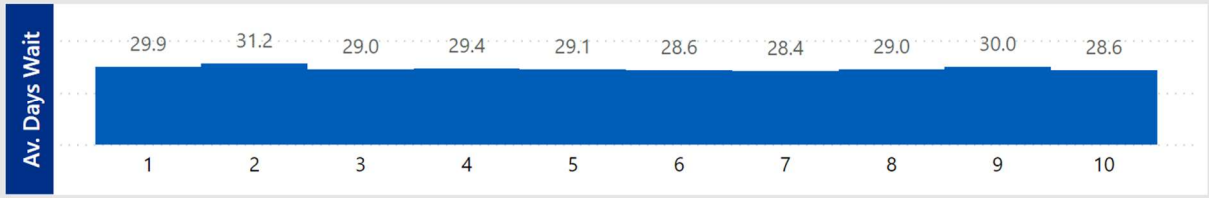


IMD	Population	Patients
1	18.66%	14.13%
2	11.94%	9.01%
3	11.19%	10.81%
4	14.93%	17.66%
5	14.93%	16.18%
6	12.69%	13.53%
7	4.48%	6.29%
8	5.22%	7.57%
9	4.48%	3.20%
10	1.49%	1.60%

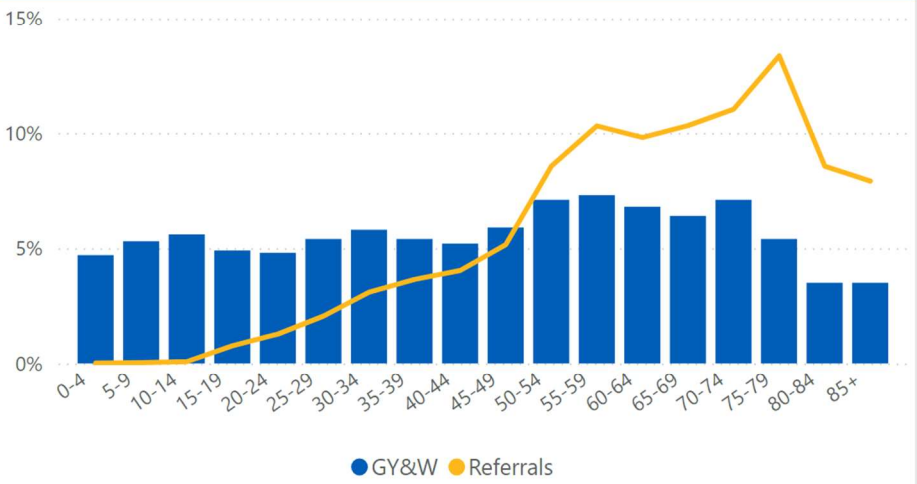
Comparing the profile of cancer referrals with the profile of IMD for GY&W, there are noticeably smaller referral cohorts in the first two deciles, with higher numbers in the 4th, 5th and 8th deciles. There was minimal variation between deciles when looking at average days between referral and diagnosis (28-31 days).

Splitting the referrals by sex reveals that a majority of referrals are for women, with the percentage split falling above the local demographic male/female split.

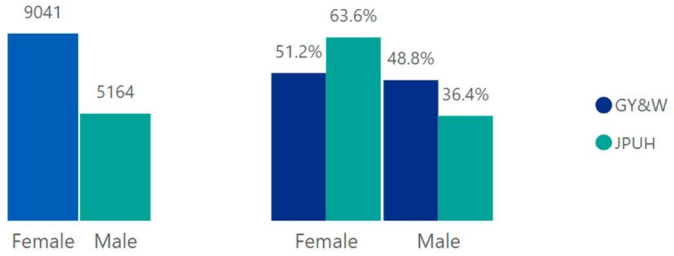
Age Band analysis shows that older cohorts are over-represented in the referral profile as might be expected. However other ethnic groups are under-represented.



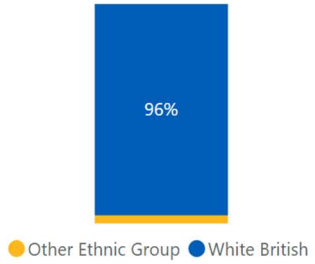
Referrals for Cancer Profile by Age Band



Treatment for Cancer Profile by Sex



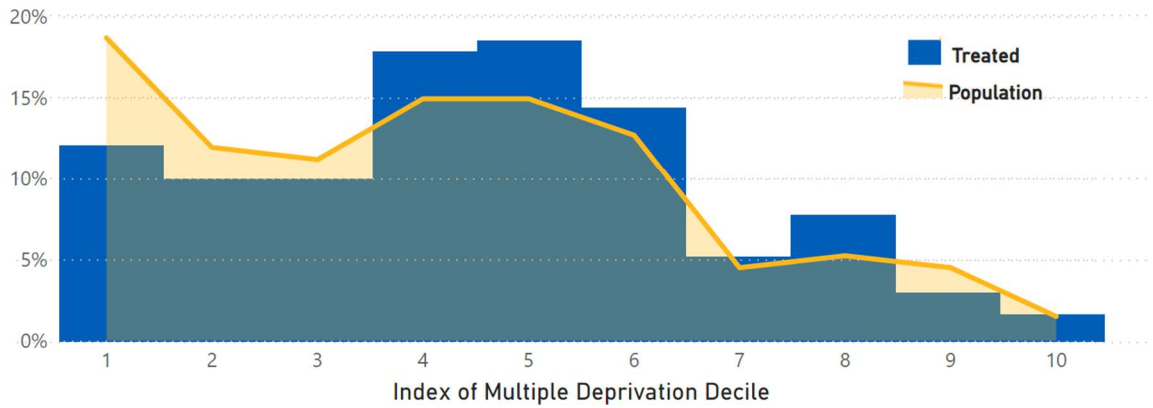
Cancer Profile by Ethnicity



Health Inequalities 2023/24 - Cancer Treatment

Information Services | NHS James Paget University Hospitals NHS Foundation Trust

Treatment for Cancer Profile by IMD decile

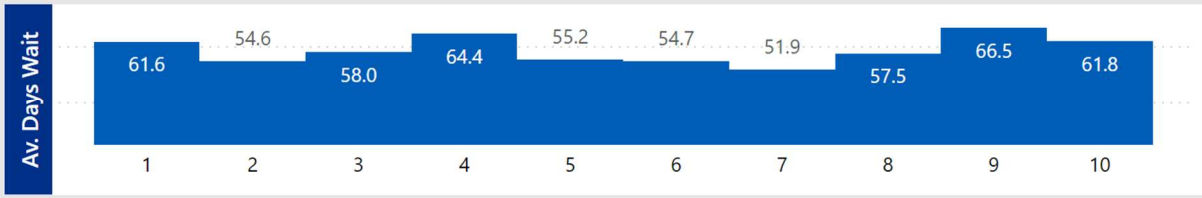


IMD	Population	Treated
1	18.66%	12.02%
2	11.94%	9.96%
3	11.19%	9.96%
4	14.93%	17.74%
5	14.93%	18.43%
6	12.69%	14.31%
7	4.48%	5.21%
8	5.22%	7.73%
9	4.48%	2.98%
10	1.49%	1.66%

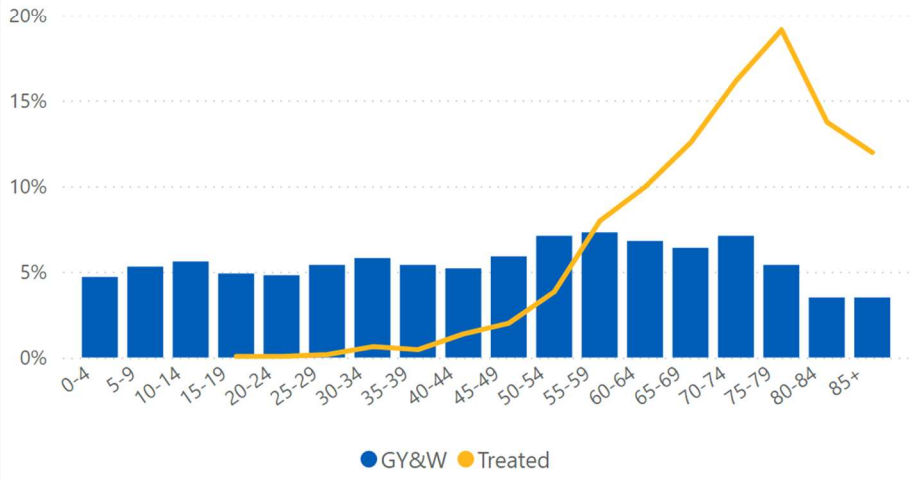
Cancer referrals that are converted to treatment are covered on this page. Age and IMD profiles are understandably similar to those on the referrals page. Average days wait to commencement of treatment is more variable (51 - 64 days) but does not correlate with referral volume and the majority sit at or below the 62 day target on average.

Sex profiles indicate that, although referrals for women are approaching double that for men, in terms of treatment, men outnumber women and the % profiles between GY&W and JPUH are more aligned.

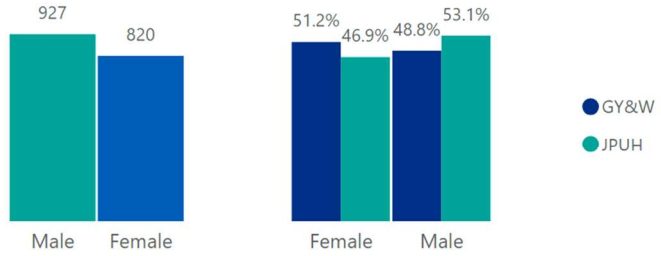
Treatment by Ethnicity mirrors the referral percentages.



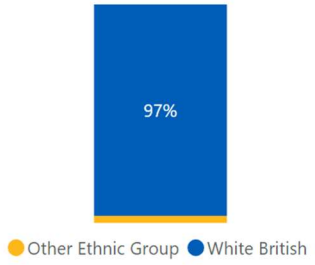
Treatment for Cancer Profile by Age Band



Treatment for Cancer Profile by Sex



Cancer Profile by Ethnicity



Collaboration – across the acute hospitals and in our locality

The three acute trusts in Norfolk and Waveney – the James Paget, Norfolk and Norwich, and Queen Elizabeth King's Lynn - continue to work together to enhance the services we provide, delivering shared priorities and aiming to deliver sustainable acute services.

The Norfolk and Waveney Acute Hospitals Collaborative (N&WAHC) has representatives from each Board of Directors of the three acute hospitals who attend regular meetings to take joint decisions on future strategy and development of acute services. The N&WAHC has confirmed its priorities as leading on the development of an Acute Clinical Strategy and implementation of the Single Electronic Patient Record, both of which require a transformational approach to change and aligning underpinning strategic enablers, including digital solutions.

In addition, the Collaborative will oversee the implementation of major acute capital projects, such as Community Diagnostic Centres, and the Norfolk & Waveney Integrated Care System's improvements to hospital discharge processes through the 'Improving Lives Together Programme'

Following the approval of the Acute Clinical Ambitions an acute clinical strategy is being developed that strives to deliver consistent patient pathways and greater resilience of acute services through close working by our clinical teams across the three hospitals. This will align to the Norfolk and Waveney Integrated Care System (ICS) Clinical Strategy and clearly identify the opportunities for integration with our system partners including primary care and community services.

The three organisations remain distinct, and each Trust's Board of Directors is accountable to its local population and will continue to lead its own organisation.

The collaborative work the Trust is fully engaged in extends to the work of the Great Yarmouth & Waveney Place Board. The Trust's Deputy Chief Executive chairs the Place Board which has representation from all key local stakeholders including local government, primary care, and community providers. With shared objectives agreed, and based upon the needs of the local community, the work undertaken by the Place Board will enable local delivery to flex to meet local need and support the delivery, at a local level, of the Norfolk & Waveney Integrated Care Partnership Strategy.

The Place Board is now well established and is chaired by the Trust's Deputy Chief Executive. The Board has a clear set of objectives that are being delivered by local partners and in support of the two Health & Wellbeing Partnerships.

Norfolk and Waveney Integrated Care System

The Norfolk & Waveney Integrated Care System has three overarching goals:

1. **To make sure that people can live as healthy a life as possible**. This means preventing avoidable illness and tackling the root causes of poor health. We know the health and wellbeing of people living in some parts of Norfolk and Waveney is significantly poorer and how healthy you are should not depend on where you live. This is something we must change.
2. **To make sure that you only have to tell your story once**. Too often people have to explain to different health and care professionals what has happened in their lives, why they need help, the health conditions they have and which medication they are on. Services have to work better together.

3. **To make Norfolk and Waveney the best place to work in health and care**. Having the best staff, and supporting them to work well together, will improve the working lives of our staff, and mean people get high quality, personalised and compassionate care.

We have fully participated in shaping how the ICS in Norfolk and Waveney will function with local delivery partnerships being pivotal. We have collaborated with partners to develop approaches where we can deliver, collaboratively, the best for our local population. An overview of what the Great Yarmouth and Waveney Place Board has achieved can be viewed here: https://www.jpaget.nhs.uk/news-media/news-events/2023-news/december/great-yarmouth-waveney-place-board-update/

Sustainability

Task force on climate-related financial disclosures (TCFD)

NHS England's NHS foundation trust annual reporting manual has adopted a phased approach to incorporating the TCFD recommended disclosures as part of sustainability yearly reporting requirements for NHS bodies, stemming from HM Treasury's TCFD aligned disclosure guidance for public sector annual reports. TCFD recommended disclosures will be implemented in sustainability reporting requirements on a phased basis up to the 2025/26 financial year. The phased approach incorporates the disclosure requirements of the governance pillar for 2023/24 and the key summary disclosures are provided below in relation to oversight, assessment and management of climate related issues at the Trust.

Oversight, assessment and management of climate related issues

The Trust's dedication to sustainability is not just a plan, but a testament to our commitment. Our efforts to decarbonise the James Paget Estate and report on climate-related issues, through the Trust Green Plan, are a clear demonstration of this. This progress is not a mere formality, but a testament to our dedication. It is formally reported annually to the Trust Board of Directors and monitored through the Sustainability Group on a monthly basis, the Finance and Performance Committee by exception on a Bi-monthly basis and six monthly into the Hospital Management Group.

Green Plan Progress

The Trust's Green Plan update report consists of thirty-four actions against which progress is reported. Aligned to the Norfolk and Waveney ICS objectives and the UN sustainable goals, the actions are spread across ten focus areas. Management assesses the plans and considers:

- The progress made and the ability to increase or accelerate agreed actions
- New initiatives generated by staff or partner organisations
- Advancements in technology and other enablers; and
- The increase in ambition and breadth of national carbon reduction initiatives and targets

The Trust's Green Plan progress report 2023/24 provides a comprehensive and detailed progress update on our overarching net zero ambitions and climate-related issues. The Green Plan is not just a document, but a living strategy that is further consolidated into Norfolk and Waveney ICS system-wide strategies. The Trust's progress is not just shared internally, but also formally reported to the relevant regional Greener NHS team by "The Greener NHS data collection" on a quarterly basis and NHSE digital by the "The Greener NHS Transport data collection" on an annual collection. This extensive reporting ensures that all relevant entities are kept informed and involved in our sustainability journey.

You can read further detail about progress towards our Green Plan here: https://www.jpaget.nhs.uk/media/725809/Annual-Green-Plan-and-Sustainability-Progress-Report-2023-to-2024.pdf

Overseas operations

There were no overseas operations during 2023/24.

Going concern

The principle of ‘going concern’ is a fundamental presumption in accounting, suggesting that an organisation will have the capacity to remain operational long enough to fulfil its commitments, obligations, and goals; the assumption is that the organisation will not be obligated to halt its operations in the immediate future.

However, there is no automatic application of the ‘going concern’ status for NHS Foundation Trusts. Instead, the directors make a yearly determination on whether it is suitable to draft the Trust’s financial statements based on this principle.

During this evaluation, the Board considers future anticipated operations and cash flow projections, taking guidance from the Government Financial Reporting Manual. The manual suggests that the expected continuation of a service in the future, typically demonstrated by allocated funding for that service in publicly available documents, provides adequate ‘going concern’ evidence.

The Board of Directors has been regularly updated on the financial plans of the Trust by the Chief Finance Officer and the Finance and Performance Committee. The Audit Committee also reviewed the Trust’s position in relation to going concern at its meeting held in February 2024, where it considered continuation of service and financial sustainability in reaching its recommendation to the Board to adopt the going concern basis in preparing the Financial Statements. This is consistent with the Group Accounting Manual 2022/23 which makes explicit reference to the Going Concern basis of preparing the accounts and is the primary source of reference for the Board in making the Going Concern assumption. The relevant sentence from the guidance states that the anticipated continuation of the provision of a service in the future, as evidenced by inclusion of financial provision for that service in published documents, is normally sufficient evidence of going concern.

The Board has agreed expenditure budgets for 2023/24 and this forms the basis of the Trust’s financial plan. The financial plan includes block contract income, which is reflected in a contract with the commissioner, and provides the Trust with revenue stability for the period ahead.

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

Jo Segasby

Chief Executive and Accounting Officer
27 June 2024

Directors' report – accountability

The Directors are responsible for preparing of the Annual Report and Accounts in accordance with the applicable reporting standards contained in HM Treasury's Financial Reporting Manual (the FReM) and NHS England's Foundation Trust Annual Reporting Manual (the FRAM).

The Directors consider the annual report and accounts, taken as a whole, are fair, balanced, and understandable and provide the information necessary for patients, regulators, and other stakeholders to assess the NHS foundation trust's performance, business model and strategy.

Role of the Trust Board of Directors

The Trust is governed by a Board of Directors (the Board) which is vested with several key functions to ensure the effective and efficient operation of the Trust. The Board is accountable to its stakeholders through a Council of Governors which is representative of the communities the hospital serves.

The Board's primary role and functions include:

- **Strategic Planning:** The Board is responsible for developing and setting the strategic direction of the Trust. The Board works closely with the Trust's Council of Governors and the executive team to understand the local healthcare needs, establish goals, and determine how best to achieve these goals within the existing financial constraints.

- **Performance Monitoring:** The Board monitors and evaluates the performance of the Trust against its strategic objectives. The Board ensures quality of care, patient safety, financial performance, and operational efficiency, among other key performance indicators.

- **Risk Management:** The Board is responsible for overseeing the management of risks to the Trust. They ensure that robust systems are in place for risk assessment and management and holds the executive team to account for the effectiveness of these systems.

- **Governance and Compliance:** The Board ensures that the Trust complies with the relevant legal and regulatory requirements and adheres to best practice in corporate governance. The Board develops policy statements setting the parameters for the policies and procedures developed by the executive to guide and control the Trust's operations and procedures. This policy-setting is a key element of the system of risk management and internal control.

- **Financial Stewardship:** The Board has a duty to ensure the financial sustainability of the Trust. It oversees the budget, monitors expenditure, and ensures the proper use of the Trust's funds.

- **Leadership and Culture:** The Board is responsible for setting the tone at the top, promoting a culture of transparency, accountability, and patient-centred care. It also plays a crucial role in leadership development and succession planning for the Trust.

- **Stakeholder Engagement:** The Board represents the Trust to external stakeholders, including the public, patients, employees, regulators, and other NHS bodies. It ensures that the Trust maintains a good relationship with these stakeholders, communicates effectively with them, and takes their views into account in decision-making.

- **Appointment and Evaluation of Senior Management:** The Board has responsibility for selecting and appointing senior managers, including the Chief Executive, other executive directors, and the Trust Secretary. This is a critical role as the quality of the Trust's leadership impacts its success and is conducted on behalf of the Board by the Nomination and Remuneration Committee.

Foundation Trust Boards are comprised of both Executive Directors (who are part of the Trust's management) and Non-executive Directors (who are independent of the Trust's management). This structure helps to balance the need for effective management with the need for separation of duties and the independent oversight and scrutiny of the work of the executive. The Non-executive Directors are appointed by the Council of Governors, the statutory body which represents the interests of stakeholders, including patients and the public in general. The Council of Governors holds the Non-executive Directors to account for the performance of the Board. The Non-executive Directors in turn appoint the Chief Executive and other Executive Directors.

The Chair of the Trust is one of the Non-executive Directors appointed by the Governors to lead both the Board and the Council of Governors, ensuring that the Board and Governors work together and remain focused on the quality and sustainability of patient care. The Board and Council of Governors are supported by a Trust Secretary who advises the directors on matters of governance, and ensures the Trust remains compliant with applicable legislation, and maintains records of the Governors' and Directors' deliberations and decision-making.

To ensure the Board discharges all the duties assigned to it throughout the financial and reporting year, it maintains a comprehensive schedule of matters to be transacted, both for the Board and its Committees. This forward plan includes a schedule of Board Development Seminars designed to develop the Board's capacity and capability to lead and oversee the operation of the Trust.

The Board and its Committees use a range of reports to monitor and steer the direction, performance, compliance, and quality of the Trust's service provision.

These reports include the Integrated Performance Report (IPR) which contains Key Performance Indicators derived from the deliverable objectives set by the Board, and a Board Assurance Framework Report which is used to document the risks associated with the Board's strategic objectives. More detail on the Board Assurance Framework Report is contained in the Annual Governance Statement in the Financial Statements.

Board meetings

The Board meets every second month throughout the year and reviews are conducted on behalf of the Board by the Committees monthly. The majority of meetings are conducted using virtual meeting facilities. This has enhanced the quality of meetings of the unitary

Board by enabling the maximum attendance possible, despite otherwise insurmountable geographic limitations.

Board engagement with patients, carers, families, and staff

The Board's focus on patients and staff is supported by several initiatives, including Non-executive Director walk-arounds and the regular Patient Experience and Ward-to-Board engagement forums. These have proven invaluable in staying closely in touch with staff needs. The Board meets in private with patients, carers, and family member to hear first-hand their experience of the hospital's services and how staff engage with them. Likewise, the Board regularly visits a department in the hospital in small groups and engages in conversation with staff to hear candidly about their working conditions, challenges, achievements, and things that make them proud. These two engagement exercises enable the directors to compare information from various sources to conduct their own 'triangulation' of evidence when testing assurances. They are also demonstrable indicators to the Board's dedication to compassionate leadership in support of their well-led programme. Details regarding the Trust's most recent rating by the Care Quality Commission (CQC) can be found on page 41.

Reciprocal mentoring for inclusion

In all appointments made to the Board we seek to be fully inclusive to enable adequate representation from the community that we serve.

The programme of reciprocal mentoring which was paused during the COVID-19 pandemic has been rekindled. Guidance has been refreshed setting out the benefits of participation. It is for each mentoring pair to discuss and agree the arrangements for their mentoring sessions. An agreement sets out the expectations, the limits such as the confidentiality of the relationship, feedback to each other and how that will work and the way in which concerns will be raised and resolved. The Board's People and Culture Committee conduct monitoring of this programme.

Members of the Trust Board of Directors

Membership of the Board is as follows:

Board Members	
	**Mark Friend - Chair** Appointed as Chair of Board of Directors from 1 October 2023 Mark has been a Non-Executive Director at community and mental health provider Northeast London NHS Foundation Trust since 2015, where he was appointed as Senior Independent Director in 2018 and has chaired the Finance and Investment Committee since 2020. Mark's background is in media, strategy and digital, working for the BBC since 1997, most recently as Controller of Digital Services, BBC Radio & Education from 2007 to 2019. He is also currently Non-Executive Director and Chair of the Audit Committee at the Provide Community Interest Company, a Trustee of the Artis Foundation since 2018, and a Trustee of the National Centre for Circus Arts since 2022.
	**Joanne Segasby - Chief Executive** Appointed as Chief Executive from 25 April 2022 A registered nurse, Jo has worked in the NHS for over 25 years, conducting clinical work in Accident and Emergency and Critical Care, at Ipswich, Addenbrooke's and the Norfolk & Norwich University Hospitals. She has held managerial roles in Cancer Services, as General Manager in Women and Children's Services and was Operational Director for Surgery at the Norfolk & Norwich University Hospital from 2014. Jo joined the James Paget team in October 2018 as Associate Chief Operating Officer and was Acting Chief Operating Officer from 1 April 2019. She became Chief Operating Officer from 1 July 2019 and secured the role of Chief Executive in Spring 2022.
	**Jonathan Barber - Deputy Chief Executive** Appointed as Director of Strategy & Transformation February 2018; permanent role from 1 March 2019. Appointed as Deputy Chief Executive 1 March 2023. Jon has worked at the hospital since 2014, initially as a joint appointment with the Great Yarmouth and Waveney CCG. Jon previously held senior management roles in both local and central government and holds an MBA in public sector management. Jonathan has held a number of other non-executive positions.
	**Paul Morris – Chief Nurse** Appointed April 2020 Paul is a registered nurse who has worked in the NHS for 20 years. He has worked in several organisations across both Suffolk and Norfolk including Acute Trusts and Public Health England. Most Paul's nursing practice has been in emergency medicine, in a variety of roles from Registered Nurse to Lead Nurse and then Senior Matron.
	**Vivek Chitre – Chief Medical Officer** Appointed August 2022. Previously Deputy Medical Director. Vivek has been a Consultant Surgeon at the James Paget University Hospital since 2004, specialising in upper gastrointestinal and laparoscopic surgery. He held several management positions along the way, including Clinical Lead and Clinical Director. He is an assessor of the MRCS surgical examinations, and Patron of the Norwich Undergraduate Surgical Society.
	**Ed Taylor - Chief Finance Officer** Appointed April 2021 Ed started working at the James Paget in 2000, initially as a Management Accountant. After taking several roles within the Finance team, Ed became Deputy Director of Finance in 2014, and then Associate Director of Finance in July 2019, taking responsibility as Executive Lead for Digital. As a graduate from the University of East Anglia, Ed's early career prior to joining the NHS was in private practice working with small business accounts and audit, during which time he also qualified as a member of the Association of Chartered Certificated Accountants. Ed has now joined the Board as a voting member.
	**Nigel Kee - Chief Operating Officer** Appointed as Interim Chief Operating Officer from April 2022, permanent role from August 2022. Nigel has a nursing background and has a wealth of board level experience across acute, community and mental health services.

Mark Flynn - Director of Strategic Projects (non-voting)

Appointed as an Executive Director April 2014

Mark has worked at the hospital since 2007 initially as Deputy Director of Finance and then as Director of Finance from 2014 until 31 March 2021. Mark was appointed as Director of Strategic Projects in April 2021, reflecting the projects in the hospital and his strategic estates leadership across the Norfolk and Waveney system. He previously held senior finance roles within the social housing sector, with over 25 years finance experience gained in both the public and private sectors. Mark is a Fellow Chartered Certificated Accountant (FCCA) and is also a member of the Association of Accounting Technicians (MAAT).

Sarah Goldie – Director of People and Culture (non-voting)

Appointed as Interim Director October 2021, permanent role from December 2021

Sarah is a Chartered Fellow of the Chartered Institute of Personnel and Development. She has more than 20 years' experience as a Human Resources (HR) professional in the NHS. Prior to joining the James Paget Hospital in 2021, she spent twelve years leading HR and organisational development at a mental health trust. Sarah's role is to implement our People and Culture Strategy to ensure that our organisation has a compassionate, supportive, and inclusive culture, to make it an attractive place to work and enable staff to deliver the highest standards of care.

Dr Sarah Whiteman - Non-executive Director

Sarah joined the Trust as a Non-executive Director in October 2023.

Dr Sarah Whiteman is a GP by background and currently works as the Chief Medical Director for the Bedfordshire, Luton, and Milton Keynes Integrated Care Board.

She has had a portfolio career that has encompassed work with the General Medical Council, Health Education England, and the States of Jersey as their Primary Care Medical Director. In addition, she has been a Trustee of Willen Hospice in Milton Keynes and the Jersey Alzheimer's Association.

Stephen Javes –Non-executive Director and Senior Independent Director (SID)

Appointed by the Council of Governors for his first three-year term of office from 1 January 2019 until 31 December 2021. Reappointed for a second three-year term from 1 January 2022 to 31 December 2024.

Stephen was Chief Executive of the Orwell Housing Group for 27 years until September 2018, setting strategy, policy, and the tone of the business. His oversight sought to ensure that solutions were found to care for people in an ever more challenging world and with an ageing population. Stephen brings a range of skills and a wealth of experience into this non-executive role having served on many private and public Boards and is the current Chair of the Lowestoft Places Board.

Caitlin Notley - Non-executive Director

Professor Caitlin Notley was appointed as a Non-executive director in October 2022 in a link role with the Norwich Medical School, University of East Anglia.

Caitlin leads the Addiction Research Group, producing high quality multidisciplinary research evidence to impact people who are affected by addiction, emphasising responsiveness to social, cultural, and pressing health needs amongst disadvantaged groups. Caitlin currently leads research projects funded by The National Institute for Health Research, Cancer Research UK, and the Medical Research Council. She is also Director of the Citizen's Academy - coordinating patient and public involvement across medicine and health teaching and research.

Sally Collier - Non-executive Director

Sally joined the Trust as a Non-executive Director in July 2023. She has had an extensive career in the Civil Service, most recently as Head of Place for the Civil Service Cabinet Office in the East of England.

Sally was the first Chief Executive of the Crown Commercial Service between 2014 and 2016 and worked as the Chief Regulator and Chief Executive of Ofqual, a non-ministerial department reporting to Parliament, between 2016 and 2020.

John Hennessey - Non-executive Director

Appointed by the Council of Governors in January 2021 for a three-year term of office, John began his second term of office in January 2024.

John grew up in Minnesota in the USA before moving to the UK in 1990. He worked for business consultancy Deloitte before joining the NHS in 1993. He was an NHS Finance Director for 24 years, working at several London-based organisations including Great Ormond Street Hospital. His last NHS post was at the Norfolk and Norwich University Hospital where he was Chief Financial Officer from 2018-20 as well as the Norfolk and Waveney STP Finance Director.

Susanne Lindqvist - Non-executive Director

Professor Susanne Lindqvist was appointed Non-executive Director in February 2023.

Susanne is Associate Dean for Learning and Teaching Quality at the FMH, UEA. In this role, she works closely with Teaching Directors and staff in the School of Medicine and the School of Health Sciences to achieve teaching excellence and help implement the UEA and FMH strategies that aim to optimise students' and staffs' experience.

	Susanne is Director for the Centre for Interprofessional Practice and leads the development and delivery of a range of educational interventions, locally, nationally, and internationally, with the ultimate purpose of improving interprofessional collaborative practice. She is a practicing coach, supporting academic and clinical leaders unlock their potential.

Board changes during the year

The following changes to the Board's membership occurred in the reported financial year.

- Chair Anna Davidson completed her second three-year term of office on 31 April 2023 and was replaced by Non-executive Director Stephen Javes as Interim Chair for the provisional period 01 May 2023 to 30 September 2023
- Non-executive Director Professor David Scott left the Trust on 30 September 2023
- Non-Executive Director Karen Knight left the Trust on 31 December 2023
- Sally Collier was appointed as a Non-executive Director with effect from 24 July 2023
- Mark Friend was appointed as the Chair with effect from 01 October 2023
- Sarah Whiteman was appointed as a Non-executive Director with effect from 01 October 2023

Board changes after year-end

- Chief Operating Officer Nigel Kee retired on 30 April 2024, and following a competitive selection process Charlotte Dillaway was appointed to the role of Chief Operating Officer with effect from 28 May 2024.

Directors' interests

The Board has an established Conflicts of Interest and Hospitality policy in accordance with national guidance. On appointment, new Board members complete a declaration with any changes during the year declared to the Trust Secretary and are formally minuted at the next Board meeting. This declaration includes signing up to the Board's Code of Conduct and forms part of the annual review of the CQC's Fit and Proper Person Requirement for Directors, with the Chair reviewing the evidence for all Board members. Further details are available from the Trust Secretary on request.

The Audit Committee continues its oversight including declarations of interests, gifts, and hospitality, with reviews of policy effectiveness. The register is published in the public domain here: https://www.jpaget.nhs.uk/about-us/declarations-of-interest/

Non-executive director independence

In accordance with the Code of Governance for NHS Provider Trusts is a new code that came into effect on April 1, 2023, replacing the previous NHS Foundation Trust Code of Governance from 2014, the Chair must meet the independence criteria which are set out in the Trust's Constitution and this element of compliance is ensured during the recruitment process.

Non-executive Directors serve a maximum of two three-year terms of office. These may be extended on an annual basis should there be exceptional circumstances as set out in the Trust Constitution and must be approved and reviewed by the Council of Governors.

The Board of Directors has confirmed that all current Non-executive Directors remain within the accepted definition of "independent."

Committees of the Trust Board of Directors

The Board has established the 'statutory' Committees required by legislation. The Executive Nominations and Remuneration Committee, and the Audit and Assurance Committee each discharge the duties set out in the Foundation Trust Constitution.

The Board has chosen to deploy three additional Committees to augment its monitoring, scrutiny, and oversight functions, particularly with respect to people, culture, quality (patient safety, clinical outcomes, and patient experience), finance, performance, and major projects. These are the Patient Safety and Quality Committee, the Finance and Performance Committee, and the People and Culture Committee.

Statutory committees

Committees required by statute or regulation.

Executive Nominations and Remuneration Committee

The purpose of the Executive Nominations and Remuneration Committee is to conduct the formal appointment to, and removal from office of Executive Directors of the Trust, other than the Chief Executive who is appointed or removed by the Non-executive Directors subject to approval by the Council of Governors. The Committee also considers succession planning for Executive Directors, considering the challenges and opportunities facing the Trust, and the skills and expertise that will be needed on the Board of Directors in the future.

The Trust is also required to appoint a Remuneration Committee in accordance with Schedule 7 of the NHS Act 2006 (paragraph 18(2)), Schedule 1 of the Constitution, and the Code of Governance.

The Executive Nominations and Remuneration Committee fulfils the dual purpose of nomination and remuneration of Executive Directors. It decides the remuneration, allowances, and other terms and conditions of office of the Executive Directors and reviews the suitability of structures of remuneration for senior managers.

Audit Committee

The Audit Committee works in parallel with the Patient Safety and Quality Committee to provide the Board with two perspectives on similar or related data, allowing for comparison or 'triangulation' in considering due processes as well as tangible patient outcomes.

Terms of Reference for both committees are available on the Trust's website. The Audit Committee consists entirely of Non-executive Directors and reviews the effectiveness of systems of governance, risk management, and internal control across the whole of the Trust's activities. The Patient Safety and Quality Committee reviews the actions being taken by the Trust to ensure the on-going maintenance of standards of quality of care, and improvements where necessary in the patient experience and clinical efficacy.

During 2023/24 the Audit Committee reviewed the adequacy of:

- risk- and control-related disclosure statements, together with any accompanying Head of Internal Audit Opinion statement, external audit opinion or other appropriate independent assurances, prior to endorsement by the Board;
- underlying assurance processes that indicate the degree of the achievement of corporate objectives, the effectiveness of the management of principal risks, the controls in place and the appropriateness of the disclosure statements;

- policies for ensuring compliance with relevant regulatory, legal and code of conduct requirements; and,
- policies and procedures for work related to fraud and corruption as set out in Secretary of State Directions and as required by the Counter Fraud and Security Management Service.

The Committee sought reports and assurances from Directors and managers as appropriate, concentrating on the over-arching systems of governance, risk management, and internal control, together with indicators of their effectiveness.

The Audit Committee assess the effectiveness of the external audit process through reports from the external auditors direct to the Committee, and through a formal management report on the work and annual review. A meeting also takes place after the end of the annual audit to reflect on the work undertaken, involving the Committee Chair, Chief Finance Officer, and external audit representatives.

The External Auditor provision of non-audit services policy was reviewed this year. KPMG did not provide any non-audit services during the year.

Membership and attendance at the Audit Committee is set out below. Internal and external auditors and the Local Counter Fraud Specialist also attend meetings.

The Chair of the Committee submitted a report to the Board following each meeting, highlighting any issues requiring disclosure to the Board.

Audit Committee Chair's opinion: In support of the Chief Executive's responsibilities as Accountable Officer for the Trust, the Audit Committee has examined the adequacy of systems of governance, risk management, and internal control at the Trust. The Committee has formed the opinion that:

- There is a generally adequate framework of control in place to provide reasonable assurance of the achievement of objectives and management of risk;
- Assurances received are sufficiently accurate, dependable, and comprehensive to meet the Accountable Officer's needs and to provide reasonable assurance;
- Governance, risk management, and internal control arrangements at the Trust include elements of exemplary practice. There are some areas in which on-going attention to the control environment is required;
- Financial controls are sufficient to provide reasonable assurance against material misstatement or loss;
- The quality of both Internal Audit and External Audit over the past year has been satisfactory.

The Committee discharged its role through the year as follows:

- reviewed the establishment and maintenance of an effective system of governance, risk management and internal control across the whole of the Trust's activities (both clinical and non-clinical)
- ensured that there was an effective internal audit function established by management that meets mandatory NHS Internal Audit Standards and provides appropriate independent assurance to the Committee. The Committee reviewed and approved the internal audit strategy, ensuring that it was consistent with the audit needs of the organisation as identified by the Assurance Framework. We considered the major findings of internal audit's work (and

management's response). The Internal Auditor had unrestricted access to the chair of the Committee for confidential discussion

- reviewed the work and findings of the external auditor and considered the implications and management's response to their work. The External Auditor had unrestricted access to the chair of the committee for confidential discussion
- reviewed the Annual Report and financial statements before submission to the Board
- ensured the Standing Financial Instructions were maintained and kept up to date, with an annual review of instances where exceptions to the rules were made
- reviewed the findings of other significant assurance functions, both internal and external to the organisation, and considered the implications to the governance of the Trust. This included a regular report from the NHS Counter Fraud Service

The Chair of the Committee submitted a report to the Board following each meeting, highlighting any issues requiring disclosure to the Board.

Non-statutory committees

The Board deployed non-statutory Committees to extend its monitoring, oversight, review processes.

Patient Safety and Quality Committee

The Board established the Patient Safety and Quality Committee to monitor independently and objectively, review and report on the suitability and efficacy of the Trust's provisions for ensuring the quality of services provided by the Trust (quality governance, including patient experience, patient safety, and clinical effectiveness).

The Committee tests on behalf of the Board, evidence, and assurance that an appropriate and effective system of quality governance and clinical risk management is in place to ensure that care is provided in accordance with applicable legislation, regulation, standards, and guidance. In this regard, the Committee takes into consideration the essential standards of quality (as determined by Care Quality Commission's registration requirements), and national targets and indicators as determined by the Single Assessment Framework.

The Committee reviews the outcomes associated with clinical services and patient experience and, the suitability and implementation of risk mitigation plans regarding their potential impact on patient experience and outcomes. The Committee is also required, as directed by the Board from time to time, to consider issues relating to quality where the Board focuses an additional level of scrutiny on a particular subject.

The Chair of the Committee submitted a report to the Board following each meeting, highlighting any issues requiring disclosure to the Board.

Finance and Performance Committee

The purpose of the Finance and Performance Committee is to gain assurance and report independently and objectively on the suitability and efficacy of the Trust's provisions for ensuring that:

- The Trust's performance and finances are aligned to the Board approved Trust Strategy
- Systems for financial and performance management are robust and effective

- Financial and performance metrics and priorities are built from reliable sources of information and support the organisation to deliver its strategic ambitions and objectives
- Risks to delivery of targets and standards are being managed and that action taken will result in the intended outcomes
- Assets are safeguarded, waste or inefficiency are avoided, and that value for money is continuously sought
- Monitoring is sufficient to meet the Care Quality Commission's Use of Resources requirements. This includes the Trust's finances, workforce, estates and facilities, technology, and procurement
- Robust systems and processes are in place for the effective management of key strategic projects across the Trust including:
    - New Hospital Plan Programme
    - Staff Residences
    - Diagnostic Assessment Centre
    - Electronic Patient Record
    - Reinforced Aerated Autoclave Concrete

The Committee evaluates evidence, and assurance that an appropriate and effective system of financial and performance management is in place to ensure that care is provided within the financial envelope provided and to the standards of performance required by the Board.

The Chair of the Committee submitted a report to the Board following each meeting, highlighting any issues requiring disclosure to the Board.

Committees in Common

The Board has also established a further committee known as the Committee in Common in collaboration with the two other acute hospital trusts in Norfolk and Waveney. The Committees in Common meet on a regular basis to enhance co-ordination and efficiency in services across the acute hospital sector. The Trust is represented at meetings of these Committees in Common by the Chair, a Non-executive Director, Chief Executive, and the Director of Strategy and Transformation (Deputy Chief Executive).

Performance of the Board and Board Committees

In 2023, the Trust commissioned its scheduled 5-yearly independent review of Corporate Governance.

The Paget appointed the Good Governance Improvement (GGI) to undertake the review using the CQC Well Led Framework as a basis. The Trust incorporated seven additional indicators that demonstrate how a well led and governed NHS Foundation Trust plays their part in an Integrated Care System:

- Effectiveness of board-level decision making
- Compassionate and visible leadership
- Staff wellbeing and support mechanisms
- Promotion of integration of Equality, Diversity, and Inclusion throughout the organisation
- Progress of plans concerning sustainability

- Partnership initiatives and collaborative relationships
- Effectiveness of system led collaboration

The GGI's analysis used the eight key lines of enquiry (KLoEs) from the Well-Led Framework to provide the logic for an assessment of current and future dynamics for the Trust.

The review was undertaken between September and December 2023 and followed the GGI's established methodology founded on the triangulation of evidence gathered through meeting observations, interviews, focus groups, and document reviews.

The GGI noted that since the previous well-led review, the trust has had to respond to the pandemic and to the ever-increasing pressure on NHS services. There have also been significant changes in the NHS with the Health and Care Act 2022 bringing new challenges and opportunities to work with other organisations across the health and care system.

The GGI report incorporates perspectives and findings from external stakeholder interviews, exploring the views of the trust's key collaborators and partners in Norfolk and Waveney Integrated Care System (ICS).

The review concluded James Paget was seen by those they spoke to as a "good organisation which is well run with strong compassionate leadership and a clear focus on operational delivery." It identified a positive culture and good governance systems.

Membership and attendance for the Board and Committees

Board of Directors meetings in public

Member Name	Title	02/06/23	30/06/23	28/07/23	29/09/23	27/10/23	01/12/23	26/01/24	05/04/24
Mark Friend	Trust Chair					Y	Y	Y	Y
David Scott	Senior Independent Director	Y	Y	Y	Y				
Joanne Segasby	Chief Executive	Y	Y	Y	Y	Y	Y	Y	Y
Jon Barber	Deputy Chief Executive	Y	Y	Y	Y	Y	Y	Y	Y
Vivek Chitre	Chief Medical Officer	N	Y	Y	Y	Y	Y	Y	Y
Mark Flynn	Director of Strategic Projects	N	Y	Y	Y	N	Y	Y	N
Sarah Goldie	Director of People and Culture	Y	Y	Y	Y	Y	Y	Y	Y
Nigel Kee	Chief Operating Officer	Y	Y	Y	Y	N	Y	Y	Y
Paul Morris	Chief Nurse	Y	Y	Y	Y	Y	Y	Y	Y
Edmund Taylor	Chief Finance Officer	Y	Y	Y	Y	Y	Y	Y	Y
John Hennessey	Non- executive Director	Y	Y	Y	Y	Y	Y	Y	Y

Stephen Javes	**Non- executive Director**	Y	Y	Y	Y	Y	Y	N	Y
Karen Knight	**Non- executive Director**	Y	Y	Y	Y	Y	Y		
Caitlin Notley	**Non- executive Director**	Y	Y	N	Y	Y	Y	Y	Y
Susanne Lindqvist	**Non- executive Director**	Y	Y	Y	Y	Y	Y	Y	Y
Sally Collier	**Non- executive Director**			Y	Y	Y	Y	Y	N
Sarah Whiteman	**Non- executive Director**					N	N	Y	Y

Executive Nomination and Remuneration Committee meetings

Member Name	Title	01/12/2023	26/01/24
Mark Friend	Trust Chair	Y (C)	Y (C)
John Hennessey	Non-executive Director	Y	Y
Stephen Javes	Senior Independent Director	Y	N
Karen Knight	Non-executive Director	Y	
Caitlin Notley	Non-executive Director	Y	Y
Sally Collier	Non-executive Director	Y	Y
Susanne Lindqvist	Non-executive Director	Y	Y
Sarah Whiteman	Non-executive Director	N	Y

Audit Committee meetings

Member Name	Title	20/4/2023	14/06/2023	20/07/2023	21/09/2023	23/11/23	22/02/24
David Scott	Senior Independent Director	Y	Y	Y	Y		
Karen Knight	Non-executive Director	N	Y	Y	Y	Y	
John Hennessey	Non-executive Director	Y (C)	Y (C)	Y (C)	Y (C)	Y (C)	Y
Caitlin Notley	Non-executive Director					Y	N

Induction, appraisal, and performance reviews

The Chair ensures that new Directors and Governors receive a comprehensive, formal, and tailored induction on joining the Board of Directors or Council of Governors. The induction programme was reviewed and re-issued by the Trust Secretary during 2023, ensuring it stayed current and reflected the most recent movements in legislation, regulation, and Board governance practices. Members of the Board undertake a mandatory training using the training programmes provided through the Electronic Staff Record.

Individual annual appraisals, including performance reviews take place once the Board has approved the Trust's Strategic objectives. This sequence ensures that all Board members focus on achieving the strategic ambitions and objectives of the Board and their performance doing so for the previous year is

assessed for any opportunities for learning and development. Appraisals are used to agree individual and shared objectives and to complete the annual Fit and Proper Person assessment for Board members.

In accordance with the NHS Foundation Trust Code of Governance, appraisals were conducted for each of the members of the Board. The Chair was appraised by the Non-executive Directors on behalf of the Council of Governors, led by the Senior Independent Director.

The Non-executive Directors were then appraised by the Chair in collaboration with the Lead Governor. The Chair then appraised the Chief Executive who in turn appraised each of the Executive Directors and the Trust Secretary.

Shared learning arising from appraisals is used in part to formulate topics for Board Development provided through the annual programme of Board Development Seminars. The information is also used for succession planning.

The Council of Governors

The role of the Council of Governors

The Council is chaired by the Chair of the Trust who is also the Chair of the Board of Directors. The role of the Council is described in the Trust Constitution, with clear processes in place to ensure information is available to Governors when they need it and that they are consulted and updated on strategic matters.

The Council of Governors plays a role in ensuring that the Trust operates in the best interests of patients, staff, and the local community. It is responsible for representing the interests of Trust members and partnering organisations, and it acts as an additional conduit from the public, represented by governors, and the Board of Directors through formal and informal channels of communication.

The Council of Governors performs several statutory duties:

Appointment and Removal of Non-executive Directors: The Council appoints and, where necessary, removes non-executive directors, including the Chair of the Board. It also decides the terms and conditions of these appointments, such as remuneration.

Approval of Significant Transactions: The Council of Governors has a statutory duty to approve significant transactions, such as mergers, acquisitions, or large-scale investments. It is required to approve any amendments to the Trust's Constitution.

Strategic Planning: While the Board of Directors is responsible for operational decisions, the Council of Governors must be involved in discussions about the strategic direction of the Trust. The Board considers the views of the Council when preparing the Trust's strategy and forward plans.

Annual Reports and Accounts: The Council of Governors has the duty to receive the annual accounts, any report of the auditor, and the annual report.

Appointment of Auditors: The Council of Governors appoints, removes, and determines the terms of engagement of the NHS foundation trust's auditor.

Governance: The Council of Governors also holds the non-executive directors individually and collectively to account for the performance of the Board of Directors and represents the interests of the members of the Trust and the public as a whole.

By fulfilling these statutory duties, the Council of Governors plays a vital role in ensuring the transparency, accountability, and effectiveness of an NHS Foundation Trust.

Members of the Board of Directors attend the Council meetings during the year. The Director of Strategy and Transformation attends to ensure that Governors are informed and engaged in strategic discussions so that the views of our members and local people can be taken into account. Debate includes the future of our services and the work of the N&WHG, reviewing Trust objectives prior to Board approval.

Non-executive Directors present reports to the Council at each meeting, providing a briefing on the activities of their committees. This process continues to be welcomed by Governors, enabling them to seek clarification and probe matters of accountability with the Non-executive Directors.

The Lead Governor, Ian Clayton is appointed for a term ending on 31 August 2024. The role is vital for representing the views of the Council and ensuring that regulatory requirements for a Lead Governor are met. The Chair and Trust Secretary meet with the Lead Governor at least monthly to agree and plan future activities including governor development and engagement activities.

Our Foundation Trust members

Anyone living in the catchment area covered by the Trust can become a member of the Public Constituency if they are aged sixteen or over; our staff are automatically members unless they choose to opt out. There is a section available on the Trust's website and membership information is displayed in the hospital, with clear contact details. We have an e-form, hard copy and a form focused on young people.

Those eligible to become a member of the Public Constituency have previously been required to live within Norfolk and Suffolk, with a preference for those living in Great Yarmouth and Waveney. An amendment to the Trust Constitution in January 2022 extended the Public Constituency to include the Rest of England.

The Council of Governors' work on membership is fully integrated with wider Trust communications and engagement with our patients, carers, and the general public. As at 31 March 2024, the staff membership is 4,782, with the public membership at 6,145, giving a total of 10,927. This is the same as last year's figure of 10,923. Both Staff and Public membership have stayed around the same level.

The Trust's membership strategy has been included into the Board's revised engagement strategy for 2023-28 and is implemented with the support of the Patient Experience and Communications and Engagement teams.

Governor training and development

Governors are provided with formal induction at the start of their time in office and receive targeted further training from time to time. A Council of Governors' Code of Conduct is in place providing support to all Governors on the requirements of the role including The Seven Principles of Public Life, also known as the Nolan Principles. All Council members are required to sign and abide by the Code as part of the election process or when new Appointed Governors join the Council. The Code also provides procedures for governors to declare any gifts, hospitality, and interests.

Governor development seminars are conducted regularly to focus on current and future matters of interest and capability. The seminars are also used to engage governors in formulating strategy with the Board.

Membership of the Council of Governors

The Council consists of 19 Governors, five appointed, ten elected by the public membership, and four elected by our staff.

Governors standing for the Staff or Public Constituency are elected by the process set out in the Trust's Constitution, using the single transferable vote system, for a three-year term of office.

Governor elections

The Board of Directors hosted a governor election in 2024 to refresh the membership of the Council, and particularly to fill the vacancies created by the departure of several members of the Council.

Changes in year

The following departures from the Council of Governors have occurred in the reporting year:

- Mary Rudd – May 2023
- Penny Carpenter – July 2023
- John Watt – September 2023
- Mike Ninnmey – November 2023

New elected and Appointed Governors

- David Beavan – November 2023
- Jose Bamonde – December 2023
- Maria Grimmer – December 2023
- Kevin Jordan – December 2023
- Peter Hargrave – December 2023
- Gordon Sewell – December 2023

Governors' Nomination & Remuneration Committee

The Committee appointed Stephen Javes, Interim Chair and Mark Friend, Trust Chair along with two Non-executive Directors, Sally Collier, and Dr Sarah Whiteman. These were all approved by the Council of Governors. John Hennessey, Non-executive Director was re-appointed.

Each appointment is made in line with the Council approved selection process. This is initially for a three-year term of office. In relation to reappointments for a further three-year term, this is presented to the Committee and the Council of Governors for approval. It relies on the latest performance assessment of an individual and an overview of their achievements in their first term of office.

Committee membership and attendance for the six meetings held this year is set out below:

Membership and attendance at meetings of the Council of Governors and Committees

Council of Governors meetings

Name	Title	15/6/2023	12/7/2023	14/09/2023	15/11/2023	10/01/2024	13/03/2024
Mark Friend	Trust Chair				Y	Y	Y
Stephen Javes	Interim Chair	Y	Y	Y			
Ian Clayton	Lead Governor	Y	Y	Y	Y	Y	Y
Tony Goldson	Public Governor	N	Y	Y	Y	Y	N
Luis Tavares	Public Governor	Y	Y	Y	N	Y	N
Stuart Everett	Public Governor	Y	N	Y	Y	Y	Y
John Watt	Public Governor	N	Y	N			
Sheena McBain	Public Governor	Y	Y	N	Y	Y	N
Jose Bamonde	Public Governor					Y	Y
Peter Hargrave	Public Governor					Y	Y
Maria Grimmer	Public Governor					Y	Y
Kevin Jordan	Public Governor					Y	Y
Gordon Sewell	Public Governor					N	N
Devender Khurana	Staff Governor	Y	N	N	N	N	N
Harry Hicks	Staff Governor	Y	Y	Y	Y	N	N
Ali Guenaoui	Staff Governor	Y	Y	N	Y	Y	N
Yvonne Hacon	Staff Governor	N	Y	N	N	N	N
Emma Flaxman-Taylor	Appointed Governor	Y	Y	N	Y	N	Y
James Reeder	Appointed Governor	N	Y	N	Y	Y	Y
Mike Ninnmey	Appointed Governor			Y			

Penny Carpenter	Appointed Governor	N	N				
David Beavan	Appointed Governor					Y	Y

Governors' Nomination and Remuneration Committee meetings

Member Name	Title	11/05/2023	01/11/2023	04/03/2024
Mark Friend	Trust Chair		Y (C)	Y (C)
Ian Clayton	Lead Governor	Y (C)	Y	Y
Emma Flaxman-Taylor	Appointed Governor	Y	Y	N
James Reeder	Appointed Governor	N/A	Y	N/A
John Watt	Public Governor	N		
Stuart Everett	Public Governor	Y	Y	Y
Luis Tavares	Public Governor	Y	Y	Y
Peter Hargrave	Public Governor			Y
Devender Khurana	Staff Governor	Y	N	N/A
Ali Guenaoui	Staff Governor	N	N	N
Harry Hicks	Staff Governor	N/A	N/A	Y


Appointed Governors (x4)
Councillor Emma Flaxman-Taylor
Great Yarmouth Borough Council
Councillor David Beavan
East Suffolk Council
Councillor James Reeder
Suffolk County Council
Councillor T.B.C.
Norfolk County Council
Public Governors (x10)
Ian Clayton (Lead Governor)
Sheena McBain
Stuart Everett
Tony Goldson
Luis Tavares
Peter Hargrave
Jose Bamonde
Maria Grimmer
Kevin Jordan
Gordon Sewell
Staff Governors (x4)
Yvonne Hacon
Devender Khurana
Ali Guenaoui
Harry Hicks

The Code of Governance for NHS Provider Trusts

The Code of Governance for NHS Provider Trusts (the Code) serves as a comprehensive guide to NHS Foundation Trusts should be governed. Like the UK Governance Code, it is adopted on a 'comply or explain' basis which means Boards can establish governance arrangements that reflect closely the principles and provisions set out in the Code or may chose equivalent provisions and explain their decision to do so, rather than following the Code as a checklist. This allows for Boards to exercise their own volition and demonstrate their accountability and responsibility in ways that suit the organisation they are entrusted to govern.

The Trust has remained compliant with the standards set out in the Code throughout the reporting year, with no developments that would constitute non-compliance with the Code. Additionally, the Trust has conducted a thorough review of Corporate Governance using the services of an independent assessor.

In accordance with the Code, the Directors consider the Annual Report and Accounts, taken as a whole, to be fair, balanced, and understandable and provides the information necessary for patients, the regulator, and stakeholders to assess the NHS Foundation Trust's performance, business model and strategy.

The Care Quality Commission Well-Led Framework

The most recent inspection undertaken by the CQC was in January 2023. More information regarding the Trust's CQC status can be read on page 41.

The independent review of corporate governance confirmed that the trust has in place a sound system of risk management and internal control with some exemplary areas highlighted.

Leadership Capacity and Capability: We have prioritised leadership development across the organisation, investing in training and development opportunities for our leaders at all levels. A robust recruitment process has been implemented to select leaders with the right skills, knowledge, and integrity, and we have taken steps towards strategic succession planning for key roles.

Vision and Strategy: We revised our Board's strategic priorities and ambitions to better reflect our commitment to high-quality, sustainable care. This strategic vision has been communicated to our staff, partners, and other stakeholders, and will be regularly reviewed and updated to ensure continued alignment with our goals.

Culture: We believe in an open, respectful, and positive culture and have implemented initiatives to foster this. We have also taken strong actions against any instances of bullying or discrimination and have made efforts to ensure patients and staff are treated with compassion, dignity, and respect at all times.

Governance and management: Our governance and management structures have been strengthened to assure the delivery of high-quality healthcare. With clear roles and responsibilities, regular Board meetings, and transparent reporting lines and accountability mechanisms, we have bolstered our commitment to sound governance.

Managing Risks, Issues, and Performance: We have established clear processes for identifying, understanding, and managing risks and issues. Performance data is consistently monitored and used to improve the quality of care. Regular audits and risk assessments are conducted, with findings actioned promptly and effectively.

Engaging and Involving People who use Services: We have made strides in including patients and their families in decisions about care and treatment. Mechanisms for capturing and acting on patient feedback have been strengthened, and we are actively working on involving patients, carers, and families in shaping services and strategies.

Engagement with Staff: Staff engagement has been a priority this year. We have taken measures to listen to feedback, address concerns, and create an environment where staff feel valued and empowered to provide the highest quality care.

Continuous Improvement and Innovation: A culture of continuous improvement and innovation has been cultivated within the trust. We have established a process for learning from incidents and near misses, sharing best practices, and supporting staff in developing and implementing new ideas.

We are proud of the progress we have made this year, but we are not complacent. We are fully committed to continuing our efforts to meet and exceed the CQC's Well-Led Framework and provide our patients with the exceptional care they deserve.

Patients at the centre

We are proud of the number of service improvements that have been possible during the last 12 months, as the hospital continues to innovate, collaborate with partners, and focus on patient needs as we emerge from the pandemic. Patients are always at the heart of what we do – and we value patient and stakeholder feedback to enable us to continue to improve.

In this section we have included an overview of our CQC ratings and recent inspections, and a selection of the changes we have made this year. Our performance against healthcare targets can be found within the Performance Report.

Care Quality Commission ratings

The Trust's most recent inspection from the Care Quality Commission (CQC) was of the hospital's maternity services, which took place on 10 January 2023. The inspection report was published on 31 May 2023.

Our Maternity Service was inspected against two of the five domains - safe and well-led - and was rated as 'inadequate' in both. Because of this, the overall rating for the James Paget's Maternity Service has fallen from 'good' to 'inadequate.' Following this outcome, the hospital's core services have been downgraded to 'Requires Improvement.' In spite of this outcome the Trust overall rating remains 'good'.

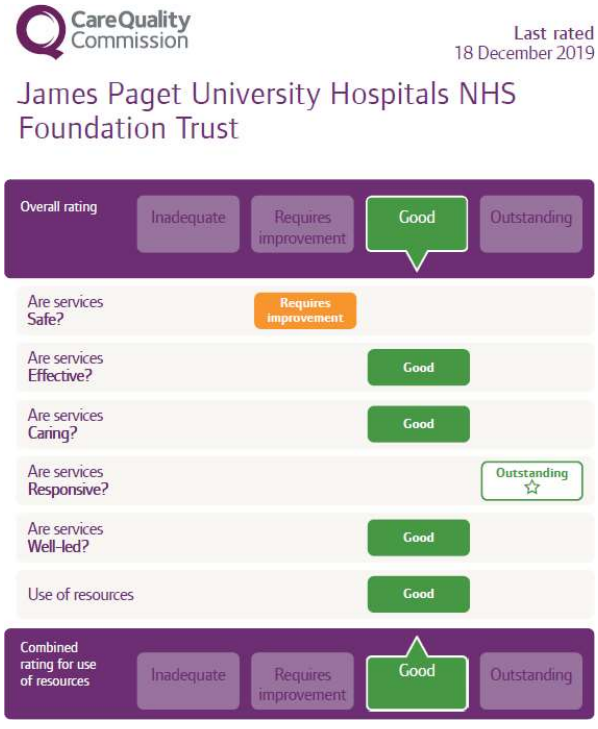
The Trust had anticipated this outcome, having received a Regulation Section 29A warning notice from the CQC regarding immediate concerns about maternity services in February 2023.

The full report outlines concerns regarding the staffing and training levels within the Trust's maternity services, the relationship between midwifery and obstetric staff, and reporting and governance arrangements within the service. Alongside the concerns raised by the CQC inspection, the report also recognised the work of the Eden Team within the Trust's maternity service, a team of three midwives who provide care to women with complex social needs and/or mental health issues, and high interest in clinical research within the service.

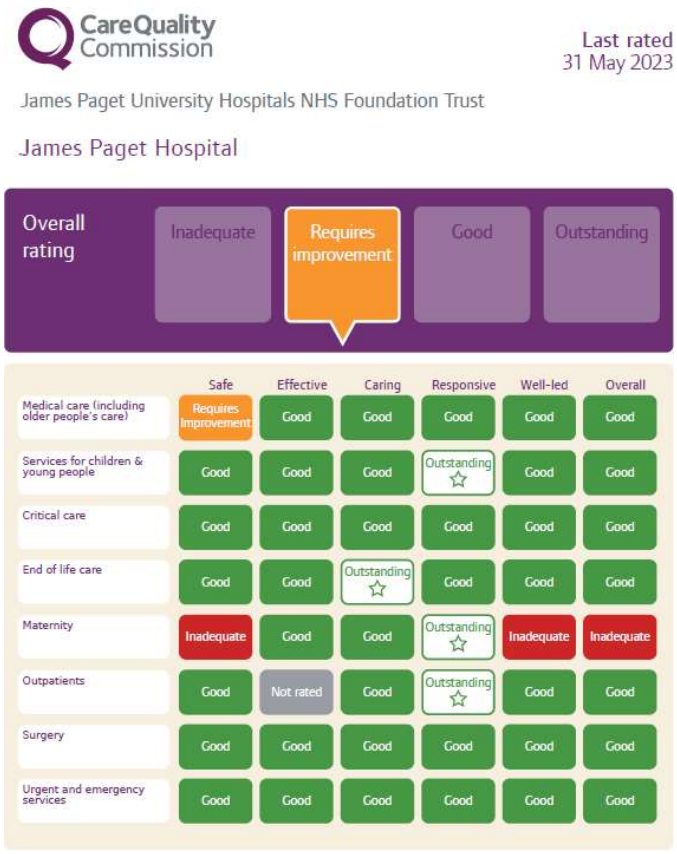
To achieve changes and rapid improvement to its services, the James Paget is implementing a comprehensive Maternity Improvement Plan. This incorporates the strategic and operational actions for maternity services in response to CQC findings and continued to work towards the recommendations and requirements outlined through the Ockenden Report of 2022.

Of the 92 actions for Trusts with maternity departments outlined in the report, the Trust has completed 74, with work towards the remaining 18 ongoing.

Trust Level Ratings



Core Service Level Ratings



Service improvements

Patient satisfaction surveys are conducted at local and national level. These enable us to develop our services based on patient feedback in terms of what works well and where improvements are required. Local patient surveys are registered with our clinical audit team to ensure they conform to the Trust format and progress through the necessary approval processes.

Here are some examples of improvements made to our services during the last year:

Innovative Concept Ward opens – The Chief Nursing Officer for England helped open an innovative ward at the James Paget which gives an insight into the way inpatient healthcare could be delivered in the future. The ward provides an opportunity for staff and patients to experience a modern healthcare environment across twenty single en-suite bedrooms in the ward, along with two four-bedded bays, and won the HSJ Healthcare Infrastructure Project of the Year at the HSJ Partnership Awards 2024.

Paget's A&E reviewed positively by patients - The biannual Urgent and Emergency Care Survey of patients using A&E departments has found that the James Paget is performing better than expected when compared with other Trusts across the country. The James Paget was rated 'better than expected' when compared with other trusts in six categories - waiting times; care and treatment; tests; hospital environment and facilities; leaving A&E and experience overall. The Trust was one of only two nationwide to achieve this overall rating.

Investment in new machines for the Renal Unit- Following significant capital investment, patients are receiving their dialysis via a fleet of 24 Fresenius machines which are more dependable, efficient, produce less waste - and, for staff, are easier to set up and operate. The project to install the machines has involved numerous departments from across the hospital, including finance, procurement, medical engineering, and the estates team, who oversaw the installation of a new pump and pipework system to deliver the treatment fluids required by the machines.

Young diabetes patients first to receive pioneering new insulin system - The James Paget University Hospital has become one of the first hospitals in the UK to use the Omnipod 5 for young patients with type 1 diabetes, with three young people among the first to get the new system, which automatically provides insulin when it is needed. The Insulin Delivery System is the first wearable, tubeless, hybrid closed loop system integrated with a Continuous Glucose Monitoring System to continuously adapt and automatically deliver basal insulin according to an individual's needs.

Paget receives Carer Friendly Tick Accreditation - The James Paget University Hospital has received the Carer Friendly Tick Accreditation in recognition of the support the team at the hospital provide to Carers and those they care for. The accreditation is awarded for having a named member of the team as a champion for carers, an agreement developed to help identify and support carers, covering issues relating to carers in staff training, displaying information about carers and projects that support them, and raising awareness in Carers Week, on Young Carers Action Day and on Carers Rights Day.

Research

- **Trust 'Out of Bed' Project receives international recognition**

A James Paget quality improvement programme – the Out Of Bed Project (OOBP), which aims to promote early mobilisation after hip fracture surgery – has been published in BMJ Open and is now reaching an international audience thanks to its innovative approach.

Initially set up by our team for Ward 6 patients at our hospital, the project saw the number of patients mobilised the day after their surgery increase dramatically – and this is linked to better outcomes for patients. Those not mobilised quickly after surgery are more likely to have issues related to post-operative confusion, pain, or low blood pressure.

A research paper on the OOBP submitted by Professional Lead for Physiotherapy Rene Gray along with Melissa Taylor and Ryan Bullock - 'The Orthopaedic Out Of Bed Project (OOBP): Improving early mobilisation following femoral fracture using a therapy-led education programme' - was accepted for publication earlier in the year and has now appeared online.

- **Paediatric Research team celebrate award win**

The Trust's Paediatric Research team won the National Institute for Health and Care Research (NIHR) Clinical Research Network (CRN) East of England Celebration Award 2023 for 'Breaking Boundaries'.

Nominations were invited in a number of categories with our team selected as finalists in the 'Breaking Boundaries' award. This highlights those that have shown initiative in collaborative working across teams and organisations to improve efficiency and patient experience.

The James Paget Paediatric Research team were judged as winners by the panel after a nomination which highlighted how the team played a key role in two ground-breaking research studies.

Improvements in patient/carer information

Social media forms a vital part of the Trust's communications, to disseminate important patient, carer, and staff information to ensure wide readership:

- The James Paget **Facebook** page (https://www.facebook.com/jamespagetuniversityhospital) is Liked by 17k people, and followed by 19k users

- The Trust **X (formerly Twitter)** account (@JamesPagetNHS) has 6.1k Followers
- James Paget's **LinkedIn** page (https://www.linkedin.com/company/james-paget-hospital) has 5.5k Followers
- The Trust's **Instagram** account (https://www.instagram.com/jamespagethospital/) has 1,510 Followers.

Information is also available on the **Trust website**: www.jpaget.nhs.uk

Complaints handling

Management of any complaints received are processed in line with the requirements set out in the NHS Complaints Procedure. All complaints received are acknowledged within three working days and initial contact is made by the Complaints Investigator, wherever possible, to discuss the detail and context. This enables a response timescale to be agreed - 45 working days for non-complex; 60 working days for complex - in discussion with the complainant.

Responding to complaints within the agreed period remains a challenge, whilst it has improved overall during the past year. Revised processes are in place to ensure performance is continually monitored and that any concerns with regards to timescales compliance are identified early.

There are five complaint-related KPIs which monitor performance, reported to the Patient Safety and Quality Committee and the Board on a monthly basis.

This year 189 formal complaints were received compared with 168 in 2021/22.

PALS - Patient Advice and Liaison Service

This service supports patients, relatives, carers, members of the public and staff who need information and advice about the health care system. PALS are pleased to help with any enquiry:

- Finding the information needed to answer questions
- Providing details about the services available within the hospital
- Resolving problems by identifying the right people to talk to
- Explaining what to do if a concern is unresolved
- Supporting staff to achieve resolution of enquiries
- Logging and sharing compliments received.

The team is still supporting COVID related enquiries, specifically signposting for vaccination queries.

There were 2,167 enquiries received compared to 1,963 the previous year. Over a third of our PALS contacts are compliments on the services we provide.

Public and patient Involvement activities

The Trust launched 'Paget's Patients: Our Patient and Public Engagement Plan for the next five years in October 2023, aligned to the Trust's five-year strategy.

The plan was developed in consultation with a range of stakeholders. The ambitions in the Plan are aligned to the Trust's Strategic Priorities 'Our Patients' as follows:

- Deliver the best and safest care for our patients
- Continuously improve patient experience
- Reduce health inequalities, ensuring equitable access for all
- Empower patient choice and personal responsibility for health

The full plan can be found on our website: jpaget.nhs.uk/media/700513/Patient-and-Public-Engagement-Plan-2023-to-2028.pdf

Stakeholder relations

We work within a wide network of stakeholders, including patient representatives and groups as part of our day-to-day operations and as a partner organisation within the Norfolk and Waveney ICS.

Over the last year, we have taken an active role in supporting discussions around the development of the ICS infrastructure locally, including helping to develop the 'Place' model for strategic and operational decision-making within the locality that the James Paget works in. This has strengthened relationships with health and care providers and local government and formed additional relationships with organisations and groups in the voluntary, community and social enterprise sectors (VCSE).

These emerging networks have supported development of our New Hospital Programme Strategic Outline Case, providing the opportunity to regularly engage with a wide range of stakeholders on the ongoing preparation of plans for our new hospital in the longer term. Through this work we have developed and maintained relationships with:

- **National stakeholders:** NHSE, Department of Health and Social Care, including the New Hospitals Programme (NHP) support team, and other NHS Trusts across England as part of the NHP cohorts
- **Regional stakeholders:** NHSE East of England team and the Clinical Senate
- **Norfolk and Waveney stakeholders:** , the Norfolk and Waveney ICS Partnership Board and related sub-groups and workstreams, Norfolk and Waveney ICB, Norfolk Health Overview and Scrutiny Committee, Suffolk Health Scrutiny Committee
- **Healthwatch Norfolk** delivered the 'Three Hospitals, Three Weeks' project, where they spent a week based at the James Paget gathering feedback from patients, carers, and employees across a range of service areas. The subsequent report provided recommendations both collectively for all three

hospitals in Norfolk and Waveney, and specific actions for the James Paget. The Trust's Patient Experience and Engagement team has led on developing and delivering a detailed action plan in response to the recommendations.

- **Healthwatch Norfolk and Healthwatch Suffolk** Chief Executives continue to meet with our Chair and Chief Executive to ensure that we support one another to enhance services for patients and local people in both Norfolk and the Waveney part of Suffolk.

- **Carers –** supporting the continued rollout of the Carer's Passport across Norfolk and Waveney.

Consultation with groups/other activities

A dedicated Service User Group is in place, which meets quarterly, and gives the opportunity for service users to comment on user feedback and offer support for any quality improvement initiatives from a patient perspective. Members have had the opportunity to be involved in the plans for the Diagnostic Assessment Centre and the Research and Quality Improvement scholarship programme.

The Together Against Cancer Group offers members the opportunity to provide feedback on services specific to cancer care, and initiate improvements to enhance the experiences of patients and their loved ones.

We work closely with our Health Overview and Scrutiny Committees in Norfolk and Suffolk, taking their advice on future items for consideration by the Committee, and providing information and support to their meetings.

Monthly Maternity Voices Partnership listening events are held online to support continued improvements in care for local people. Our Non-executive Director and Maternity Safety champion also meets regularly with the Partnership.

Financial disclosures

Cost allocation and charging guidance

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

Political donations

The Trust has made no political donations to any individual, body, or organisation during 2023/24 or 2022/23.

Better payment practice code

The Better Payment Practice Code requires that all valid invoices be paid by their due date or within 30 days of receipt. The Trust's performance against the code during the year, split between NHS and non-NHS suppliers, is shown in the table below.

Value of invoices paid	NHS			Non-NHS			Total		
	Total paid £'000	Paid in 30 days £'000	Paid in 30 days %	Total paid £'000	Paid in 30 days £'000	Paid in 30 days %	Total paid £'000	Paid in 30 days £'000	Paid in 30 days %
2023/24	14,831	11,063	75%	184,981	169,247	91%	199,812	180,311	90%
2022/23	14,346	8,263	58%	142,461	116,864	82%	156,807	125,128	82%

Number of invoices paid	NHS			Non-NHS			Total		
	Number paid	Number paid in 30 days	Number paid in 30 days %	Number paid	Number paid in 30 days	Number paid in 30 days %	Number paid	Number paid in 30 days	Number paid in 30 days %
2023/24	1,238	872	70%	56,364	49,731	88%	57,602	50,603	88%
2022/23	783	462	59%	49,684	41,731	84%	50,467	42,193	84%

Liability to pay interest

There was a liability to pay interest, by virtue of failing to pay invoices within the 30-day period where obligated to do so of £3k (2022/23 £1k).

Fees and charges (income generation)

The Trust does not levy any fees and charges raised under legislation, where the full cost exceeds £1 million, or where the service is otherwise material to the accounts. Full disclosure of other non-patient care income is included within note 4.2 of the financial statements.

Income disclosure

Under the requirements of Section 43(2A) of the NHS Act 2006 (as amended by the Health and Social Care Act 2012) the Trust can confirm that income from the provision of goods and services for the purpose of health services in England is greater than the income generated from the provision of goods and services for any other purpose.

Income to the Trust from non-NHS sources has a positive impact on the provision of goods and services for the purposes of the health service, as all income is used for the benefit of NHS patients.

Disclosure to the auditors

As far as the Directors are aware, there is no relevant audit information of which the Trust's auditors are unaware. The Directors have taken all the steps that they ought to have taken as Directors in order to

make themselves aware of any relevant audit information and to establish that the Trust's auditors are aware of that information.

Income and expenditure

The Trust reported a deficit of £19.3m for 2023/24 excluding the impact of consolidating its charitable funds (2022/23 deficit: £28.8m). This position includes within operating expenses an impairment charge of £18.6m (2022/23 charge: £2.8m) which, when excluded, leaves a deficit excluding impairments of £0.7m (2022/23 deficit: £26.0m). On a control total basis for 2023/24 the Trust reported a breakeven position (2022/23 deficit £24.9m).

Capital investments

Capital investments of **£51.0m** were made during 2023/24 as shown in the table below.

Capital Investments 2023/24	£'000	PDC funded £'000
Community Diagnostics Centre	12,567	12,567
Orthopaedic Elective Hub	11,478	11,478
RAAC	7,816	7,816
Diagnostic Assessment Centre	7,500	7,500
Digital Health Investments	3,587	1,242
New Hospital Programme	3,033	1,811
Equipment replacement	2,679	46
Estates Work	2,301	0
Total	**50,961**	**42,460**

Cash and financing

The Trust's non-consolidated cash position increased by £26.2m during 2023/24, with cash and cash equivalents of £34.6m held at 31 March 2024. Of the £51.0m of capital expenditure, £42.5m was funded through new Public Dividend Capital (PDC) issued to the Trust by the Department of Health and Social Care, relating to a variety of projects including Digital Maturity, RAAC, Orthopaedic Elective Hub (OEH), Diagnostic Assessment Centre (DAC), Community Diagnostics Centre (CDC) and New Hospital Programme (NHP). The OEH, DAC and CDC are multi-year schemes to be completed during 2024/25, the RAAC scheme is a multi-year scheme which commenced in 2020/21 with total PDC funded spend to 31 March 2024 of £28.9m. The NHP is a multi-year scheme which commenced during 2020/21 with spend to 31 March 2024 of £6.6m of which £5.3m has been funded through PDC.

The Trust has £3.1m of finance lease liabilities. The largest contracts include decontamination scopes and washers procured as part of the Endoscopy Decontamination refurbishment recorded in the accounts as a finance lease with a net liability of £0.8m as at 31 March 2024. The Trust also has finance lease contracts in place for Radiology equipment of £0.5m in total. There were new right of use asset and finance leases entered into during 2023/24 of £1.2m, the largest of which was for Health record scanners £0.4m.

Efficiencies and transformation

In 2023/24 the Trust's financial plan included an efficiency savings target of £16.1m. The Trust achieved savings during 2023/24 of £16.4m, of which £8.3m was non-recurrent and £8.1m was recurrent. The total of £16.4m represents 4.7% of the Trust's expenditure before efficiencies.

NHS Oversight Framework

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

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

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

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

Segmentation

During the entire year 2023/24 the Trust has been classified as in segment two and there has been no enforcement action taken. Current segmentation information for NHS trusts and foundation trusts is published on the NHSE website.

Norfolk and Waveney ICB was classified as Segment 3 in the most recently published information as at 4 March 2024. Norfolk and Waveney ICB was classified as in Segment 4 during 2023/24 but came out of the recovery support programme formerly known as special measures on 1 March 2024.

This segmentation information is the trust's position as at 27 June 2024. Current segmentation information for NHS trusts and foundation trusts is published on the NHS England website: https://www.england.nhs.uk/publication/nhs-system-oversight-framework-segmentation/.

Finance and use of resources (UoR)

The Trust was not subject to a CQC UoR assessment during 2023/24. The UoR assessment report published by the CQC in December 2020 is therefore the most current position. It rated the Trust as 'Good' following a full assessment by NHSE/I held in September 2020. This was an improvement on the 2018/19 'Requires Improvement' rating, and the first time that a combined Quality and Use of Resources rating was given.

Jo Segasby
Chief Executive and Accounting Officer 27 June 2024

Remuneration Report

Annual statement on remuneration

The Trust has two Committees dealing with Board pay and appointments, one for Executive Directors and the other for Non-executive Directors. Succession planning, appointments and remuneration are a key focus for each Committee. A senior member of the Workforce team and the Trust Secretary support both.

We are a Medium Trust with a turnover of over £200m. Executive salaries are confirmed in line with the published national lower, median, and upper quartile salaries for different roles. Non-executive salaries are aligned with national NHSE/I guidance published in September 2019 to ensure parity of remuneration across all Trusts. Executive and Senior Managers' remuneration is aligned with nationally agreed rates.

The level of remuneration for senior management in the Trust is assessed under the terms and conditions and pay arrangements for Agenda for Change staff. This involves a rigorous process of job evaluation to assess the banding level and associated pay scale and aligns to like positions with similar levels of job demands and responsibilities across the wider NHS.

Senior Managers Remuneration Policy

Our Remuneration Policy is focused on Board level positions. We use NHSE benchmark data and guidance as a basis for determining appropriate remuneration. Our policy sets out the principles considered when setting Board remuneration.

Executive Remuneration Policy

1.0 Policy statement

1.1 The relevant Committees agree this policy – Executive Nomination and Remuneration Committee for Executive Directors and Governors' Nomination and Remuneration Committee for Non-executive Directors.

2.0 Executive Directors

2.1 The remuneration policy for Executive Directors is set by the Executive Nomination & Remuneration Committee ('the EN&RC').

2.2 The policy applies to salaries of Executives whether engaged on a substantive or fixed term basis. It includes internal 'acting up' arrangements, secondments from other organisations and conversions from 'off payroll' interim arrangements to 'on payroll.'

2.3 Directors (notably the Chief Medical Officer) who by virtue of their qualifications and the requirements of the post are eligible to be on the standard NHS consultant contract will

be paid in accordance with the terms and conditions relevant to that contract subject to an additional management allowance for the Executive responsibilities, to be determined by the EN&RC.

2.4 The policy for setting the appropriate level of remuneration for Executive members is to pay a fair market rate, in line with current Secretary of State and NHSE guidance on Very Senior Manager (VSM) pay. The fair market rate will be assessed through annual benchmarking against the current published NHSE established pay rate information.

2.5 The exact salary is determined by the EN&RC based on the Trust's performance and the individual's contribution. The following principles, however, will be used as a guide to ensure fair pay in line with the Trust's commitments to equality, diversity, and inclusion. Protected characteristics, including (not exclusively) gender, age, ethnicity, sexual orientation, and disability will not be factors in determining salaries.

- In line with NHSE guidance, any pay increases on appointment should be limited to a maximum of 10% unless this is insufficient to raise the pay level to the lower quartile point of the relevant range.

- Executive salaries will exceed the highest Agenda for Change Band 9 pay point.

- Directors appointed to their first Executive position will ordinarily be appointed to the lower quartile of the relevant range, for review after their first year of appointment. The same will apply to first time Chief Executive appointments.

- Other than for Directors in their first Executive or Chief Executive position, appointments will ordinarily be in line with the median quartile of the relevant range, subject to individual circumstances. Appointments to the upper quartile will be considered on an exceptional basis and will take account of market availability of suitably capable candidates and the strengths of the candidate being considered.

2.6 The EN&RC will seek approval from NHSE and Her Majesty's Treasury for any annual salaries of £150,000 or more, including increases to salaries (other than resulting from nationally recommended pay awards). This includes approval of the Chief Medical Officer's total remuneration should this be £150,000 or more.

2.7 Any changes to salaries will ordinarily be effective from 1 April unless otherwise determined by the EN&RC.

2.8 Any national recommendations on pay awards for VSM pay will be considered following notification from NHSE and, where agreed by EN&RC, will be backdated in line with the national guidance to the relevant effective date.

2.9 Executive remuneration levels, benefits and pension entitlements are published in the Trust's Annual Report.

3.0 SENIOR MANAGERS' REMUNERATION

3.1 The national Agenda for Change NHS terms and conditions and pay structure apply to positions reporting into Executive Directors. Any exceptions will be subject to approval by

the EN&RC as Very Senior Manager Pay. Pay in relation to interim appointments will be approved by the Chief Executive within the authority delegated by the EN&RC.

4.0 CHAIR AND NON-EXECUTIVE DIRECTORS

4.1 The Council of Governors has responsibility for setting non-executive remuneration, following the recommendations of the Governors' Nomination & Remuneration Committee ('the GN&RC'). This forms part of the review of all terms and conditions of engagement, including expenses.

4.2 As with Executive remuneration, non-executive remuneration is set in line with NHSE guidance.

4.3 The current rates of pay are as set out below and take account of the NHSE pay structure published in November 2019.

Board role	Requirement	Indicative Minimum Days	Salary
Trust Chair	Statutory	Three per week	Lower quartile £44,100 Median £47,100 Upper quartile £50,000 Minimum remuneration must be consistent with the median value
Non-executive Director	Statutory (majority on the Board)	Three per month	£13,000
Additional responsibilities			
Committee Chairs (Patient Safety & Quality; Finance & Performance; Audit; People & Culture)	Discretionary	As above	£14,000

4.4 Under the framework, for a Trust of our size, there is local discretion to award a supplementary payment of £2,000 per annum for a maximum of two individuals in recognition of designated extra responsibilities such as chairing principal Committees of the Board and undertaking duties of senior independent director. The Frequently Asked Questions associated with the guidance further clarifies that Trusts have discretion to choose to pay a lower amount to more individuals in recognition of additional roles provided this remains within the designated limit (£4,000 for a Trust of our size). Our policy is to pay an additional £1,000 to each Committee chair.

4.5 The Senior Independent Director will be one of the Committee chairs.

4.6 The GN&RC affords the Chair the discretion to appoint a Deputy Chair if required. This will either be the Senior Independent Director, or another Non-executive appointed following a selection process.

4.7 When the duties attracting an additional payment cease, remuneration reverts to the standard NED remuneration rate.

Expenses are paid, with the Council reviewing the policy on an annual basis for Non-executive Directors. Executive Directors' expenses are paid in line with the Trust's Expenses Policy.

Details of the expenses paid during 2023/24 for all Board members and Governors can be found below.

Governor and Board Expenses (subject to audit)

Table of disclosures	2023/24	2022/23
Governors		
The total number of governors in office	**21**	**18**
The number of governors receiving expenses in the reporting period; and	**0**	**0**
The aggregate sum of expenses paid to governors in the reporting period.	**£0**	**£0**
Directors		
The total number of directors holding office during the year	**18**	**20**
The number of directors receiving expenses in the reporting period; and	**7**	**7**
The aggregate sum of expenses paid to directors in the reporting period.	**£1,662**	**£1,725**

Senior Managers' remuneration (subject to audit)

	Figures from 'Remuneration Details' tab						*Figures taken from 2023 filed accounts*					
	Year Ended 31st March 2024	Year Ended 31st March 2024	Year Ended 31st March 2024	Year Ended 31st March 2024	Year Ended 31st March 2024	Year Ended 31st March 2024	Year Ended 31st March 2023	Year Ended 31st March 2023	Year Ended 31st March 2023	Year Ended 31st March 2023	Year Ended 31st March 2023	Year Ended 31st March 2023
	Salary	Expense payments (taxable)	Performance pay and bonuses	Long term performance pay and bonuses	All pension-related benefits	TOTAL (a to e)	Salary	Expense payments (taxable)	Performance pay and bonuses	Long term performance pay and bonuses	All pension-related benefits	TOTAL (a to e)
	(bands of £5,000) £000	to nearest £100 £	(bands of £5,000) £000	(bands of £5,000) £000	(bands of £2,500) £000	(bands of £5,000) £000	(bands of £5,000) £000	to nearest £100 £	(bands of £5,000) £000	(bands of £5,000) £000	(bands of £2,500) £000	(bands of £5,000) £000
Mr JG Barber Deputy Chief Executive	**130 - 135**	**0**	**0**	**0**	**0**	**130 - 135**	**115 - 120**	**0**	**0**	**0**	**60.0 - 62.5**	**175 - 180**
Mr VV Chitre Chief Medical Officer	**210 - 215**	**0**	**0**	**0**	**102.5 - 105.0**	**310 - 315**	**85 - 90**	**0**	**0**	**0**	**292.5 - 295.0**	**380 - 385**
Mrs S Collier Non-executive Director from 24/07/23	**05 - 10**	**100**	**0**	**0**	**0**	**05 - 10**	**NOT IN POST**					
Ms AL Davidson Chair until 30/04/23	**00 - 05**	**300**	**0**	**0**	**0**	**00 - 05**	**45 - 50**	**600**	**0**	**0**	**0**	**45 - 50**

Mr MD Flynn Director of Strategic Projects	125 - 130	0	0	0	0	125 - 130	130 - 135	0	0	0	35.0 - 37.5	165 - 170
Mr M Friend Chair from 02/10/23	20 - 25	0	0	0	0	25 - 30	NOT IN POST					
Mrs SJ Goldie Director of People and Culture	110 - 115	0	0	0	20.0 - 22.5	135 - 140	100 - 105	0	0	0	110.0 - 112.5	215 - 220
Mr JJ Hennessey Non-executive Director	10 - 15	0	0	0	0	10 - 15	10 - 15	0	0	0	0	10 - 15
Mr S Javes Non-executive Director	25 - 30	200	0	0	0	25 - 30	10 - 15	100	0	0	0	10 - 15
Mr NS Kee Chief Operating Officer	140 - 145	0	0	0	0	140 - 145	130 - 135	0	0	0	0.0 - 0.0	130 - 135
Ms KE Knight Non-executive Director until 31/12/23	05 - 10	0	0	0	0	05 - 10	10 - 15	0	0	0	0	10 - 15
Professor SM Lindqvist Non-executive Director	10 - 15	500	0	0	0	10 - 15	00 - 05	0	0	0	0	00 - 05
Mr PC Morris Chief Nurse	125 - 130	0	0	0	0	125 - 130	120 - 125	0	0	0	0	120 - 125

Professor CJ Notley Non-executive Director	**10 - 15**	**0**	**0**	**0**	**0**	**10 - 15**	**05 - 10**	**0**	**0**	**0**	**0**	**05 - 10**
Professor DGI Scott Non-executive Director, Senior Independent Director until 30/09/23	**00 - 05**	**200**	**0**	**0**	**0**	**05 - 10**	**10 - 15**	**0**	**0**	**0**	**0**	**10 - 15**
Miss J Segasby Chief Executive	**190 - 195**	**0**	**0**	**0**	**257.5 - 260.0**	**450 - 455**	**175 - 180**	**0**	**0**	**0**	**112.5 - 115.0**	**290 - 295**
Mr EW Taylor Chief Finance Officer	**135 - 140**	**0**	**0**	**0**	**67.5 - 70.0**	**205 - 210**	**115 - 120**	**0**	**0**	**0**	**80.0 - 82.5**	**195 - 200**
Dr SJ Whiteman Non-executive Director from 01/10/23	**05 - 10**	**0**	**0**	**0**	**0**	**05 - 10**	**NOT IN POST**					
Mrs A Hills Chief Executive until 25/04/22	**COMPARISON ONLY**						**10 - 15**	**0**	**0**	**0**	**0**	**10 - 15**
Dr WH Stuart Medical Director until 21/08/22	**COMPARISON ONLY**						**60 - 65**	**0**	**0**	**0**	**0**	**60 - 65**
Mrs PR Kerr Non-executive Director until 31/10/22	**COMPARISON ONLY**						**05 - 10**	**100**	**0**	**0**	**0**	**05 - 10**
Professor L Bowater	**COMPARISON ONLY**						**05 - 10**	**0**	**0**	**0**	**0**	**05 - 10**

Non-executive
Director until
30/09/22

None of the senior managers above were in receipt of performance-related bonuses or long-term performance-related bonuses during the reporting period. Eleven employees have been paid more than the highest paid director (2022/23 seven).

Mr V Chitre's total remuneration paid by the entity as disclosed above, includes
£67,197.18 paid in relation to his clinical duties and not in relation to his managerial role.

The taxable expense payments consist of all expense allowances subject to UK income tax, such as car mileage allowances.

The annual increase in pension related benefits disclosed above represents the increase or (decrease), adjusted for inflation, between the amounts as at 31 March 2023 and the amounts as at 31 March 2024.

The pension related benefit is calculated following a prescribed formula issued by HMRC, derived from s229 of the Finance Act 2004, modified by paragraph 10(1)(e) of

schedule 8 of SI 2008/410 (as replaced by SI 2013/1981). The calculated pension benefit figure is representative of the benefits that would be payable to the senior manager if they became entitled to it at the end of the financial year. The calculation is based upon 20 x annual pension income, plus the lump sum payable. Factors determining the variation in the values recorded between individuals include a change in role with a resulting impact on pension benefits.

Fair Pay Disclosure (subject to audit)

Ratio of Highest Paid Director to Other Staff

Reporting bodies are required to disclose the relationship between the remuneration of the highest-paid director in their organisation and the upper quartile, median and lower quartile remuneration of the organisation's workforce. Total remuneration of the employee at the 25th percentile, median and 75th percentile is further broken down to disclose the salary component. The midpoint of the banded remuneration of the highest-paid director in the James Paget University Hospitals NHS Foundation Trust in the financial year 2023/24 was £217,500 (2022/23 - £197,500). This was 4.74 times (2022/23 - 4.61 times) the upper quartile remuneration of the workforce, which was £45,906 (2022/23 - £42,859). This was 8.48 times (2022/23 - 8.19 times) the lower quartile remuneration of the workforce, which was £25,644 (2022/23 - £24,113). This was 6.28 times (2022/23 - 6.21 times) the median remuneration of the workforce, which was £34,623 (2022/23 - £31,794).

The median and 25th and 75th percentile full time equivalent remuneration of the workforce has been calculated based on those receiving remuneration. The remuneration received has been annualised for basic pay and based on actuals for other allowances including

enhancements and overtime and excludes the highest paid director. In calculating the workforce remuneration performance related pay has been excluded for all non-consultant staff on the basis that it is nil. Further to this, employees on apprenticeship schemes and benefit in kind have been excluded from salaried and total remuneration, however this does not have a material impact on the accuracy of the calculations. Included within the figures to calculate the median full time equivalent remuneration is the annualised remuneration of agency staff working at the Trust at 31 March 2024.

There has been an overall increase in staff remuneration from the last financial year due to a mixture of an inflationary increase and a net progression of staff with incremental increases within the AFC pay scales. Remuneration ranged from £14,687 to £309,777 (2022/23: £14,299 to £270,338). 11 employees (2022/23 - 7) received remuneration in excess of the highest paid director.

Pay ratio information table

2023-24	25th percentile	Median	75th percentile
All staff' remuneration based on annualised, full-time equivalent remuneration of all staff (including temporary and agency staff)	£25,644	£34,623	£45,906
Salary component of 'all staff' remuneration based on annualised, full-time equivalent remuneration of all staff (including temporary and agency staff)	£25,466	£34,581	£45,305
All staff' remuneration based on annualised, full-time equivalent remuneration of all staff (including temporary and agency staff): Midpoint of band of highest paid director	8.48	6.28	4.74

2022-23	25th percentile	Median	75th percentile
All staff' remuneration based on annualised, full-time equivalent remuneration of all staff (including temporary and agency staff)	£25,405	£33,144	£44,164
Salary component of 'all staff' remuneration based on annualised, full-time equivalent remuneration of all staff (including temporary and agency staff)	£25,311	£32,528	£43,567
All staff' remuneration based on annualised, full-time equivalent remuneration of all staff (including temporary and agency staff): Mid band of highest paid director	7.77	5.96	4.47

Percentage Change in Remuneration of Highest Paid Director

	% Change from previous financial year in Salary and Allowances	% Change from previous financial year in Performance Pay and Bonuses
Highest Paid Director (midpoint of band)	10.13%	N/A*
All Employees (total for all employees on an annualised basis, excluding the highest paid director, divided by the FTE number of employees (also excluding the highest paid director).	21.31%	N/A*

*No Performance Pay and Bonus payments are made by the FT.

Senior Managers' pension entitlements (subject to audit)

2023/24

Name and title	(a)	(b)	(c)	(d)	(e)	(f)	(g)	(h)
Name and title	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 2024 (bands of £5,000)	Lump sum at pension age related to accrued pension at 31 March 2024 (bands of £5,000)	Cash Equivalent Transfer Value at 1 April 2023	Real increase in Cash Equivalent Transfer Value	Cash Equivalent Transfer Value at 31 March 2024	Employer's contribution to stakeholder pension
	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000
Mr J Barber Deputy Chief Executive	0	0	20 - 25	0 - 5	314	19	395	0
Mr V Chitre Chief Medical Officer	5.0 - 7.5	25.0 - 27.5	70 - 75	195 - 200	1,433	0	120	0

Mr M Flynn Director of Strategic Projects	0	32.5 - 35.0	30 - 35	75 - 80	484	95	645	0
Mrs S Goldie Director of People and Culture	0.0 - 2.5	30.0 - 32.5	35 - 40	100 - 105	539	179	789	0
Mr N Kee Chief Operating Officer	0	5.0 - 7.5	50 - 55	140 - 145	1,188	0	302	0
Mr PC Morris Chief Nurse	0	0	15 - 20	50 - 55	341	0	354	0
Miss J Segasby Chief Executive	5.0 - 7.5	50.0 - 52.5	70 - 75	205 - 210	1,005	341	1642	0
Mr E Taylor Chief Finance Officer	0.0 - 2.5	40.0 - 42.5	40 - 45	110 - 115	562	221	879	0
2022/23 - COMPARISON ONLY								
	(a)	**(b)**	**(c)**	**(d)**	**(e)**	**(f)**	**(g)**	**(h)**

Name and title	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 2023 (bands £5,000)	Lump sum at pension age related to accrued pension at 31 March 2023 (bands of £5,000)	Cash Equivalent Transfer Value at 1 April 2022	Real increase in Cash Equivalent Transfer Value	Cash Equivalent Transfer Value at 31 March 2023	Employer's contribution to stakeholder pension
	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000
Mr J Barber Director of Strategy and Transformation	2.5 - 5.0	0.0 - 2.5	20 - 25	0 - 0	253	40	314	0
Mr V Chitre Chief Medical Officer from 01/08/22	7.5 - 10.0	20.0 - 22.5	60 - 65	155 - 160	1,064	208	1433	0
Mr M Flynn Director of Strategic Projects	2.5 - 5.0	0.0 - 2.5	30 - 35	40 - 45	431	22	484	0
Mrs S Goldie Director of People and Culture	5.0 - 7.5	10.0 - 12.5	30 - 35	60 - 65	426	86	539	0
Mrs A Hills Chief Executive	0.0 - 2.5	0.0 - 2.5	50 - 55	110 - 115	746	11	963	0
Mr N Kee Chief Operating Officer from 19/04/22	0.0 - 2.5	0.0 - 2.5	50 - 55	120 - 125	1190	0	1188	0
Mrs J Segasby	5.0 - 7.5	10.0 - 12.5	55 - 60	115 - 120	864	107	1005	0

Chief Operating Officer								
Mr E Taylor	2.5 - 5.0	2.5 - 5.0	35 - 40	55 - 60	476	59	562	0
Chief Finance Officer								

As non-executive members do not receive pensionable remuneration there will be no entries in respect of pensions for non-executive members.

A Cash Equivalent Transfer Value (CETV) is the actuarially assessed capital value of the pension scheme benefits accrued by a member at a particular point in time. The benefits valued are the member's accrued benefits and any contingent spouse's pension payable from the scheme. A CETV is a payment made by a pension scheme, or arrangement to secure pension benefits in another pension scheme or arrangement when the member leaves a scheme and chooses to transfer the benefits accrued in their former scheme. The pension figures shown relate to the benefits that the individual has accrued as a consequence of their total membership of the pension scheme, not just their service in a senior capacity to which the disclosure applies. The CETV figures, and from 2004-05 the other pension details, include the value of any pension benefits in another scheme or arrangement which the individual has transferred to the NHS pension scheme. They also include any additional pension benefit accrued to the member as a result of their purchasing additional years of pension service in the scheme at their own cost. CETVs are calculated within the guidelines and framework prescribed by the Institute and Faculty of Actuaries.

In calculating the actuarial value of the CETV as at 31 March 2024 the NHS Pensions Agency has used factors which include the indexation of pension benefits in line with the Consumer Price Index (CPI) and not the Retail Price Index (RPI). This follows the Government announcement in July 2010 that pension benefits from 2011 will be indexed in line with CPI and not RPI. The change in inflation assumption led to a decrease in the CETV value as at 31 March 2011 compared with the CETV as at 31 March 2010. Revised guidance was issued by HM Treasury on 26 October 2011 regarding the calculation of CETVs in public service pension schemes. Based on this guidance the NHS Pensions Agency, with effect from 8 December 2011, has used revised and updated actuarial factors produced by GAD when calculating CETVs within the NHS Pension Scheme.

Real Increase / (decrease) in CETV - This reflects the increase in CETV effectively funded by the employer. It takes account of the increase in accrued pension due to inflation, contributions paid by the employee (including the value of any benefits transferred from another pension scheme or arrangement) and uses common market valuation factors for the start and end of the period.

Senior managers' pension entitlement disclosures are subject to external audit.

Jo Segasby
Chief Executive and Accounting Officer
27 June 2024

Staff Report - Our People Plan

Paget's People is our new five-year People Plan, published in June 2023. We are proud of our Trust and know that what makes it such a special place to receive care and to work is its people. Not only are they skilled, they share the Trust's Values, which were also refreshed in 2023, of Collaboration, Accountability, Respect, Empowerment, and Support (CARES).

Our Plan is focused on four key ambitions:

- Promoting and inclusive, fair, and safe workplace
- Developing compassionate and effective leadership
- Attracting, engaging, developing, and deploying our staff to deliver the best care for our patients
- Promoting wellbeing opportunities to keep our staff healthy and well.

The People and Culture Committee receives updates on progress with the delivery of the plan and reviews the plan annually. Over the last year, we have particularly focused on developing and implementing our new Values and Behaviours Framework, Fair Recruitment, Just Culture and our #ChooseRespect approach aimed at reducing abusive behaviour towards staff.

Our People Plan is aligned to the NHS People Plan, NHS People Promise and NHS Long Term Plan. It also supports delivery of the Norfolk and Waveney ICS (Integrated Care System) People Plan.

We are a partner within the Norfolk and Waveney health and care system and proactively collaborate on the people agenda.

Recruitment – Attracting Talent

Our Trust performs fourth highest out of all acute Trusts in the East of England for recommending the Trust as a place to work. This supports us having one of the lowest vacancy rates in the country and a stable turnover.

The recruitment of some staff groups and specialties remains a challenge for the NHS and our Trust is no exception. As such, we continue to review innovative ways to consider the skills requirements, role design and development of our services to ensure we can attract quality and diverse talent, as well as having a robust 'grow our own' approach.

Our staff report higher than average experience of flexible working when compared to other acute hospitals. This is something we are committed to continuing to develop to attract, support and retain great staff, aligned to operational needs. We also offer flexible retirement opportunities, assisting us to retain experienced staff.

Recognising our staff

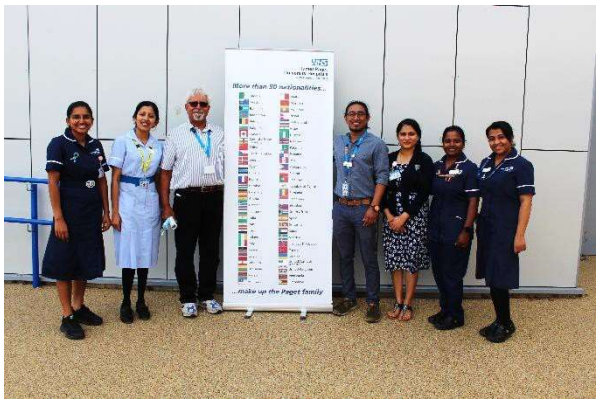
Our staff are at the core of everything we deliver. We could not be prouder of their extraordinary efforts as we continue to face significant operational pressures.

We were delighted to celebrate the fantastic achievements of individuals and teams in our Paget's People Awards in October 2023. We saw more than 360

nominations from both patients and staff and over two hundred guests attended the ceremony to celebrate everyone nominated and our winners.

Additionally, we run an Employee of the Month Scheme. This staff recognition scheme was implemented as a result of feedback from a National Staff Survey some years ago. Nominations can be shared with the Chief Executive by patients, visitors and colleagues who can put forward any member of staff, including bank colleagues, who have gone above and beyond in their roles. These monthly recognition awards are presented to the individual by the Chief Executive and celebrated through our staff communication forums.

Equality, diversity, and human rights



Equality, diversity, and inclusion (EDI) is the responsibility of everyone in the Trust. Our People Plan sets out our ambition to ensure that equity, diversity, and inclusion is a thread through all we do. We want our staff to be representative of the community we serve and for everyone to have a sense of belonging. Respect is one of our new Trust Values - “we are anti-discriminatory, treating people fairly and creating a sense of belonging and pride.” This is an important priority for us in the provision of services to the people we serve and as an inclusive employer of choice.

Whilst we have much more work to do, we are making positive progress and are pleased to see this reflected in several of the Workforce Race and Disability Equality Standards (WRES/WDES). Our staff networks (ethnically diverse, LGBTQ+, Ability and Menopause) are key partners and we thank them for their openness, honesty, and collaboration in developing and delivering plans to be effective for staff experience. Key areas of focus over the last year have included our #ChooseRespect work to raise awareness of reporting of incidents of violence and aggression towards our staff and improved support for those affected, Fair Recruitment, which has included supporting staff with interview technique, the introduction of stakeholder panels for senior positions and more diverse panels and the roll out of Adjustment Passports to support staff with long term health conditions. Additionally, our networks have played an important role in ensuring our dress code policy is inclusive and we now have trained Menopause Advocates.

We have aligned our EDI priorities to the NHS Six High Impact EDI Actions, including incorporating EDI objectives in Board member objectives.

We embrace NHS equality frameworks and respond positively to the Workforce Disability Equality Standard (WDES); Workforce Race Equality Standard (WRES); Gender Pay Gap and Equality Delivery System (EDS2) with outcomes being used to inform our plans. EDI performance is monitored by the EDI Steering Group, which reports to the Hospital Management Group. Performance reports are considered by the People and Culture Committee for assurance and are presented in public Board meetings and published in line with national reporting requirements.

WRES and WDES

The WRES and WDES set out specific measures that enable NHS organisations to compare the experiences of minority ethnic staff and white staff and disabled and non- disabled staff.

These measures cover areas such as membership of the Board of Directors, recruitment, bullying and harassment, and the likelihood of staff to be involved in formal processes. This information is used to develop local action plans, which enables us to demonstrate progress against the indicators of race and disability equality.

EDI Performance (NHS Staff Survey 2023)

Table 1: Trust Wide Data

NHS Staff Survey 2023 – Trust Wide	Best Trust	Average	JPUH 2023	JPUH 2022
We are compassionate and inclusive	7.7	7.2	7.07	7.02
Equal opportunity career development and progression	70.1%	55.9%	53.8%	54.3%
Discrimination – patients/public	3.2%	8.0%	9.7%	9.5%
Discrimination – manager/staff	3.8%	9.2%	10.5%	9.9%

Table 2: Workforce Disability Equality Standard (WDES)

NHS Staff Survey 2023 – Trust Wide	LTC Average	JPUH 2023	JPUH 2022
Equal opportunities for career progression or promotion	51.5%	49.9%	51.7%
Bullying and Harassment – patients/public	30.4%	36.1%	42.8%
Bullying and Harassment - manager	15.9%	17.8%	21.0%
Bullying and Harassment - colleague	25.9%	31.1%	34.1%
Reporting Bullying and Harassment	50.4%	53.6%	54.4%
Felt pressure to come to work despite not feeling well enough	28.6%	24.3%	31.9%
Organisation values their work	35.7%	28.4%	31.4%
Provision of reasonable adjustments	73.4%	73.4%	66.7%

Table 3: Workforce Race Equality Standard (WRES)

NHS Staff Survey 2021 – Trust Wide	BME Average	JPUH 2023	JPUH 2022
Equal opportunities for career progression or promotion	49.6%	46.5%	43.9%
Bullying and Harassment – patients/public	28.1%	35.1%	41.8%
Bullying and Harassment – staff/manager	26.2%	36.4%	34.4%
Discrimination – manager or other colleague	16.2%	23.2%	21.9%

Modern Slavery Act 2015 and Human Trafficking Statement

In accordance with section 54(1) of the Modern Slavery Act 2015, James Paget University Hospitals NHS Foundation Trust ('the Trust') has zero tolerance of slavery and human trafficking and is committed to preventing such activities, taking all reasonable actions to ensure our supply chains and operational activities are free from ethical and labour standards abuses.

The Trust provides services from its main hospital site in Gorleston and a small number of other sites.

Policies, procedures, governance, and legal arrangements are robust, ensuring that proper checks and due diligence are applied in employment procedures to ensure compliance with legislation and NHS employment check standards.

All colleagues working at the Trust have a personal responsibility for the prevention of slavery and human trafficking, with our procurement department having lead responsibility for overall compliance.

Training for staff includes awareness and consideration of duties in relation to modern slavery and human trafficking, taking appropriate action in relation to any concerns and collaborating with partner organisations when relevant. The Trust's safeguarding policies provide further guidance and clear reporting procedures. They are reviewed every three years as a minimum. In addition, the Safeguarding Team is available to colleagues, providing enhanced knowledge and support.

We use supply chains engaged through relevant NHS and public sector approved procurement framework arrangements to support temporary staffing needs, with compliance with NHS standards being a condition of engagement.

To ensure a high level of understanding of the risks of modern slavery and human trafficking in our supply chains and our business, our procurement staff receive training in this area.

In addition, we take the following steps:

- Include specific clauses that reflect our obligations under the Modern Slavery Act 2015 in terms and conditions for supply.
- Include pass/fail criteria for Procurement led tender processes and new vendor requests.
- Upskill the Procurement and Supplies Team on the implications of the Act in order that they can support the wider organisation in its implementation.
- Communicate to all high-risk suppliers providing an overview of the legislation, stating our intent and expectations.
- Include a specific right to audit against the obligations of the Modern Slavery Act 2015 for those contracts deemed to be high risk.
- Ensure suppliers engaged outside the normal procurement processes comply with the Modern Slavery Act 2015.
- Ensure staff and other workers are paid at or above National Minimum Wage requirements and in line with NHS terms and conditions where the Trust directly employs them.
- Commit to referring to the appropriate authorities/agencies any concerns of modern slavery or human trafficking that we may identify.

This statement has been approved by our Board of Directors for the year ended 31 March 2024.

Freedom to Speak Up

One of our new Trust Values is **Empowerment**, with the supporting headline behaviour, “We speak out when things don’t feel right, we are innovative and make changes to support continuous improvement.”

Speaking up is about highlighting anything that gets in the way of providing good care or other issues of concern. It is important because it helps us to keep our patients safe and to keep improving our services for all patients and the working environment for our staff. Our Board and senior leaders are committed to an open and supportive culture.

Our Freedom to Speak Up (FTSU): Raising Concerns Policy sets out how staff can raise concerns, the process that is followed and the support available. Our policy aligns to NHS England guidance.

We have reviewed our Freedom to Speak Up service within the last year and are introducing a new independent service from the end of April 2024. This service will be available 24 hours a day, 7 days a week, and includes a swift escalation process to Executive Directors in the event of concerns relating to patient or staff safety.

The Guardian attends the Board in person twice a year, with a detailed report available to the public. The reports detail key themes, updates to national guidance and provide assurance that the Speaking Up agenda is being met.

Speaking up can take courage. We are therefore committed to nurturing a culture where people feel psychologically safe. Our Just and Learning Culture work and Patient Safety Incident Response Framework supports this.

The Guardian regularly visits wards/departments and attends team meetings to raise awareness of speaking out. Posters and flyers have been circulated to ensure our staff know who to contact and how, and there is a screen saver on office monitors. The Guardian has also been promoting Freedom to Speak Out e-learning. The Guardian also meets regularly with the Non-Executive Director Speaking Out Board champion.

We would like to thank everyone who has spoken up in the last year; their voice makes a difference.

Data and policies

Staff Numbers contracted as at 31 March 2024

Workforce 31.03.24	Female WTE	Male WTE	Total WTE
Directors (excluding non-executives)	2.00	5.90	7.90
Senior Managers	20.51	22.64	43.15
Employees	2821.38	881.06	3702.44
Total	2843.89	909.60	3753.49

Average Staff Numbers – Whole Time Equivalents (WTEs)

Staff Group	Total WTE	Permanent WTE	Other WTE
Medical and Dental	440	195	245
Ambulance Staff	0	0	0
Administration and Estates	1072	1014	58
Healthcare assistants and other support staff	775	668	108
Nursing, midwifery, and health visiting staff	1108	1000	108
Nursing, midwifery, and health visiting learners	14	1	13
Scientific, therapeutic, and technical staff	280	266	13
Healthcare science staff	29	28	1
Social care staff	0	0	0
Other	0	0	0
Total Average numbers (WTE)	3717.80	3171	546

Figures are subject to audit

Staff Costs Analysis

	Year Ended 31 March 2024			Year Ended 31 March 2023
	Permanent	Other	Total	Total
	£ 000	£ 000	£ 000	£ 000
Employee expenses and numbers				
Employee expenses				
Salaries and wages	**166,205**	**1,719**	**167,923**	162,687
Social security costs	**17,998**	**293**	**18,291**	14,947
Apprenticeship levy	**878**	**9**	**887**	765
Employer contributions to NHS Pensions	**19,216**	**310**	**19,526**	18,224
Pension cost - employer contributions paid by NHSE on provider's behalf (6.3%)	**8,404**	**136**	**8,540**	7,722
Pension cost - other	**41**	**9**	**50**	60
Agency / contract staff	**-**	**8,542**	**8,542**	9,258
	212,741	**11,017**	**223,759**	213,663
Employee expenses recharged to other organisations	**(123)**	**-**	**(123)**	(282)
Employee expenses capitalised as part of assets	**(727)**	**-**	**(727)**	(452)
	211,892	**11,017**	**222,910**	212,929

Figures are subject to audit

Sickness absence data

Our staff do amazing work every day in difficult circumstances. In addition to line management, we offer a wide range of wellbeing and other support to our staff. Within the last year, we have implemented a new Employee Assistance Programme, which provides a range of on-line information and support for staff. We have also introduced an enhanced psychological wellbeing service, which has positively impacted mental health-related absence. We have over forty nurses trained as Professional Nurse Advocates to support the resilience of our nursing workforce but with this also being available to the wider workforce. We have also recently updated our annual appraisal discussions to include a focus on wellbeing as an integral element.

The data below shows the sickness absence figures for the Trust:

Sickness Absence	2023/24
Percentage of Long-Term Sick (over 28 days)	2.54%
Percentage of Short Term	3.08%
Average Working Days Lost (ESRBI Average Days (FTE) per FTE) – Full Time Equivalent	6.37
Percentage of staff with no sick leave	11.54%

Top Sickness Reasons	Year 2023/24	
	% (of all Sickness	% (of all fte available)
S10 Anxiety/stress/depression/other psychiatric illnesses	23.89%	1.34%
S13 Cold, Cough, Flu - Influenza	12.30%	0.69%
S25 Gastrointestinal problems	9.27%	0.52%
S12 Other musculoskeletal problems	8.73%	0.49%
S28 Injury / fracture	7.49%	0.42%

Staff policies and their application

The application of workforce policies is in line (and often exceeds) legal requirements and national guidance from NHS Employers and NHSE. Policies include:

- **Recruitment, Equality and Diversity and Managing Attendance Policies –** for giving full and fair consideration to applications for employment; setting our expectations regarding anti-discriminatory behaviour in the workplace; and supporting staff who require time absent from work due to ill health.

- **Just and Learning Workplace Policy –** This is a new policy developed in partnership with our local Staffside colleagues. Its focus is on managing issues of concern, whether employee concerns or employer concerns in a way that is fair, proportionate and has a focus on organisational learning.

- **Freedom to Speak Up: Raising Concerns Policy** – Encourages staff to speak out if there is anything that concerns them and explains how they can do this.

- **Consultation and Engagement** - we proactively encourage staff and their representatives to share views and ideas so these can be considered in making

decisions which are likely to affect them.

- **Change Management, Redeployment and Redundancy Policy** - sets out how we consult staff and manage organisational change within the Trust.

- **Health and Safety Policy; Occupational Health** – sets out our framework for managing health and safety within the Trust. Regular Occupational Health reports are received by our Health and Safety Committee.

- **Anti-fraud and Corruption Policy** – sets out our commitment to reducing fraud, bribery and corruption in the NHS and taking appropriate action where there are concerns or where any fraudulent acts have been identified.

We are working with other NHS Trusts across Norfolk and Waveney to move to having a set of core joint workforce policies.

Staff turnover

The retention of skilled and experienced staff is an important element of the Trust's People Plan. Our total turnover rate at 6.5% is below the average for NHS acute hospitals and we have good workforce stability with over 90% of our people still working for the Trust a year after their appointment. Despite this, we have an ongoing focus on continuously improving staff experience and retaining our talented people, particularly given national skills shortages and local competition for employment. Good retention is supported by our People Plan and the delivery of our Staff Experience Plan. We provide and promote a range of flexible working options to support staff's work/life balance, retire and return and partial retirement. In addition to offering stay conversations, the Trust's HR Business Partners also conduct exit questionnaires to all leavers and exit discussions.

Information on staff turnover is provided at this link:

https://digital.nhs.uk/data-and-information/publications/statistical/nhs-workforce-statistics

Staff engagement and the NHS Staff Survey

We proactively seek to engage staff and their representatives at a corporate and a local level in relation to issues that may affect them, examples of some of the forums available below:

- Joint Partnership Forum – held between Staffside representatives and Trust Executives.
- Staffside Meetings – Fortnightly meetings held between the Staffside Chair and Secretary and Chief Executive and Director of People and Culture.
- Local Negotiating Committee – quarterly meeting between senior managers and British Medical Association representatives.
- Annual NHS Staff Survey – anonymous survey sent to all staff.
- Chief Executive's Surgeries – fortnightly Teams briefing, and question and answer sessions open to all staff to provide key updates and to enable immediate feedback from staff and the opportunity to ask questions.
- Leadership Summits – Quarterly engagement events for all Trust leaders on key people-related topics.
- Staff Networks – Executive sponsored networks focused on issues relevant to protected characteristic groups.
- Staff Experience Working Groups – Profession-based working groups each led by a relevant senior professional to explore issues relevant to the staff group and to collaborate on plans.
- Your Voice – Listening and engagement sessions held regularly in both clinical divisions.
- Chief Executive's Breakfast Sessions – These are held monthly we invites to staff whose birthday it is in the month. They provide an opportunity for an informal conversation over breakfast with the Chief Executive and other Executive Directors on any topics of interest.

NHS Staff Survey

We want our staff to feel truly proud to work at the Paget. We therefore value receiving feedback from our staff to inform our plans to deliver the best possible work experience for them. We know that great staff experience supports great patient experience.

The NHS Staff Survey is conducted annually and is focused on seven NHS People Promise Themes, as well as Staff Morale and Engagement.

Following efforts to improve our engagement with staff on the importance of the Staff Survey, we are delighted that our response rate for the 2023 Staff Survey showed a notable increase from 34% to 42%. We will aim even higher for the 2024 survey. For the second year, bank staff were also included in the survey, with approximately 20% responding.

At a Trust level, we saw improvement across all People Promise themes and Staff Engagement and Morale over the last year. We perform better than the national average for We Work Flexibly. Despite the significant operational pressures that staff have experienced over the last year, this shows that delivery of our People Plan is having some impact.

2023/24 and 2022/23

Scores for each indicator together with that of the survey benchmarking group (acute and acute & community Trusts) are presented below.

Indicators ('People Promise' elements and themes)	**2023/24**		**2022/23**	
	Trust score	Benchmarking group score	Trust score	Benchmarking group score
People Promise:				
We are compassionate and inclusive	7.07	7.24	7.0	7.2
We are recognised and rewarded	5.67	5.94	5.5	5.7
We each have a voice that counts	6.51	6.70	6.5	6.6
We are safe and healthy	5.87	6.07	5.7	5.9
We are always learning	5.43	5.61	5.2	5.4
We work flexibly	6.26	6.20	6.1	6.0
We are a team	6.46	6.75	6.3	6.6
Staff engagement	6.78	6.91	6.7	6.8
Morale	5.75	5.91	5.5	5.7

We are pleased to be the fourth best performing acute Trust (out of 13) in the East of England for staff engagement.

2023/24

The following provides more detail on the elements that make up each of the People Promise themes, Staff Engagement and Morale, showing where we saw our highest improvements and any negative or low change areas.

Highest Areas of Increase	Trust	Change
Appraisals	4.49	0.38
Work pressure	4.94	0.28
Thinking about leaving	6.16	0.20
Health and safety climate	5.29	0.19
Burnout	4.79	0.18
Support for work-life balance	6.27	0.17
Line management	6.54	0.16
We are recognised and rewarded	5.67	0.14
Negative experiences	7.50	0.13
Stressors	6.15	0.13

Negative or Low Change Areas	Trust	Change
Raising concerns	6.17	-0.02
Diversity and equality	7.98	-0.02
Flexible working	6.15	0.03
Inclusion	6.54	0.04
Advocacy	6.77	0.06

Future priorities and targets

Whilst our Staff Survey results are showing improvement, our People Plan sets out our commitment to having an unrelenting focus on staff experience. We have a Staff Experience Plan with delivery being overseen by a Staff Experience Programme Board. The work includes a continued focus on Leadership and Management, Values and Behaviours, Inclusive Workplace, and Wellbeing. Working Groups with a focus on experience for different professional staff groups also report to the Programme Board.
We are committed to improving our staff experience over the next year to be in line or better than the acute sector average, with an ambition to be in the top quarter over the next four years.

Trade union facility time disclosures

We value positive working relationships with our trade union colleagues. We have a Staffside Chair and Staffside Secretary who have dedicated roles. We also provide facilities for all recognised trade union representatives to perform their duties. The Chief Executive and the Director of People and Culture meet regularly with the Staffside Chair and the Staffside Secretary. We also hold Joint Partnership Forum meetings with trade union representatives to discuss issues of interest and to support formal consultation processes where required.

- **Relevant Union Officials**

Number of employees who were relevant union officials during the relevant period	Full-time equivalent employee number
11	1.71 WTE

- **Percentage of time spent on facility time**

Percentage of time	Number of employees
0%	4,273 staff
0-50%	9 staff
51-99%	0 staff
100%	2 staff

- **Percentage of pay bill spent on facility time**

Facility Time	Figures
Total cost of facility time	£80,011.84
Total pay bill	£222,910,000
Percentage of the total pay bill spent on facility time	0.04%

Other disclosures

Off Payroll engagements

All substantive employees are paid through our payroll. Any off-payroll engagements are subject to risk-based assessments to ensure full compliance with Her Majesty's Revenue and Customs requirements either by the Trust or external agencies.

No members of the Board of Directors were engaged on an interim and off payroll basis during the year.

For all off-payroll engagements as of 31 March 2024 for more than £245 per day and that last for longer than six months	2023/24
Number of existing engagements as of 31 March 2024	0
Of which:	
Number that have existed for less than one year at the time of reporting	0
Number that have existed for between one and two years at the time of reporting	0
Number that have existed for between two and three years at the time of reporting	0
Number that have existed for between three and four years at the time of reporting	0
Number that have existed for four or more years at the time of reporting	0

Exit packages

There are processes in place for exit packages which take account of national guidance on how these cases will be dealt with and include compliance and approval through NHSE/I as required.

There have been ten staff exit packages during 2023/24.

Exit package cost band	Number of compulsory redundancies	Cost of compulsory redundancies	Number of other departures agreed	Cost of other departures agreed	Total number of exit packages	Total cost of exit packages
<£10,000	0	0	10	35	10	35
£10,000 - £25,000	0	0	0	0	0	0
£25,001 - £50,000	0	0	0	0	0	0
£50,001 - £100,000	0	0	0	0	0	0
£100,001 - £150,000	0	0	0	0	0	0
£150,001 - £200,000	0	0	0	0	0	0
>£200,000	0	0	0	0	0	0
Total	**0**	**0**	**10**	**35**	**10**	**35**

Figures are subject to audit

Exit packages: non-compulsory departure payments

	Agreement Numbers 2023/24	Total Value of agreements £000
Voluntary redundancies including early retirement contractual costs	0	0
Mutually agreed resignations (MARS) contractual costs	0	0

Early retirements in the efficiency of the service contractual costs	0	0
Contractual payments in lieu of notice	10	35
Exit payments following employment tribunals or court orders	0	0
Non-contractual payments requiring HMT approval	0	0
Total	**10**	**35**
Of which: Non-contractual payments requiring HMT approval made to individuals where the payment value was more than 12 months of their annual salary	0	0

The policy on payment for loss of office

Director notice periods are set by the EN&RC and for other senior managers on Agenda for Change terms and conditions of employment, these are agreed through our Joint Partnership Forum.

Any payments for loss of office will be in line with contractual entitlements. This would include, where appropriate, a payment in lieu of notice and payment of outstanding annual leave. The circumstances of the loss of office may impact entitlement, for example, in the event of a summary dismissal from employment due to gross misconduct, no notice would be payable.

Expenditure on consultancy

There were two management consultancy appointments made during 2023/24 which had a contract value greater than £50,000 in relation to advice provided to the Trust. These were provided by Church Barn Consulting Ltd for midwifery services consultancy (£50,412) and GGI development and research LLP for a governance review (£57,822).

Total expenditure on management consultancy during the year was £181,287 (2022/23: £154,043) as shown in note 5 on page 32 of the financial statements.

NHS

James Paget University Hospitals

NHS Foundation Trust

FINANCIAL STATEMENTS

FOR THE YEAR ENDED 31 MARCH 2024

Financial Statements

Statement of Accounting Officer's Responsibilities

Statement of the Chief Executive's responsibilities as the Accounting Officer of the James Paget University Hospitals 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 [name] 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 [name] NHS Foundation Trust and of its income and expenditure, other items of comprehensive income and cash flows for the financial year.

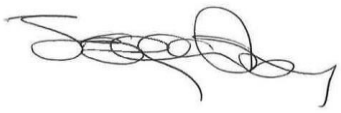
In preparing the accounts and overseeing the use of public funds, the Accounting Officer is required to comply with the requirements of the Department of Health and Social Care's Group Accounting Manual and in particular to:

- 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; 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.



Jo Segasby
Chief Executive
27 June 2024

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 James Paget University Hospitals 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 James Paget University Hospitals NHS Foundation Trust for the year ended 31 March 2024 and up to the date of approval of the annual report and accounts.

Capacity to manage risk

The Trust has in place a Risk Management and Assurance Strategy (the Risk Strategy) which makes it clear that overall leadership and responsibility for risk management is delegated by the Trust Board of Directors to the Chief Executive. The Audit Committee receives reports and assurance from the directors and managers as appropriate, concentrating on the overarching systems of integrated governance, risk management and internal control, together with indicators of their effectiveness. While responsibility for monitoring and assessing the suitability of the system of internal control is delegated to the Audit Committee, each of the other Board Committees has a responsibility for risk as defined in their Terms of Reference. In each instance, the Committee seeks and tests evidence and assurance that the Trust has effective systems and processes in place to identify and manage risk related to the subject specialism of the Committee, for example, finance, performance, quality, and safety.

Each Committee is required to review the suitability and implementation of risk mitigation plans with reference to their potential impact on service quality and patient outcomes. Taking into consideration the Board's Risk Appetite Statement, each Committee shall review:

- The Corporate Risk Register;
- The Board Assurance Framework report; and,
- Exception reports from the Executive members and required attendees of the Committee.

All Board Committees seek and test assurance that risks to the specialist subject of the Committee are being effectively identified and treated.

Responsibility for the management of risk is delegated by the Chief Executive to several formal Management Groups which are overseen by the Executive and the Hospital Management Group. These Management Groups include:

- Executive Risk Oversight Group
- Hospital Management Group
- Patient Safety and Experience Group
- Clinical Effectiveness Group
- Education and Development Steering Group
- Equity, Diversity, and Inclusion (EDI) Steering Group
- People and Culture Steering Group
- Digital Transformation Group

- Estates Delivery Group
- Health and Safety Committee (a management group)
- Information Governance Management Group
- Divisional Boards
- Divisional Governance Groups

The Risk Strategy also identifies the responsibilities of Executive Directors, Deputy Directors, Divisional Directors, managers, and all staff and clearly defines their role and function in the risk management framework. The Board of Directors has clearly articulated that it has no appetite for risk to patients and set out its wider risk appetite as follows:

“The Trust Board has the lowest tolerance for risks that negatively impact on patient safety; including risks to achieving national minimum safe staffing levels applicable at any given time. The Trust has a greater appetite to take considered risks in relation to areas that provide potential benefits for patients. The Trust has the greatest appetite to pursue innovation, challenge current working practices and take opportunities where there are anticipated benefits for our local population, whilst operating within appropriate governance arrangements (including using Clinical Quality Risk Assessments as part of any change) and regulatory constraints, and accepting potential reputational risks.”

In addition, the Board included the following statement in relation to its strategic ambitions:

“The Trust Board will ensure that patients are at the centre of what we do and will not by choice introduce service changes or risks that negatively impact on patient safety. As a minimum, the Trust will always maintain the applicable national safe staffing levels as set by NHS England. However, the Trust recognises that in a financially challenged NHS the need to work differently and reconfigure services may have a negative impact on patient safety as well as the patient’s view of their experience. We will robustly assess risks using our risk assessment processes where local circumstances require deviation from nationally imposed minimum standards.”

The Board Committees receive and review the Risk Register at each meeting. Additionally, regular review of the Board Assurance Framework report is undertaken by the Committees and includes an analysis of whether achievement of the strategic objectives is on track and if not, whether the Board may wish to consider reviewing priorities to address risk in the applicable operating environment and context.

Suitable risk management training is provided to all staff in accordance with the Risk Policy to ensure staff are aware of their responsibilities in relation to the identification and management of risk.

The Trust records and manages incidents using a digital system which is overseen and kept up to date by nominated staff.

An introduction to the risk reporting system is provided for staff at induction together with information on what should be reported and when. This introduction is supplemented by bespoke training for individuals, departments, and staff groups on request or if deemed necessary following incidents. Awareness-raising is undertaken periodically in relation to incident reporting including when new national guidance is issued, such as in the case of Never Events. All incidents are investigated and ways to cascade the learning are included in action plans signed off and monitored by Divisions.

All relevant policies are available on the Trust’s intranet and guidelines covering all elements of risk management are available in the procedural document library.

Public and other stakeholders engage in the identification and management of risks which might impact them, including the following organisations and forums:

- Health Overview and Scrutiny Committees
- Local Authorities and Social Services

- Partners and neighbours of the Integrated Care Board, the Integrated Care System, including Norfolk and Norwich University Hospitals NHS Foundation Trust, East of England Ambulance Service NHS Trust, Norfolk and Suffolk NHS Foundation Trust, Queen Elizabeth Hospital King's Lynn NHS Foundation Trust, and East Coast Community Health Community Interest Company

The risk and control framework

Risk is assessed using a risk estimation matrix which has been developed for use throughout the Trust to standardise the risk ratings assigned to each identified risk, taking into account the Board's Risk Appetite statement. Standardisation in this way allows for the Board to consider what levels of tolerance to apply to each risk or set of risks identified in the Risk Register and Board Assurance Framework report.

The Trust's Board Assurance Framework sets out the principal risks to delivery of its strategic objectives. The Executive Director with delegated responsibility for managing and monitoring each risk is clearly identified. The Board Assurance Framework identifies the assurances available to the Board of Directors in relation to the achievement of the Trust's key priorities and objectives. The principal risks to the delivery of these objectives are mapped to key controls.

The Trust's risk management approach establishes the appetite for risk and determines whether risks are to be tolerated or not. Where it is determined that risks are to be managed, priorities are assigned with resources and timescales for remedial action identified. Each of the Board Committees consider high and extreme risks at each meeting and reviews additions, closures, and amendments to the risk register. The Audit Committee reviews and receives assurance from the relevant Executive Director in relation to the key risks to their portfolio annually and on a rolling basis.

Issues related to data security and general cyber security are monitored through the IT Security Group which reports to the Information Governance Management Group (IGMG) which in turn reports to the Hospital Management Group. Risks and adverse incidents are reviewed at every meeting of the IGMG.

The Trust has an overarching People Plan which looks to the medium- and long-term workforce planning and supply in support of the resourcing requirements of the Trust's strategic ambitions and objectives. In terms of operational assurance, daily dynamic risk assessment reviews are undertaken for nursing and allied health professionals to ensure the continuity and suitability of safe staffing levels. The Trust undertakes regular establishment reviews in accordance with national guidance, best practice, and professional judgement and provides significant assurance to the Board of Directors via dedicated reports published in the public domain.

"Developing Workforce Safeguards" guidance sets out a clear accountability framework for NHS organisations in relation to expectations for the delivery of best practice standards for workforce deployment and planning. The Trust's compliance with the recommendations in relation to the nursing workforce are regularly reported to the Board. The Board's People and Culture Committee receives a report from the Chief Medical Officer with respect to recruitment challenges and solutions regarding the medical workforce.

The Trust collaborates closely with partners across the Norfolk and Waveney Integrated Care System (the ICS) to explore opportunities for future workforce development. The Trust's Digital Workforce Team lead system-wide projects on bank and agency collaborations.

The Trust continues to develop a comprehensive mental health improvement programme for patients, visitors, and staff. The programme covers five work streams across the organisation which include: Staff Mental Wellbeing and Experience, Patient and Staff Safety, Staff Education and Training, Carer and Patient Experience and Patient Pathway. This has been integrated into the Trusts Wellbeing Programme.

The Trust has a Staff Engagement and Wellbeing Manager, a role which is an important conduit between staff and employer, spending dedicated time engaging, listening, and conversing with staff. The role has concentrated in identifying and reaching “hard to reach” staff groups across the Trust.

The Trust has a Freedom to Speak Up (FTSU) service with a dedicated Lead FTSU Guardian who reports in line with publications from the National FTSU Guardian’s office and presents at public Board meetings twice a year. There is a Non-executive Director lead for Freedom to Speak Up.

The Chief Executive continues to support the Time to Change Employer Pledge, a national movement working towards eliminating discrimination and stigma in mental health, demonstrating that the Trust is an organisation which is taking positive action towards improving mental health interventions for staff. The Trust supports an Inclusion Network which helps to promote equity, diversity, and inclusion. The aim of the network being to encourage diversity and address any areas of discrimination and inequality.

The Trust has 25 trained Wellbeing Champions located in a wide range of areas across the organisation. The Wellbeing Champions have training in Mental Health First Aid and play a vital role in providing a listening ear to staff and signposting them to a range of wellbeing events throughout the year.

The Trust is considered to be fully compliant with the registration requirements of the Care Quality Commission.

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

Control measures are in place to ensure that all the organisation’s obligations under equality, diversity and human rights legislation are discharged effectively. We publish an up-to-date register of declarations of interests, gifts, and hospitality as required by the ‘Managing Conflicts of Interest in the NHS’ guidance.

The Trust has undertaken risk assessments and has plans in place which take account of the “Delivering a Net Zero Health Service” report under the Greener NHS programme. The Trust ensures that its obligations under the Climate Change Act and the Adaptation Reporting requirements are complied with.

In addition to the detailed risk management activities undertaken across the Trust, the Board was concerned with risk in several key areas as follows.

Key Risks and management overview

In the past year, the Trust has proactively identified and managed several critical risks that could significantly impact our strategic priorities. The Board Assurance Framework (BAF) has been instrumental in monitoring these risks, ensuring that robust controls and mitigation actions are in place to protect the Trust’s operations and objectives. We have developed our BAF Report considerably so that it clearly outlines the primary risks, their potential impact on our strategic priorities, the measures implemented to control and mitigate these risks, and the residual status following our risk management actions.

Insufficient capacity to meet demand (Risk 434)

One of the major risks identified is the insufficient capacity to meet the growing demand for healthcare services, which threatens our ability to provide timely and effective care. This risk impacts our strategic priority of optimising our physical and financial resources. To control this

risk, we have established a day-to-day operational structure and enhanced our demand forecasting and capacity planning processes. Despite these efforts, the residual risk remains moderately high due to the ongoing pressures on our services. The Executive continues to monitor this risk closely, implementing further actions as necessary to manage fluctuations in demand.

Regulatory oversight and compliance (Risk 437)

Regulatory oversight remains a critical area, with the potential for non-compliance leading to significant operational and reputational damage. This risk impacts our priority of providing the best and safest care for our patients. Our controls include active participation in national programs such as the National Maternity Safety Support Programme, rigorous internal audits, and continuous training for compliance with regulatory standards. Although these controls are largely effective, the residual risk rating remains considerable, reflecting the dynamic regulatory environment and our attention to service quality.

The Trust's most recent inspection from the Care Quality Commission (CQC) was of the hospital's maternity services, which took place on 10 January 2023. The inspection report was published on 31 May 2023.

Our Maternity Service was inspected against two of the five domains – safe and well-led – and was rated as 'inadequate' in both. This outcome caused the overall rating for the James Paget's Maternity Service to change from 'good' to 'inadequate' and the hospital's core services to be classified as 'Requires Improvement'.

The Trust also received a Regulation Section 29A warning notice from the CQC regarding concerns about maternity services in February 2023. The report outlined concerns about staffing and training levels in maternity services, the relationship between midwifery and obstetric staff, and reporting arrangements in the service. By contrast, the report recognised the work of the Eden Team of three midwives providing care to birthing people with complex social and/or mental health needs.

To achieve changes and rapid improvement to its services, the James Paget implemented a comprehensive Maternity Improvement Plan. This plan incorporated strategic and operational actions for maternity services, and continued work towards the quality recommendations outlined in the Ockenden Report of 2022.

Workforce shortages and skill mix gaps (Risk 412)

Workforce shortages pose a significant risk to our ability to deliver high-quality patient care and achieve our strategic priority of maintaining a skilled and motivated workforce. Mitigation strategies include daily staffing summits, an annual job planning review, and the implementation of flexible working arrangements to attract and retain staff. The residual risk has been reduced but remains a concern due to external factors influencing workforce availability and retention. Ongoing efforts are focused on improving staff recruitment and retention strategies to address this risk.

Funding and resource constraints (Risk 413)

Insufficient funding and resource constraints are critical risks that could impede the Trust's ability to achieve its strategic goals. This risk affects our ability to provide safe and effective care. To mitigate this risk, we have implemented robust budget setting processes, yearly capital investment plans, and continuous financial monitoring including close monitoring of the financial improvement plan.

While these measures have been effective in managing the immediate risks, the residual risk remains at a moderate level, necessitating continuous oversight and adjustment of our financial strategies and improvement plans.

Health inequalities and diverse needs (Risk 416)

Ensuring that we meet the diverse needs of our population and reduce health inequalities is a fundamental priority. The risk of failing to adequately address these needs can lead to disparities in health outcomes. Our controls include joint working groups with system partners, targeted health promotion initiatives, and community engagement programs. These efforts have been partly effective in mitigating the risk, with a residual risk rating indicating that there is still work to be done to fully address all aspects of health inequalities.

In summary, the Trust has implemented comprehensive controls and mitigation strategies to manage key risks effectively. The Board remains vigilant, continuously reviewing and enhancing our risk management processes to ensure that any emerging risks are promptly addressed. While residual risks persist in certain areas, the Executive is committed to ongoing risk mitigation efforts, ensuring that our strategic priorities are safeguarded and that we continue to provide high-quality, safe, and equitable care to all our patients within the available funding envelope.

Principal risks to compliance with the NHS Provider Licence Section 4 (Governance)

The principal risks to compliance with the NHS provider licence section 4 (governance) primarily revolve around the effectiveness of governance structures, the responsibilities of directors and committees, reporting lines and accountabilities, the submission of timely and accurate information, and the degree of oversight by the Board over the Trust's performance.

Effectiveness of governance provisions

The governance structures are designed to ensure clear leadership and accountability within the Trust. The Board of Directors holds ultimate responsibility for the strategic direction and oversight of the organisation. To mitigate risks, the Board regularly reviews the effectiveness of these structures and makes adjustments as necessary. Regular audits and independent reviews are conducted to ensure that governance frameworks are robust and meet regulatory requirements. The Patient Safety and Quality Committee (PSQC) plays a significant role in maintaining oversight and ensuring that quality governance aligns with the Trust's strategic objectives.

In addition to the standard operation of our system of risk management and internal control, this year we commissioned an independent review of Corporate Governance, including a review of compliance with the CQC Well-led Framework. The review constitutes the 5-yearly review recommended as good practice in the NHS England Code of Governance for NHS Provider trusts. Results of the review were presented at the end of the year, and all recommendations for adopting enhanced levels of governance and risk management are being implemented and will be reported in the next Annual Report.

In summary, the report found "the Trust James Paget is seen by those consulted as being a good organisation which is well run with strong compassionate leadership and a clear focus on operational delivery. There is a positive culture and good governance systems. We saw much that was very good and the areas for improvement that we have identified need to be seen in that context to help the trust on a journey to outstanding."

Responsibilities of directors and committees

The responsibilities of directors and committees are clearly defined within the governance framework which is founded on the NHS Foundation Trust Constitution. Directors are accountable for their respective areas, ensuring that risks are identified, assessed, and managed effectively. Board committees such as the Audit Committee and PSQC have specific mandates to review and oversee the efficacy of risk management processes, ensuring compliance with accepted governance standards. Training and guidance are provided to directors and committee members to equip them with the necessary skills and knowledge to fulfil their responsibilities effectively.

Reporting lines and accountabilities

Clear reporting lines and accountabilities between the Board, its committees, and the Executive team are established to ensure efficient communication and decision-making. These provisions are documented in organisational charts and terms of reference. Regular reporting mechanisms

provide the Board with timely and accurate information on risk management and compliance. This includes monthly and quarterly reviews of risk registers, performance reports, and compliance audits. These mechanisms ensure that any changes in risk profiles are promptly addressed and managed.

Submission of timely and accurate information

The Trust has established procedures to ensure the timely and accurate submission of information necessary to assess compliance with the NHS provider licence. This includes regular data quality checks and audits to verify the accuracy of submitted information.

Degree and rigour of Board oversight

The Board of Directors exercises rigorous oversight over the Trust's performance through a comprehensive framework of reviews, audits, and performance monitoring. This includes regular meetings, detailed performance reports, and risk management updates. The Chief Nurse, as the Executive lead for risk, ensures that any issues identified are addressed promptly and that continuous improvement processes are in place. The effectiveness of internal controls and the overall governance framework is regularly assessed to ensure they meet the highest standards of accountability and transparency.

Risk management is an integral component of our Trust's operations, permeating all aspects of our activities to ensure patient safety, clinical effectiveness, and an enhanced patient experience.

This structured approach to governance and risk management ensures that the Trust remains compliant with the NHS provider licence.

Our commitment to embedding risk management includes:

Equality Impact Assessments (EIAs)

EIAs are systematically integrated into our core business processes. They are conducted for all new policies, procedures, and service changes to ensure that no group is disadvantaged. This proactive approach helps us identify potential disparities and implement measures to mitigate them, fostering an inclusive environment.

Incident reporting

We maintain a culture of openness and transparency in incident reporting. Staff are encouraged to report any incidents or near misses through our established reporting system without fear of retribution. This data is then used to analyse trends, identify risks, and implement corrective actions to prevent future occurrences. Regular training and communication ensure that all staff understand the importance of incident reporting and are proficient in using the reporting tools.

Risk registers

The Trust maintains a single repository (register) for all risk data. The system supports risk reporting pertinent to departmental, corporate, and Board-level scrutiny. Risk reports are reviewed regularly by the Executive, hospital management groups, Board committees, and the Board (using the Board Assurance Framework Report) to ensure that risks are being managed effectively and that any emerging risks are promptly identified, quantified, and addressed.

Involvement of stakeholders in managing risks

Public stakeholders play a crucial role in our risk management processes. We engage with them through various channels to ensure their input is considered in our decision-making:

Consultations

We conduct regular public consultations to gather feedback on potential risks and the effectiveness of our risk management strategies. This includes surveys, focus groups, and public meetings. The insights gained from these consultations help us tailor our risk management approaches to better meet the needs and expectations of our community.

Patient and public engagement

We have established groups that include patient representatives and members of the public. These groups are actively involved in reviewing our risk management plans and providing input on key decisions. Their perspectives are invaluable in ensuring that our strategies are comprehensive and community focused.

Transparent communication

We are committed to keeping our stakeholders informed about our risk management activities. Regular updates are provided through our website, newsletters, and public reports. This transparency helps build Trust and ensures that stakeholders are aware of how we are managing risks that may impact them.

Ensuring safe, sustainable, and effective workforce strategies

To ensure that our workforce strategies are safe, sustainable, and effective, we adhere to the principles outlined in the “Developing Workforce Safeguards” guidance, including:

Workforce Planning

We conduct thorough workforce planning to ensure that staffing levels meet the demands of our services. This includes forecasting future staffing needs based on service projections and patient acuity levels. We also develop contingency plans to address unexpected changes in staffing requirements.

Staffing Systems

Our staffing systems are designed to monitor and manage workforce capacity in real-time. We use electronic rostering and acuity tools to ensure that staffing levels are appropriate for the patient load. This allows us to quickly address any staffing shortfalls and maintain safe care environments.

Training and Development

Continuous professional development is a cornerstone of our workforce strategy. We provide regular training programs to enhance the skills and competencies of our staff. This includes mandatory training, specialised clinical training, and leadership development programs. By investing in our staff, we ensure that they are equipped to deliver high-quality care.

Information governance

The Trust reported one information governance matter related to the Maternity (E3) records management system. The incident was notified to the Information Commissioner’s Office (the ICO) and investigated by the ICO under reference INV/0173/2023. The ICO confirmed their awareness of the concern as NHS England had previously issued a Patient Safety Alert on 07 December 2023 in reference to the identified safety risks arising from the maternity information system. The ICO confirmed the incident remains under review as their enquiries in relation to this incident are not complete and are being incorporated into a larger piece of work by the ICO.

Data quality assurance

There are standards and processes in place to ensure that data and metrics used to determine quality and performance are accurate, up to date, and complete. These controls are subject to review to confirm that they are working effectively in practice and the data underpinning the measures of performance are robust and dependable, conform to specified data quality standards and prescribed definitions, and are subject to appropriate scrutiny and review.

The systems in place to collect and report on quality metrics have been transformed into a comprehensive Integrated Performance Report (IPR) used by the Board of Directors and the Executive Team to monitor performance, quality, and safety metrics. The report is presented at each public meeting of the Board. Each key performance indicator that the Board monitors is assigned to a Committee of the Board whose work plan is shaped around the key risks and these KPIs. There are monthly performance meetings between the Executive and Divisional Management focussing on quality and performance metrics. Reporting by clinical divisions to the Hospital Management Group, and onwards to the Board Committees ensures Board oversight of

the key priorities for Quality as set out in the Quality Report. Progress on achieving the agreed quality priorities is presented directly to the Board each quarter.

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

The internal audit work methodology highlights areas as advisory where inefficiencies or good practice have been identified.

The Trust has in place a Local Counter Fraud Specialist whose work plan includes providing information to and engaging with staff, prevention through the work of the Fraud Risk Group, including fraud specific risk assessments, and holding to account through investigations. Ahead of the submission of the Counter Fraud Functional Standard Return (CFFSR) on 31st May 2024.

The Trust's usual transformation methodology and approach identifies and highlights any potential for the furtherance of economy, efficiency and effectiveness and is balanced and further assured through the clinical quality risk assessment process. The Trust's transformation governance and processes were reviewed and updated to enhance the support and delivery of efficiencies during 2023/24. In 2023/24 the Trust's financial plan included an efficiency savings target of £16.1m. The Trust achieved savings during 2023/24 of £16.4m, of which £8.3m was non-recurrent and £8.1m was recurrent. The total of £16.4m represents 4.7% of the Trust's expenditure before efficiencies.

The Board of Directors receives assurances on the use of resources from agencies outside the Trust including NHSE, which requires the Board of Directors to self-assess in accordance with the Single Oversight Framework. The Trust has a rating of 'good' following its most recent use of resources CQC inspection during 2019. Other sources of assurance include reviews conducted by Royal Colleges and Getting it Right First Time (GIRFT).

The Trust further obtains assurance of its systems and processes and tests efficiency through benchmarking by membership of NHS Providers and the NHS Benchmarking Network where other bodies share good practice. Also, the Trust continues to take part in the nationally mandated cost collection exercise which, amongst other purposes, provides information on the relative efficiency and assessment of productivity. The Trust's most recent National Cost Collection Index score of 106 relates to 2021/22 data.

Another source of benchmarking assurance is provided through the data published in Model Health System. The Trust has in place governance arrangements to oversee internal projects to implement recommendations as and when new information is released to the Model Health portal.

The Board of Directors receives a monthly report of Care Hours per Patient Day (CHPPD) actual versus required, which reflects nursing hours only. This is one of many tools used by the Board to monitor safe staffing levels across all areas of the Trust.

Review of effectiveness of the system of risk management and internal control

During the fiscal year 2023-24, an extensive internal audit programme was conducted by PwC, following the Public Sector Internal Audit Standards, to evaluate the robustness of our risk management and internal control systems. We do not shy away from difficult areas and approached our audit plan by focussing on areas of concern. These planned internal audit reviews have highlighted key findings, which are summarised below.

Overall assurance

PwC's internal audit opinion for 2023-24 indicates that while the internal control systems are generally satisfactory, and no critical risk findings were raised, there are areas within the control environment where improvements can be made. These finding highlights opportunities to enhance these systems further to fully support the achievement of the

Trust's objectives.

Findings

The audit identified six "high-risk" findings which necessitate prompt attention to mitigate potential impacts:

Key financial controls - Cost Improvement Programme (CIP)

The internal audit identified opportunities to enhance our Performance Management Framework, which will clarify roles and escalation processes within CIP governance. Additionally, completing and documenting all gateway documents for CIP schemes, including approvals, risks, and milestones, will further strengthen our processes.

Identity access management

The audit highlighted opportunities to improve the efficiency and timeliness of user access removal for leavers. Addressing this will ensure accounts are deactivated promptly upon employment termination. Regular, rather than ad hoc, reviews of user access rights will enhance compliance with the Trust's IT Security Policy.

Temporary staffing

The audit found opportunities to improve the authorisation processes for personnel performing critical tasks within the HealthRoster system. Additionally, timely updates of bank and agency shifts will enhance the accurate validation of worked shifts.

Other opportunities for improvement

The internal audit identified areas to further strengthen our governance, risk management, and control mechanisms. Enhancing the tracking and validation of completed actions will lead to more reliable reporting of action closure to the Audit Committee.

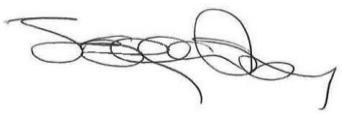
The Trust has made significant progress in addressing previous audit recommendations, achieving closure on several high- and medium-risk items. Moving forward, the Executive team will implement more robust documentation practices to ensure thorough follow-up on all action items, thereby reinforcing our commitment to continuous improvement and excellence in governance.

Conclusion

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, including the Independent Review of Corporate Governance and the Well-led Framework conducted in-year by the Good Governance Institute.

While the internal audit findings underscore the need for ongoing enhancements in our internal control frameworks and risk management processes, no significant internal control issues have been identified in this reporting period.

We are committed to addressing the identified opportunities promptly and effectively, ensuring that our governance structures remain robust and capable of supporting the Trust's strategic objectives. These improvements will also align with the principles outlined in our governance documentation, including the Three Lines of Defence model. We will continue to monitor and improve our systems to ensure they provide the necessary assurances for effective governance, risk management, and internal control.



Jo Segasby, Chief Executive, 27 June 2024

Independent Auditor's Report to the Council of Governors

Report on the audit of the Financial Statements

Opinion

We have audited the financial statements of James Paget University Hospitals NHS Foundation Trust ("the Trust") for the year ended 31 March 2024 which comprise the Statement of Comprehensive Income, Statement of Financial Position, Consolidated Statement of Changes in Taxpayers' Equity and Consolidated Statement of Cash Flows, and the related notes, including the accounting policies in note 1.

In our opinion the financial statements:

- give a true and fair view of the financial position of the Group and the Trust as at 31 March 2024 and of the Group's and the Trust's income and expenditure for the year then ended; and
- have been properly prepared in accordance with the accounting policies directed by NHS England with the consent of the Secretary of State in February 2024 as being relevant to NHS Foundation Trusts and included in the Department of Health and Social Care Group Accounting Manual 2023/24; and
- have been prepared in accordance with the requirements of the National Health Service Act 2006 (as amended).

Basis for opinion

We conducted our audit in accordance with International Standards on Auditing (UK) ("ISAs (UK)") and applicable law. Our responsibilities are described below. We have fulfilled our ethical responsibilities under and are independent of the Group and Trust in accordance with, UK ethical requirements including the FRC Ethical Standard. We believe that the audit evidence we have obtained is a sufficient and appropriate basis for our opinion.

Going concern

The Accounting Officer has prepared the financial statements on the going concern basis as they have not been informed by the relevant national body of the intention to either cease the Group and the Trust's services or dissolve the Group and the Trust without the transfer of their services to another public sector entity. They have also concluded that there are no material uncertainties that could have cast significant doubt over their ability to continue as a going concern for at least a year from the date of approval of the financial statements ("the going concern period").

In our evaluation of the Accounting Officer's conclusions, we considered the inherent risks associated with the continuity of services provided by the Group and the Trust over the going concern period.

Our conclusions based on this work:

- we consider that the Accounting Officer's use of the going concern basis of accounting in the preparation of the financial statements is appropriate; and
- we have not identified and concur with the Accounting Officer's assessment that there is not, a material uncertainty related to events or conditions that, individually or collectively, may cast significant doubt on the Group's and the Trust's ability to continue as a going concern for the going concern period.

However, as we cannot predict all future events or conditions and as subsequent events may result in outcomes that are inconsistent with judgements that were reasonable at the time they were made, the above conclusions are not a guarantee that the Group and the Trust will continue in operation.

Fraud and breaches of laws and regulations – ability to detect

Identifying and responding to risks of material misstatement due to fraud

To identify risks of material misstatement due to fraud ("fraud risks") we assessed events or conditions that could indicate an incentive or pressure to commit fraud or provide an opportunity to commit fraud. Our risk assessment procedures included:

- Enquiring of management, the Audit Committee and internal audit as to the Group's and Trust's high-level policies and procedures to prevent and detect fraud, as well as whether they have knowledge of any actual, suspected, or alleged fraud.
- Reading Board and Audit Committee minutes.
- Using analytical procedures to identify any unusual or unexpected relationships.

We communicated identified fraud risks throughout the audit team and remained alert to any indications of fraud throughout the audit.

As required by auditing standards and taking into account possible pressures to meet delegated targets, we performed procedures to address the risk of management override of controls in particular the risk that Group and Trust management may be in a position to make inappropriate accounting entries. On this audit we did not identify a fraud risk related to revenue recognition due to the block nature of the majority of funding provided to the Trust during the year, and that other income streams are high volume transactions with a low value, and with simple recognition criteria which present minimal year end cut off risk. We therefore assessed that there was limited opportunity for the Trust to manipulate the income that was reported.

We identified a fraud risk related to the cut off of non-pay, non-depreciation expenditure in response to incentives to manipulate the results of the Trust and System to meet the expectations or performance targets set by the government or external regulators and the opportunity to manipulate the non-pay, non-depreciation expenditure at year end, particularly in relation to accruals.

We identified a fraud risk related to the completeness of liabilities and related expenses for the purchases of goods or services as a result of the significant reduction in accruals balances compared to prior year.

We did not identify any additional fraud risks.

We performed procedures including:

- Identifying journal entries to evaluate based on risk criteria and comparing the identified entries to supporting documentation. These included unusual cash, expenditure during the close down period, and income code combinations.
- Assessing whether the judgements made in making accounting estimates are indicative of a potential bias.
- Inspecting a sample of non-pay, non-depreciation expenditure items before and after the year end date to verify they have been recognised and accrued in the correct period.
- Inspecting a sample of payments made post year end, to determine whether the in-year expenditure and associated liabilities are complete.

We identified areas of laws and regulations that could reasonably be expected to have a material effect on the financial statements from our general sector experience and through discussion with the Accounting Officer and other management (as required by auditing standards) and discussed with the Accounting Officer and other management the policies and procedures regarding compliance with laws and regulations.

As the Trust is regulated, our assessment of risks involved gaining an understanding of the control environment including the entity's procedures for complying with regulatory requirements.

We communicated identified laws and regulations throughout our team and remained alert to any indications of non-compliance throughout the audit.

The potential effect of these laws and regulations on the financial statements varies considerably.

Firstly, the Group and Trust is subject to laws and regulations that directly affect the financial statements, including the financial reporting aspects of NHS legislation. We assessed the extent of compliance with these laws and regulations as part of our procedures on the related financial statement items.

Secondly, the Group and Trust is subject to many other laws and regulations where the consequences of non-compliance could have a material effect on amounts or disclosures in the financial statements, for instance through the imposition of fines or litigation. We identified the following areas as those most likely to have such an effect: health and safety, data protection laws, anti-bribery, employment law, recognising the nature of the Group's and the Trust's activities. Auditing standards limit the required audit procedures to identify non-compliance with these laws and regulations to enquiry of the Accounting Officer and other management and inspection of regulatory and legal correspondence, if any. Therefore, if a breach of operational regulations is not disclosed to us or evident from relevant correspondence, an audit will not detect that breach.

Context of the ability of the audit to detect fraud or breaches of law or regulation

Owing to the inherent limitations of an audit, there is an unavoidable risk that we may not have detected some material misstatements in the financial statements, even though we have properly planned and performed our audit in accordance with auditing standards. For example, the further removed non-compliance with laws and regulations is from the events and transactions reflected in the financial statements, the less likely the inherently limited procedures required by auditing standards would identify it.

In addition, as with any audit, there remained a higher risk of non-detection of fraud, as fraud may involve collusion, forgery, intentional omissions, misrepresentations, or the override of internal controls. Our audit procedures are designed to detect material misstatement. We are not responsible for preventing non-compliance or fraud and cannot be expected to detect non-compliance with all laws and regulations.

Other information in the Annual Report

The Accounting Officer is responsible for the other information, which comprises the information included in the Annual Report, other than the financial statements and our auditor's report thereon. Our opinion on the financial statements does not cover the other information and, accordingly, we do not express an audit opinion or, except as explicitly stated below, any form of assurance conclusion thereon.

Our responsibility is to read the other information and, in doing so, consider whether, based on our financial statements audit work, the information therein is materially misstated or inconsistent with the financial statements or our audit knowledge. Based solely on that work:

- we have not identified material misstatements in the other information; and
- in our opinion the other information included in the Annual Report for the financial year is consistent with the financial statements.

Annual Governance Statement

We are required by the Code of Audit Practice published by the National Audit Office in April 2020 on behalf of the Comptroller and Auditor General (the "Code of Audit Practice") to report to you if the Annual Governance Statement has not been prepared in accordance with the requirements of the NHS Foundation Trust Annual Reporting Manual 2023/24. We have nothing to report in this respect.

Remuneration and Staff Reports

In our opinion the parts of the Remuneration and Staff Reports subject to audit have been properly prepared, in all material respects, in accordance with the NHS Foundation Trust Annual Reporting Manual 2023/24.

Accounting Officer's responsibilities

As explained more fully in the statement set out on page 2, the Accounting Officer is responsible for the preparation of financial statements that give a true and fair view. They are also responsible for: such internal control as they determine is necessary to enable the preparation of financial statements that are free from material misstatement, whether due to fraud or error; assessing the Group's and the Trust's ability to continue as a going concern, disclosing, as applicable, matters related to going concern; and using the going concern basis of accounting unless they have been informed by the relevant national body of the intention to either cease the services provided by the Group and the Trust or dissolve the Group and the Trust without the transfer of their services to another public sector entity.

Auditor's responsibilities

Our objectives are to obtain reasonable assurance about whether the financial statements as a whole are free from material misstatement, whether due to fraud or error, and to issue our opinion in an auditor's report. Reasonable assurance is a high level of assurance but does not guarantee that an audit conducted in accordance with ISAs (UK) will always detect a material misstatement when it exists. Misstatements can arise from fraud or error and are considered material if, individually or in aggregate, they could reasonably be expected to influence the economic decisions of users taken on the basis of the financial statements.

A fuller description of our responsibilities is provided on the FRC's website at www.frc.org.uk/auditorsresponsibilities

Report on other legal and regulatory requirements

Report on the Trust's arrangements for securing economy, efficiency and effectiveness in its use of resources

Under the Code of Audit Practice, we are required to report if we identify any significant weaknesses in the arrangements that have been made by the Trust to secure economy, efficiency and effectiveness in its use of resources.

We have nothing to report in this respect.

Respective responsibilities in respect of our review of arrangements for securing economy, efficiency and effectiveness in the use of resources

As explained more fully in the statement set out on page 2, the Accounting Officer is responsible for ensuring that the Trust has put in place proper arrangements for securing economy, efficiency and effectiveness in its use of resources.

Under Section 62(1) and paragraph 1(d) of Schedule 10 of the National Health Service Act 2006 we have a duty to satisfy ourselves that the Trust has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources.

We are not required to consider, nor have we considered, whether all aspects of the Trust's arrangements for securing economy, efficiency and effectiveness in its use of resources are operating effectively.

We planned our work and undertook our review in accordance with the Code of Audit Practice and related statutory guidance, having regard to whether the Trust had proper arrangements in place to ensure financial sustainability, proper governance and to use information about costs and performance to improve the way it manages and delivers its services. Based on our risk assessment, we undertook such work as we considered necessary.

Statutory reporting matters

We are required by Schedule 2 to the Code of Audit Practice to report to you if any reports to the Regulator have been made under paragraph 6 of Schedule 10 of the National Health Service Act 2006 because we have reason to believe that the Trust, or a director or officer of the Trust, is about to make, or has made, a decision which involves or would involve the incurring of expenditure which is unlawful, or is about to take, or has taken, a course of action which, if pursued to its conclusion, would be unlawful and likely to cause a loss or deficiency.

We have nothing to report in this respect.

The purpose of our audit work and to whom we owe our responsibilities

This report is made solely to the Board of Directors 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 Board of Directors of the Trust, as a body, those matters we are required to state to them in an auditor's report and for no other purpose. To the fullest extent permitted by law, we do not accept or assume responsibility to anyone other than the Board of Directors of the Trust, as a body, for our audit work, for this report, or for the opinions we have formed.

Certificate of completion of the audit

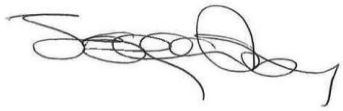
We certify that we have completed the audit of the accounts of James Paget University Hospitals NHS Foundation Trust for the year ended 31 March 2024 in accordance with the requirements of Schedule 10 of the National Health Service Act 2006 and the Code of Audit Practice.

Emma Larcombe

Emma Larcombe
for and on behalf of KPMG LLP
Chartered Accountants
Botanic House
20 Station Road
Cambridge
CB1 2JD
27 June 2024

Foreword to the Accounts

These accounts for the year ended 31 March 2024 have been prepared by the James Paget University Hospitals NHS Foundation Trust in accordance with paragraphs 24 and 25 of schedule 7 to the National Health Service Act 2006 and are presented to Parliament pursuant to Schedule 7, paragraph 25 (4) (a) of the National Health Service Act 2006.



Jo Segasby
Chief Executive
27 June 2024

Statement of Comprehensive Net Expenditure

	Note	**Group Year Ended 31 March 2024 £ 000**	Group Year Ended 31 March 2023 £ 000	**Trust Year Ended 31 March 2024 £ 000**	Trust Year Ended 31 March 2023 £ 000
Operating income from continuing operations	4.2	**326,975**	288,188	**327,008**	288,497
Operating expenses of continuing operations	5	**(347,472)**	(315,770)	**(347,250)**	(315,653)
Operating (deficit)/surplus		**(20,497)**	(27,582)	**(20,242)**	(27,156)
Finance costs					
Finance income	8	**1,208**	471	**1,133**	404
Finance expense - financial liabilities	9 & 21.1	**(56)**	(102)	**(56)**	(102)
Public Dividend Capital - dividends payable		**(2,125)**	(1,557)	**(2,125)**	(1,557)
Net finance costs		**(973)**	(1,188)	**(1,048)**	(1,255)
(Losses)/gains of disposal of assets		**(72)**	-	**(72)**	-
Operating (deficit)/surplus for the year		**(21,543)**	(28,770)	**(21,361)**	(28,411)
Other comprehensive income					
Impairments		**(719)**	-	**(719)**	-
Revaluations		**310**	800	**310**	800
Fair Value gains/(losses) on Available-for-sale financial investments		**128**	(177)	**-**	-
Total comprehensive (expense)/income for the year		**(21,824)**	(28,147)	**(21,771)**	(27,611)

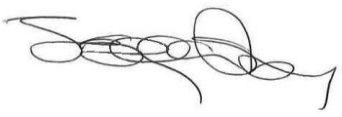
All income and expenditure is derived from continuing operations, and all surplus/deficit and comprehensive income/expense is attributable to the owners of the parent.

The accompanying notes on pages 20 to 54 form part of these accounts.

Statement of Financial Position

	Note	Group As at 31 March 2024 £ 000	Group As at 31 March 2023 £ 000	Trust As at 31 March 2024 £ 000	Trust As at 31 March 2023 £ 000
Non-current assets					
Intangible assets	12	**6,324**	5,627	**6,324**	5,627
Property, plant and equipment	13.1/13.	**109,045**	90,264	**109,045**	90,264
Right of use assets	13.3/13.4	**2,835**	3,322	**2,835**	3,322
Other investments	13.6	**2,643**	2,465	**-**	-
Trade and other receivables	15.2	**666**	473	**666**	473
Total non-current assets		**121,512**	102,151	**118,870**	99,686
Current assets					
Inventories	14.1	**3,469**	2,878	**3,469**	2,878
Trade and other receivables	15.1	**13,809**	20,458	**14,024**	20,522
Cash and cash equivalents	16	**34,852**	8,936	**34,571**	8,419
Total current assets		**52,130**	32,272	**52,064**	31,819
Current liabilities					
Trade and other payables	17.1	**(56,919)**	(55,127)	**(56,919)**	(54,972)
Borrowings	19.1	**(1,575)**	(1,681)	**(1,575)**	(1,681)
Provisions	21.2	**(234)**	(506)	**(234)**	(506)
Other liabilities	17.3	**(1,879)**	(1,585)	**(1,879)**	(1,585)
Total current liabilities		**(60,607)**	(58,899)	**(60,607)**	(58,744)
Total assets less current liabilities		**113,035**	75,524	**110,326**	**72,761**
Non-current liabilities					
Borrowings	19.2	**(1,571)**	(2,252)	**(1,571)**	(2,252)
Provisions	21.3	**(853)**	(984)	**(853)**	(984)
Total non-current liabilities		**(2,424)**	(3,236)	**(2,424)**	(3,236)
Total assets employed		**110,612**	72,288	**107,903**	69,525
Financed by taxpayers' and others' equity					
Charitable funds reserves		**2,709**	2,763	**-**	-
Public dividend capital		**162,365**	102,217	**162,365**	102,217
Revaluation reserve	22	**2,847**	3,256	**2,847**	3,256
Income and expenditure reserve		**(57,309)**	(35,948)	**(57,309)**	(35,948)
Total taxpayers' and others' equity		**110,612**	72,288	**107,903**	69,525

The financial statements on pages 20 to 54 were approved by the Board on 27 June 2024 and signed on its behalf by:



Chief Executive

Chief Finance Officer

The accompanying notes form part of these financial statements.

Consolidated Statement of Changes in Taxpayers' Equity

	Public Dividend Capital £ 000	Revaluation Reserve £ 000	Income and Expenditure Reserve £ 000	Trust Total £ 000	Charitable Funds Reserves £ 000	Group Total £ 000
Taxpayers' equity at 1 April 2023 as stated	102,217	3,256	(35,948)	69,525	2,763	72,288
Taxpayers' equity at 1 April 2023	102,217	3,256	(35,948)	**69,525**	2,763	**72,288**
Surplus/(Deficit) for the year	-	-	(21,668)	**(21,668)**	125	**(21,544)**
Impairments	-	(719)	-	**(719)**	-	**(719)**
Revaluations - property, plant and equipment	-	310	-	**310**	-	**310**
Fair Value gains/(losses) on Available-for-sale financial investments	-	-	-	**-**	128	**128**
Other - charitable funds consolidation	-	-	307	**307**	(307)	**-**
Public Dividend Capital received	60,148	-	-	**60,148**	-	**60,148**
Taxpayers' equity at 31 March 2024	**162,365**	**2,847**	**(57,309)**	**107,902**	**2,709**	**110,611**
Taxpayers' equity at 1 April 2022	80,258	2,456	(7,537)	75,177	3,299	78,476
Surplus/(Deficit) for the year	-	-	(28,907)	(28,907)	137	(28,770)
Impairments	-	-	-	-	-	-
Revaluations - property, plant and equipment	-	800	-	800	-	800
Fair Value gains/(losses) on Available-for-sale financial investments	-	-	-	-	(177)	(177)
Other - charitable funds consolidation	-	-	496	496	(496)	-
Public Dividend Capital received	21,959	-	-	21,959	-	21,959
Taxpayers' equity at 31 March 2023	102,217	3,256	(35,948)	69,525	2,763	72,288

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 used by the trust, is payable to the Department of Health and Social Care as the public dividend capital dividend.

Revaluation reserve

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

Income and expenditure reserve

The balance of this reserve is the accumulated surpluses and deficits of the Trust.

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 28.

The accompanying notes form part of these financial statements.

Consolidated Statement of Cash Flows

	Group Year Ended 31 March 2024 £ 000	Group Year Ended 31 March 2023 £ 000	Trust Year Ended 31 March 2024 £ 000	Trust Year Ended 31 March 2023 £ 000
Cash flows from operating activities				
Operating (deficit)/surplus from continuing operations	**(20,497)**	(27,582)	**(20,242)**	(27,156)
Operating surplus	**(20,497)**	(27,582)	**(20,242)**	(27,156)
Non-cash income and expense:				
Depreciation and amortisation	**10,599**	9,190	**10,599**	9,190
Impairments	**20,889**	2,796	**20,889**	2,796
Income recognised in respect of capital donations	**-**	-	**(58)**	(80)
(Increase)/decrease in trade and other receivables	**6,386**	(10,366)	**6,245**	(10,336)
(Increase)/decrease in Inventories	**(591)**	304	**(591)**	304
Increase/(decrease) in trade and other payables	**(12,868)**	17,763	**(12,868)**	17,763
Increase/(decrease) in other liabilities	**295**	(898)	**295**	(898)
Increase/(decrease) in provisions	**(378)**	(305)	**(378)**	(305)
NHS Charitable Funds - net adjustments for working capital movements, non-cash transactions and non-operating cash flows	**(122)**	140	**-**	-
Other movements in operating cash flows	**-**	-	**-**	-
Net cash generated from/(used in) operating activities	**3,712**	(8,958)	**3,891**	(8,722)
Cash flows from investing activities:				
Interest received	**1,003**	365	**1,003**	365
Purchase of intangible assets	**(515)**	(1,726)	**(515)**	(1,726)
Purchase of property, plant and equipment	**(34,558)**	(27,001)	**(34,558)**	(27,001)
Receipt of cash donations to purchase capital assets	**-**	-	**58**	78
Net cash generated from/(used in) investing activities	**(34,070)**	(28,362)	**(34,012)**	(28,284)
Cash flows from financing activities:				
Public dividend capital received	**60,148**	21,959	**60,148**	21,959
Capital element of finance lease rental payments	**(1,860)**	(1,643)	**(1,860)**	(1,643)
Interest element of finance lease	**(79)**	(126)	**(79)**	(126)
PDC Dividend paid	**(1,937)**	(2,162)	**(1,937)**	(2,162)
Net cash generated from/(used in) financing activities	**56,272**	18,028	**56,272**	18,028
Increase/(decrease) in cash and cash equivalents	**25,915**	(19,292)	**26,151**	(18,978)
Cash and cash equivalents at 1 April	**8,936**	28,228	**8,419**	27,397
Cash and cash equivalents at 31 March	**34,852**	8,936	**34,571**	8,419

The accompanying notes form part of these financial statements.

Notes to the Accounts

1 Significant Accounting policies and other information

1.1.1 Basis of preparation

NHS England has directed that the financial statements of NHS Foundation Trusts 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 DHSC Group Accounting Manual 2023-24, 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 DHSC Group Accounting Manual permits a choice of accounting policy, the accounting policy that is judged to be most appropriate to the particular circumstances of the NHS Foundation 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.

1.1.2 Accounting convention

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

1.1.3 Going concern

The James Paget University Hospitals NHS Foundation Trust annual report and accounts have been prepared on a going concern basis. The James Paget University Hospitals NHS Foundation Trust is supply financed and draws its funding from the Department of Health and Social Care (DHSC). Parliament has demonstrated its commitment to fund DHSC for the foreseeable future, and DHSC has demonstrated its commitment to the funding of the Trust. Long term planning and realistic plans for future transformation savings delivery provide the necessary assurance that the Trust is a going concern. There is an anticipated continuation of the provision of a service in the future, as evidenced by inclusion of financial provision for that service in published documents.

1.1.4 IFRS Standards that have been issued but have not yet been adopted

The DHSC GAM does not require the following IFRS Standards and Interpretations to be applied in 2023-24. These Standards are still subject to HM Treasury FReM adoption.

- IFRS 17 Insurance Contracts – The Standard is effective for accounting periods beginning on or after 1 January 2023. IFRS 17 is yet to be adopted by the FReM which is expected to be from the 1 April 2025. Early adoption is not permitted.

1.1.5 Critical accounting judgements and key sources of estimation uncertainty

In the application of the James Paget University Hospitals NHS Foundation Trust accounting policies, management is required to make various judgements, estimates and assumptions. These are regularly reviewed.

1.1.6 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's accounting policies and that have the most significant effect on the amounts recognised in the financial statements:

- The Trust does not have any contractual arrangements that contain material embedded leases that are required to be capitalised under IFRIC 4.
- The Trust has used component lives based on data provided by the Trust's appointed valuer Montagu Evans LLP to depreciate building and dwellings on a component basis.
- The Trust has estimated the provisions for pensions relating to former staff using estimates provided by the NHS Pensions Agency provided at the time of the member's early retirement. These are updated if the member dies or if it becomes apparent that the provision is not sufficient to meet the liability.
- A full valuation of land and building assets was conducted by Montagu Evans LLP, and was applied on 31 March 2024 based on an alternate site, modern equivalent asset basis.

1.1.7 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:

In order to calculate the carrying value of the Trust's provisions there are a number of areas which require to be estimated, these are;

- The Trust will need to estimate the amount of its liability. In the case of legal claims, for example, it uses the advice of experts but the actual amount of the liability will not be known until the outcome of the litigation.

- The Trust will need to estimate the probability of a liability existing. The outcome of litigation may be uncertain, but the Trust will use the advice of its experts on whether it is probable that it will be found liable.
- In the cases of pension and other benefits payable in the future, an estimate will be made of the length of time that payment will be required to be made, to estimate the present value of the estimated future

1.2 Basis of consolidation

1.2.1 NHS Charitable Funds

The NHS Foundation Trust is the corporate Trustee to the James Paget University Hospitals NHS charitable fund. The Foundation 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

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

Results of the consolidated group and of the Foundation Trust are reported separately in the primary statements, for all other notes to the accounts the results of the consolidated group are reported.

1.2.2 Other Subsidiaries

Entities over which The Trust has the power to exercise control are classified as subsidiaries and are consolidated. The Trust has control when it has the ability to affect the variable returns from the other entity through its power to direct relevant activities. The income, expenses, assets, liabilities, equity and reserves of the subsidiary are consolidated in full into the appropriate financial statement lines. The capital and reserves attributable to non-controlling interests are included as a separate item in the Statement of Financial Position. Appropriate adjustments are made on consolidation where the subsidiary's accounting policies are not aligned with The Trust or where the subsidiary's accounting date

Subsidiaries that are classified as 'held for sale' are measured at the lower of their carrying amount or 'fair value less costs to sell'.

1.2.3 Associates

Entities over which The Trust has the power to exercise significant influence so as to obtain economic or other benefits are classified as associates and are recognised in these financial statements using the equity method. The investment is recognised initially at cost and is adjusted subsequently to reflect The Trust's share of the associate's profit or loss and other gains or losses. It is also reduced when any distribution is received by The Trust from the associate.

Associates which are classified as 'held for sale' are measured at the lower of their carrying amount and 'fair value less costs to sell'.

1.2.4 Joint arrangements

Arrangements over which The Trust has joint control with one or more other entities are classified as joint arrangements. Joint control is the contractually agreed sharing of control of an arrangement. A joint arrangement is either a joint operation or a joint venture.

A joint operation exists where the parties that have joint control have rights to the assets and obligations for the liabilities relating to the arrangement. Where The Trust is a joint operator, it recognises its share of, assets, liabilities, income and expenses in its own accounts.

1.2.5 Joint ventures

A joint venture is a joint arrangement whereby the parties that have joint control of the arrangement have rights to the net assets of the arrangement. Joint ventures are recognised as an investment and accounted for using the equity method.

1.2.6 Transfer of functions

As public sector bodies are deemed to operate under common control, business reconfigurations within the DHSC group are outside the scope of IFRS 3 Business Combinations. Where functions transfer between two public sector bodies, the GAM requires the application of 'absorption accounting'. Absorption accounting requires that entities account for their transactions in the period in which they took place. Where assets and liabilities transfer, the gain or loss resulting is recognised in the Statement of Comprehensive Net Expenditure and is disclosed separately from operating costs.

1.3 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.

In the application of IFRS 15 a number of practical expedients offered in the Standard have been employed. These are as follows;

The Trust is not required to disclose information regarding performance obligations that are part of a contract that has an original expected duration of one year or less,

The Trust is not required to disclose information where revenue is recognised in line with the practical expedient offered in the Standard, where the right to consideration corresponds directly with value of the performance completed to date.

The GAM has mandated the exercise of the practical expedient offered in C7A of the Standard that requires the Trust to reflect the aggregate effect of all contracts modified before the date of initial application.

1.3.1 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) which replaced the National Tariff Payment System on 1 April 2023. 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. In 2023/24 API contracts contain both a fixed and variable element. Under the variable element, providers earn income for elective activity (both ordinary and day case), out-patient procedures, out-patient first attendances, diagnostic imaging and nuclear medicine, and chemotherapy delivery activity. The precise definition of these activities is given in the NHSPS. Income is earned at NHSPS prices based on actual activity. The fixed element includes income for all other services covered by the NHSPS assuming an agreed level of activity with 'fixed' in this context meaning not varying based on units of activity. Elements within this are accounted for as variable consideration under IFRS 15 as explained below.

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

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

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

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

Elective recovery funding provides additional funding to integrated care boards to fund the commissioning of elective services within their systems. In 2023/24, Trusts do not directly earn elective recovery funding, instead earning income for actual activity performed under API contract arrangements as explained above. The level of activity delivered by the Trust contributes to system performance and therefore the availability of funding to the Trust's commissioners. In 2023/24 elective recovery funding for providers was separately identified within the aligned payment and incentive contracts.

Revenue in respect of services provided is recognised when (or as) performance obligations are satisfied by transferring promised services to the customer and is measured at the amount of the transaction price allocated to that performance obligation.

Where income is received for a specific performance obligation that is to be satisfied in the following year, that income is deferred.

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.

1.3.2 Note 1.5 Other forms of income

Grants and donations
Government grants are grants from government bodies other than income from commissioners or Trusts for the provision of services. Where a grant is used to fund revenue expenditure it is taken to the Statement of Comprehensive Income to match that expenditure. Where the grant is used to fund capital expenditure, it is credited to the Statement of Comprehensive Income once conditions attached to the grant have been met. Donations are treated in the same way as government grants.

Apprenticeship service income
The value of the benefit received when accessing funds from the Government's apprenticeship service is recognised as income at the point of receipt of the training service. Where these funds are paid directly to an accredited training provider from the Trust's Digital Apprenticeship Service (DAS) account held by the Department for Education, the corresponding notional expense is also recognised at the point of recognition for the benefit.

1.4 Expenditure on employee benefits

1.4.1 Short-term employee benefits

Salaries, wages and employment-related payments, including payments arising from the apprenticeship levy, are recognised in the period in which the service is received from employees, including non-consolidated performance pay earned but not yet paid. The cost of leave earned but not taken by employees at the end of the period is recognised in the financial statements to the extent that employees are permitted to carry forward leave into the following period.

1.4.2 Pension costs

Past and present employees are covered by the provisions of the NHS Pensions Schemes. These schemes are unfunded, defined benefit schemes that cover NHS employers, General Practices and other bodies allowed under the direction of the Secretary of State in England and Wales. The schemes 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, the schemes are accounted for as though they were defined contribution schemes: the cost to the Trust of participating in a scheme is taken as equal to the contributions payable to the scheme for the accounting period.

For early retirements other than those due to ill health the additional pension liabilities are not funded by the scheme. The full amount of the liability for the additional costs is charged to expenditure at the time the Trust commits itself to the retirement, regardless of the method of payment.

The schemes are subject to a full actuarial valuation every four years and an accounting valuation every year.

1.5 Expenditure on other goods and services

Other operating expenses are recognised when, and to the extent that, the goods or services have been received. They are measured at the fair value of the consideration payable.

1.6 Value Added Tax

Most of the activities of the Trust are outside the scope of VAT and, in general, output tax does not apply and input tax on purchases is not recoverable. Irrecoverable VAT is charged to the relevant expenditure category or included in the capitalised purchase cost of fixed assets. Where output tax is charged or input VAT is recoverable, the amounts are stated net of VAT.

1.7 Corporation Tax

Income from commercial activities is subject to corporation tax under section 519A Income and Corporation Taxes Act 1988 (519A ICTA 1988), as amended by section 148 of the Finance Act 2004. However, provision of Healthcare authorised under section 43 of the National Health Service Act 2006 is not treated as commercial income.

The total non-healthcare related activities conducted by the Foundation Trust during the period which are deemed to be commercial activities are not subject to corporation tax because annual taxable profits are below the de minimus limit of £50,000.

1.8 Property, plant and equipment

1.8.1 Recognition

Property, plant and equipment is capitalised where:

- it is held for use in delivering services or for administrative purposes;
- it is probable that future economic benefits will flow to, or service potential will be supplied to the Trust;
- it is expected to be used for more than one financial year;
- the cost of the item can be measured reliably; and either
  - 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 a cost of more than £250, where the assets are functionally interdependent, had broadly simultaneous purchase dates, are anticipated to have simultaneous disposal dates and are under single managerial control;
  - form part of the initial setting-up cost of a new building or refurbishment of a ward or unit, irrespective of their individual or collective cost.

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

1.8. Subsequent expenditure

Subsequent expenditure relating to an item of property, plant and equipment is recognised as an increase in the carrying amount of the asset when it is probable that additional future economic benefits or service potential deriving from the cost incurred to replace a component of such item will flow to the enterprise and the cost of the item can be determined reliably. Where a component of an asset is replaced, the cost of the replacement is capitalised if it meets the criteria for recognition above. The carrying amount of the part replaced is de- recognised. Other expenditure that does not generate additional future economic benefits or service potential, such as repairs, and maintenance is charged to the Statement of Comprehensive Income in the period in which it is incurred.

1.8.3 Measurement

Valuation

All property, plant and equipment assets are measured initially at cost, representing the costs directly attributable to acquiring or constructing the asset and bringing it to the location and condition necessary for it to be capable of operating in the manner intended by management. Assets are measured subsequently at valuation. Assets which are held for their service potential and are in use (i.e. operational assets used to deliver either front line services or back-office functions) are measured at their current value in existing use. Assets that were most recently held for their service potential but are surplus with no plan to bring them back into use are measured at fair value where there are no restrictions on sale at the reporting date and where they do not meet the definitions of investment properties or assets held for sale.

Revaluations of property, plant and equipment are performed with sufficient regularity to ensure that carrying amounts are not materially different from those that would be determined at the end of the reporting period. Current values in existing use are determined as follows:

- Land and non-specialised buildings – market value for existing use.
- Specialised buildings – depreciated replacement cost on a modern equivalent asset basis.
- Assets held at depreciated replacement cost have been valued on an alternative site basis where this would meet the location requirements of the service being provided.
- The latest land and building asset valuation undertaken was conducted by Montagu Evans LLP, and was applied on 31 March 2024.
- Non-property assets are carried at depreciated historic cost as a proxy for fair value.

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

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, borrowing costs. Assets are revalued and depreciation commences when they are brought into use.

IT equipment, transport equipment, furniture and fittings, and plant and machinery that are held for operational use are valued at depreciated historic cost where these assets have short useful lives or low values or both, as this is not considered to be materially different from current value in existing use.

An increase arising on revaluation is taken to the revaluation reserve except when it reverses an impairment for the same asset previously recognised in expenditure, in which case it is credited to expenditure to the extent of the decrease previously charged there. A revaluation decrease that does not result from a loss of economic value or service potential is recognised as an impairment charged to the revaluation reserve to the extent that there is a balance on the reserve for the asset, and thereafter to expenditure. Gains and losses recognised in the revaluation reserve are reported as other comprehensive net income/expenditure in the Statement of Comprehensive Net Expenditure.

1.8.4 Depreciation, amortisation and impairments

Freehold land, assets under construction or development and assets held for sale are not depreciated/amortised.

Otherwise, depreciation or amortisation is charged to write off the costs or valuation of property, plant and equipment and intangible assets, less any residual value, on a straight-line basis over their estimated useful lives. The estimated useful life of an asset is the period over which the Trust expects to obtain economic benefits or service potential from the asset. This is specific to the Trust and may be shorter than the physical life of the asset itself. Estimated useful lives and residual values are reviewed each year end, with the effect of any changes recognised on a prospective basis.

Assets held under finance leases are depreciated over the shorter of the lease term and the estimated useful life, unless The Trust expects to acquire the asset at the end of the lease term, in which case the asset is depreciated in the same manner as for owned assets.

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

Buildings	20 to 60 years	Transport Equipment	5 to 15 years
Dwellings	20 to 60 years	Information Technology	3 to 16 years
Plant and Machinery	3 to 16 years	Furniture and Fittings	8 to 11 years

At each financial year end, the Trust checks whether there is any indication that its property, plant and equipment or

intangible assets have suffered an impairment loss. If there is indication of such an impairment, the recoverable amount of the asset is estimated to determine whether there has been a loss and, if so, its amount. Intangible assets not yet available for use are evaluated for impairment annually at the financial year end.

Impairment losses that arise from a clear consumption of economic benefit are taken to expenditure. Where an impairment loss subsequently reverses, the carrying amount of the asset is increased to the revised estimate of the recoverable amount but capped at the amount that would have been determined had there been no initial impairment loss. The reversal of the impairment loss is credited to expenditure.

1.8.5 Donated and grant funded assets

Donated and government grant funded non-current assets are capitalised at current value in existing use, if they will be held for their service potential, or otherwise at fair value on receipt, with a matching credit to income. They are valued, depreciated and impaired as described above for purchased assets. Gains and losses on revaluations, impairments and sales are treated in the same way as for purchased assets. Deferred income is recognised only where conditions attached to the donation preclude immediate recognition of the gain. The donated and grant funded assets are subsequently accounted for in the same manner as other items of property, plant and equipment.

1.9 Intangible assets

1.9.1 Recognition

Intangible assets are non-monetary assets without physical substance, which are capable of sale separately from the rest of the Trust's business or which arise from contractual or other legal rights. They are recognised only when it is probable that future economic benefits will flow to, or service potential be provided to, the Trust; where the cost of the asset can be measured reliably; and where the cost is at least £5,000.

Software that is integral to the operating of hardware, for example an operating system, is capitalised as part of the relevant item of property, plant and equipment. Software that is not integral to the operation of hardware, for example application software, is capitalised as an intangible asset.

Expenditure on research is not capitalised: it is recognised as an operating expense in the period in which it is incurred. Internally generated assets are recognised if, and only if, all of the following have been demonstrated:

- the technical feasibility of completing the intangible asset so that it will be available for use;
- the intention to complete the intangible asset and use it;
- the ability to sell or use the intangible asset;
- how the intangible asset will generate probable future economic benefits or service potential;
- the availability of adequate technical, financial and other resources to complete the intangible asset and sell or use it; and
- the ability to measure reliably the expenditure attributable to the intangible asset during its development.

The range of useful economic lives for Intangible Assets is 3-10 years

1.9.2 Measurement

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

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

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

1.9.3 Amortisation

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

1.10 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.

There are further expedients or election that have been employed by the Trust in applying IFRS 16. These include;

The measurement requirements under IFRS 16 are not applied to leases with a term of 12 months or less under paragraph 5 (a) of IFRS 16.

The measurement requirements under IFRS 16 are not applied to leases where the underlying asset is of a low value which are identified as those assets of a value of less than £5,000, excluding any irrecoverable VAT, under paragraph 5 (b) of IFRS 16.

The Trust will not apply IFRS 16 to any new leases of intangible assets applying the treatment described in section 1.9 instead.

HM Treasury have adapted the public sector approach to IFRS 16 which impacts on the identification and measurement of leasing arrangements that will be accounted for under IFRS 16.

The Trust is required to apply IFRS 16 to lease like arrangements entered into with other public sector entities that are in substance akin to an enforceable contract, that in their formal legal form may not be enforceable. Prior to accounting for such arrangements under IFRS 16 the Trust has assessed that in all other respects these arrangements meet the definition of a lease under the Standard.

The Trust is required to apply IFRS 16 to lease like arrangements entered into in which consideration exchanged is nil or nominal, therefore significantly below market value. These arrangements are described as peppercorn leases. Such arrangements are again required to meet the definition of a lease in every other respect prior to inclusion in the scope of IFRS 16. The accounting for peppercorn arrangements aligns to that identified for donated assets. Peppercorn leases are different in substance to arrangements in which consideration is below market value but not significantly below market value.

The nature of the accounting policy change for the lessee is more significant than for the lessor under IFRS 16. IFRS 16 introduces a singular lessee approach to measurement and classification in which lessees recognise a right of use asset.

For the lessor leases remain classified as finance leases when substantially all the risks and rewards incidental to ownership of an underlying asset are transferred to the lessee. When this transfer does not occur, leases are classified as operating leases.

1.10.1 The Trust as lessee

At the commencement date for the leasing arrangement a lessee shall recognise a right of use asset and corresponding lease liability. The Trust employs a revaluation model for the subsequent measurement of its right of use assets unless cost 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 below market value, cost is not considered to be an appropriate proxy to value the right of use asset.

Lease payments are apportioned between finance charges and repayment of the principal. Finance charges are recognised in the Statement of Comprehensive net expenditure

Irrecoverable VAT is expensed in the period to which it relates and therefore not included in the measurement of the lease liability and consequently the value of the right of use asset.

The incremental borrowing rate of 3.51% has been applied to the lease liabilities recognised at the date of initial application of IFRS 16.

Where changes in future lease payments result from a change in an index or rate or rent review, the lease liabilities are remeasured using an unchanged discount rate.

Where there is a change in a lease term or an option to purchase the underlying asset, the Trust applies a revised rate to the remaining lease liability.

Where existing leases are modified the Trust must determine whether the arrangement constitutes a separate lease and apply the Standard accordingly.

Lease payments are recognised as an expense on a straight-line or another systematic basis over the lease term, where the lease term is in substance 12 months or less or is elected as a lease containing low value underlying asset by the Trust.

1.10.2 The Trust as lessor

A lessor shall classify each of its leases as an operating or finance lease. A lease is classified as finance lease when the lease substantially transfers all the risks and rewards incidental to ownership of an underlying asset. Where substantially all the risks and rewards are not transferred, a lease is classified as an operating lease.

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.

Income from operating leases is recognised on a straight-line 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.

Where the Trust is an intermediate lessor, being a lessor and a lessee regarding the same underlying asset, classification of the sublease is required to be made by the intermediate lessor considering the term of the arrangement and the nature of the right of use asset arising from the head lease.

On transition the Trust has reassessed the classification of all of its continuing subleasing arrangements

1.11 Inventories

Inventories are valued at the lower of cost and net realisable value, using the First In, First Out (FIFO) method. Inventories are subject to a planned inventory count as at 31 March.

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

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.

1.13 Provisions

Provisions are recognised when the Trust has a present legal or constructive obligation as a result of a past event, it is probable that the Trust will be required to settle the obligation, and a reliable estimate can be made of the amount of the obligation. The amount recognised as a provision is the best estimate of the expenditure required to settle the obligation at the end of the reporting period, taking into account the risks and uncertainties. Where a provision is measured using the cash flows estimated to settle the obligation, its carrying amount is the present value of those cash flows using HM Treasury's discount rates.

Early retirement provisions are discounted using HM Treasury's pension discount rate of 2.45% (2022/23: 1.70%) in real terms. All general provisions are subject to four separate discount rates according to the expected timing of cashflows from the Statement of Financial Position date:

		Nominal rate	Prior year rate
Short-term	Up to 5 years	4.26%	3.27%
Medium-term	After 5 years up to 10 years	4.03%	3.20%
Long-term	After 10 years up to 40 years	4.72%	3.51%
Very long-term	Exceeding 40 years	4.40%	3.00%

HM Treasury provides discount rates for general provisions on a nominal rate basis. Expected future cash flows are therefore adjusted for the impact of inflation before discounting using nominal rates. The following inflation rates are set by HM Treasury, as at 31 March 2024:

	Inflation rate	Prior year rate
Year 1	3.60%	7.40%
Year 2	1.80%	0.60%
Into perpetuity	2.00%	2.00%

1.13.1 Clinical negligence costs

NHS Resolution operates a risk pooling scheme under which the Trust pays an annual contribution to NHS Resolution, which, in return, settles all clinical negligence claims. Although NHS Resolution is administratively responsible for all clinical negligence cases, the legal liability remains with the Trust. The total value of clinical negligence provisions carried by NHS Resolution on behalf of the Trust is disclosed at note 21.4 but is not recognised in the Trust's accounts.

1.13.2 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.

1.14 Contingent liabilities and contingent assets

A contingent liability is:

a possible obligation that arises from past events and whose existence will be confirmed only by the occurrence or non-occurrence of one or more uncertain future events not wholly within the control of the Trust, or a present obligation that is not recognised because it is not probable that a payment will be required to settle the obligation, or the amount of the obligation cannot be measured sufficiently reliably.

A contingent liability is disclosed unless the possibility of a payment is remote, (note 21.5).

A contingent asset is a possible asset that arises from past events and whose existence will be confirmed by the occurrence or non-occurrence of one or more uncertain future events not wholly within the control of the Trust. A contingent asset is disclosed where an inflow of economic benefits is probable.

Where the time value of money is material, contingent liabilities and contingent assets are disclosed at their present value.

1.15 Financial assets

Financial assets are recognised when the Trust becomes party to the contractual provision of the financial instrument or, in the case of trade receivables, when the goods or services have been delivered. Financial assets are derecognised when the contractual rights have expired or when the asset has been transferred and the Trust has transferred substantially all of the risks and rewards of ownership or has not retained control of the asset.

Financial assets are initially recognised at fair value plus or minus directly attributable transaction costs for financial assets not measured at fair value through profit or loss. Fair value is taken as the transaction price, or otherwise determined by reference to quoted market prices, where possible, or by valuation techniques.

Financial assets are classified into the following categories: financial assets at amortised cost, financial assets at fair value through other comprehensive income, and financial assets at fair value through profit and loss. The classification is determined by the cash flow and business model characteristics of the financial assets, as set out in IFRS 9, and is determined at the time of initial recognition.

1.15.1 Financial assets at amortised cost

Financial assets measured at amortised cost are those held within a business model whose objective is to hold financial assets in order to collect contractual cash flows and where the cash flows are solely payments of principal and interest. This includes most trade receivables, loans receivable, and other simple debt instruments.

After initial recognition, these financial assets are measured at amortised cost using the effective interest method, less any impairment. The effective interest rate is the rate that exactly discounts estimated future cash receipts through the life of the financial asset to the gross carrying amount of the financial asset.

1.15.2 Financial assets at fair value through other comprehensive income

Financial assets measured at fair value through other comprehensive income are those held within a business model whose objective is achieved by both collecting contractual cash flows and selling financial assets and where the cash flows are solely payments of principal and interest.

1.15.3 Financial assets at fair value through income and expenditure

Financial assets measured at fair value through profit or loss are those that are not otherwise measured at amortised cost or fair value through other comprehensive income. This includes derivatives and financial assets acquired principally for the purpose of selling in the short term.

1.15.4 Impairment of financial assets

For all financial assets measured at amortised cost or at fair value through other comprehensive income (except equity instruments designated at fair value through other comprehensive income), lease receivables and contract assets, the Trust recognises a loss allowance representing expected credit losses on the financial instrument.

The Trust adopts the simplified approach to impairment, in accordance with IFRS 9, and measures the loss allowance for trade receivables, contract assets and lease receivables at an amount equal to lifetime expected credit losses. For other financial assets, the loss allowance is measured at an amount equal to lifetime expected credit losses if the credit risk on the financial instrument has increased significantly since initial recognition (stage 2), and otherwise at an amount equal to 12-month expected credit losses (stage 1).

The Trust determines expected credit losses based on information about past events, including historical experience, current conditions, and reasonable and supportable forecasts affecting the collectability of the reported amount.

HM Treasury has ruled that central government bodies may not recognise stage 1 or stage 2 impairments against other government departments, their executive agencies, the Bank of England, Exchequer Funds, and Exchequer Funds' assets where repayment is ensured by primary legislation. The Trust therefore does not recognise loss allowances for stage 1 or stage 2 impairments against these bodies. Additionally, the Department of Health and Social Care provides a guarantee of last resort against the debts of its arm's length bodies and NHS bodies (excluding NHS charities), and the Trust does not recognise loss allowances for stage 1 or stage 2 impairments against these bodies.

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 the estimated future cash flows discounted at the financial asset's original effective interest rate. Any adjustment is recognised in profit or loss as an impairment gain or loss.

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

1.16 Financial liabilities

Financial liabilities are recognised when the Trust becomes party to the contractual provisions of the financial instrument or, in the case of trade payables, when the goods or services have been received. Financial liabilities are de-recognised when the liability has been extinguished – that is, the obligation has been discharged or cancelled or has expired.

1.16.1 Other financial liabilities

After initial recognition, all other financial liabilities are measured at amortised cost using the effective interest method. The effective interest rate is the rate that exactly discounts estimated future cash payments through the life of the asset, to the amortised cost of the financial liability. In the case of DHSC loans that would be the nominal rate charged on the loan.

1.17 Public Dividend Capital (PDC) and PDC dividend

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 used by the Trust, is payable as public dividend capital dividend. The charge is calculated at the rate set by HM Treasury (currently 3.5%) on the average relevant net assets of the Trust during the financial year. Relevant net assets are calculated as the value of all assets less the value of all liabilities, with certain additions and deductions as defined in the PDC dividend policy issued by the Department of Health and Social Care. This policy is available at https://www.gov.uk/government/publications/guidance-on-financing-available-to-nhs-Trusts-and-foundation-Trusts.

In accordance with the requirements laid down by the Department of Health and Social Care (as the issuer of PDC), the dividend for the year is calculated on the actual average relevant net assets as set out in the "pre-audit" version of the annual accounts. The dividend calculated is not revised should any adjustment to net assets occur as a result the audit of the annual accounts.

1.18 Foreign currencies

The Trust's functional currency and presentational currency is pounds sterling, and figures are presented in thousands of pounds unless expressly stated otherwise. Transactions denominated in a foreign currency are translated into sterling at the spot exchange rate on the date of the transaction. At the end of the reporting period, monetary items denominated in foreign currencies are retranslated at the spot exchange rate on 31 March.

Exchange gains and losses on monetary items (arising on settlement of the transaction or on retranslation at the Statement of Financial Position date) are recognised in the Statement of Comprehensive Net Expenditure in the period in which they arise.

1.19 Third party assets

Assets belonging to third parties (such as money held on behalf of patients) are not recognised in the accounts since the Trust has no beneficial interest in them. Details of third-party assets are given in note 24 to the accounts.

1.20 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 managed.

Losses and special payments are charged to the relevant functional headings in expenditure on an accruals basis. The losses and special payments note is compiled directly from the losses and compensations register which reports on an accrual basis with the exception of provisions for future losses.

1.21 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.

2 Segmental reporting

Under the definitions of operating segments contained within International Financial Reporting Standard 8, the Trust has a single operating segment where the revenues are derived from the provision of healthcare services.

The products and services provided to external customers are identified in notes 4.1 and 4.2 below under the headings “Income from activities analysed by service type” and “Other operating income”.

All revenues from external customers are derived from within the UK, and all non-current assets are located in the UK.

3 Subsidiaries

The James Paget University Hospitals NHS Foundation Trust acts as the corporate Trustee of the James Paget University Hospitals Charitable Fund and in accordance with the Charity’s declaration of Trust, members of the Foundation Trust’s Board of Directors act as ex-officio Trustees of the Charitable Funds.

This Trustee arrangement satisfies the relevant tests of control under IAS 27 and therefore the Charitable Fund is a subsidiary of the Foundation Trust. The Foundation Trust has prepared group accounts for the year ended 31 March 2024.

The James Paget University Hospitals Charitable Fund is a registered charity located in England, and the Foundation Trust as the sole corporate Trustee has 100% of the voting rights. The Foundation Trust does not have any financial investment in the Charitable Fund.

The ability of the subsidiary to transfer funds to the Foundation Trust is significantly restricted by the charitable objects and the legal requirement for the Trustees to act independently and ensure that all funds are spent in accordance with the donors’ wishes.

4 Operating income

4.1 Income from activities analysed by service type

		Year Ended 31 March 2024 £ 000	Year Ended 31 March 2023 £ 000
API contract / system envelope income		**274,143**	226,719
High-cost drugs income from commissioners		**11,169**	9,944
Other NHS clinical income		**10,205**	6,746
Private patient income		**691**	717
Elective recovery fund (comparative only)		**-**	8,808
Agenda for change pay offer central funding		**121**	6,834
Additional pension contribution central funding		**8,540**	7,722
Other clinical income		**1,003**	942
	Note 4.2	**305,872**	268,432

The majority of income from Integrated Care Board’s and NHS England is included in API contract/system envelope income and is not split by activity type.

Following the passing of the Health and Care Act (2022), 42 Integrated Care Systems were established across England on a statutory basis on 1 July 2022. This established the Integrated Care Board’s with statutory responsibility for NHS budget and arranging for the provision of health services within ICS areas.

4.2 Analysis of operating income by source

		Year Ended 31 March 2024 £ 000	Year Ended 31 March 2023 £ 000
Income from activities			
NHS Foundation Trusts		**3,207**	2,458
NHS England		**32,060**	94,773
Integrated Care Boards		**268,900**	169,511
NHS Other		**221**	28
Non-NHS:			
Private patients		**691**	717
Overseas patients	Note 4.4	**177**	142
NHS injury scheme *		**584**	497
Other		**32**	306
Total income from activities		**305,872**	268,432
Other operating income from contracts with customers:			
Research and development		**923**	1,168
Education and training (excluding notional apprenticeship levy income)		**10,992**	10,789
Non-patient care services to other bodies		**212**	226
Top-up income**		**-**	372
Other non-contract operating income:			
Catering		**667**	469
Education and training - notional income from apprenticeship fund		**916**	895
Rental revenue from operating leases	Note 4.3	**307**	287
Accommodation		**623**	769
Car parking		**755**	657
Charitable and other contributions to expenditure		**(139)**	(309)
Contributions to expenditure - consumables (inventory) donated from DHSC		**146**	579
Miscellaneous		**5,428**	3,667
NHS Charitable Funds: Incoming Resources excluding investment income		**273**	187
Total other operating income		**21,103**	19,756
Total operating income		**326,975**	288,188

* NHS Injury Scheme income is subject to a provision for expected credit losses of 23.07% (2022/23 - 24.86%) to reflect expected rates of collection.

** Top-up income of £nil has been allocated to the Trust during 2023/24 (2022/23 Top-up income of £372,000 relating to vaccination cost reimbursement).

4.3 Operating lease income

	Year Ended 31 March 2024 £ 000	Year Ended 31 March 2023 £ 000
Rents recognised as income in the period	**307**	287
	307	287

4.3 Operating lease income - continued

Future minimum lease receipts due:

	Year Ended 31 March 2024 Buildings	Total
Within 1 year	**307**	**307**
Between 1 and 5 years	**851**	**851**
After 5 years	**692**	**692**
	1,850	**1,850**

	Year Ended 31 March 2023 Buildings	Total
Within 1 year	256	256
Between 1 and 5 years	807	807
After 5 years	672	672
	1,735	1,735

4.4 Overseas visitor income

	Year Ended 31 March 2024 £ 000	Year Ended 31 March 2023 £ 000
Income recognised in this year	**177**	142
Cash payments received in-year (relating to invoices raised in current and previous years)	**31**	8
Amounts added to provision for impairment of receivables (relating to invoices raised in current and prior years)	**147**	15
Amounts written off in-year (relating to invoices raised in current and previous years)	**-**	-

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

	Year Ended 31 March 2024 £ 000	Year Ended 31 March 2023 £ 000
Revenue recognised in the reporting period that was included within contract liabilities at the previous period end	**561**	1,914
Revenue recognised from performance obligations satisfied (or partially satisfied) in previous periods	**449**	419

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

	31 March 2024 £ 000	31 March 2023 £ 000
Revenue from existing contracts allocated to remaining performance obligations is expected to be recognised:		
Within one year	**1,205**	698
Total revenue allocated to remaining performance obligations	**1,205**	698

5 Operating expenses

		Year Ended 31 March 2024 £ 000	Year Ended 31 March 2023 £ 000
Services from NHS Bodies		**4,722**	5,156
Purchase of healthcare from non-NHS bodies		**8,142**	8,510
Employee expenses - executive directors		**800**	679
Employee expenses - non-executive directors		**135**	133
Employee expenses - staff		**222,110**	212,251
Drug costs		**25,167**	23,659
Supplies and services - clinical (excluding drug costs)		**24,718**	22,911
Supplies and services - clinical: utilisation of DHSC consumables donated - COVID		**184**	848
Supplies and services - general		**4,034**	3,269
Establishment		**2,207**	2,544
Transport		**209**	260
Premises		**10,316**	9,815
Increase / (Decrease) in provision for impairment of receivables		**168**	188
Change in provisions discount rate		**(7)**	(260)
Inventories write down		**2**	2
Depreciation on property, plant and equipment and right of use assets		**9,513**	8,374
Amortisation of intangible assets and right of use intangibles assets		**1,086**	816
Net Impairments of property, plant and equipment	Note 10	**20,889**	2,796
Audit fees - statutory audit*		**191**	137
Audit fees - Charitable Fund Accounts		**13**	7
Internal Audit and Local Counter Fraud Services		**152**	108
Clinical negligence		**8,317**	8,299
Legal fees		**94**	236
Consultancy costs		**181**	154
Training, courses and conferences		**2,913**	3,751
Patient travel		**47**	36
Operating lease expenditure (net)		**137**	168
Insurance		**184**	199
Other contracted services		**654**	407
Losses, ex gratia and special payments		**19**	33
Other		**(34)**	174
NHS Charitable funds: Other resources expended		**210**	110
		347,472	315,770

* There is a £1,000,000 limitation on auditor's liability.

	Year Ended 31 March 2024 £ 000	Year Ended 31 March 2023 £ 000
6 Operating leases		
6.1 Lease payments recognised as an expense in the period		
Minimum lease payments	**137**	109
	137	109

	Year Ended 31 March 2024			Year Ended March 2023
	Permanent £ 000	**Other £ 000**	**Total £ 000**	Total £ 000
7 Employee expenses and numbers				
7.1 Employee expenses				
Salaries and wages	**154,970**	**12,953**	**167,923**	162,687
Social security costs	**17,998**	**293**	**18,291**	14,947
Apprenticeship levy	**878**	**9**	**887**	765
Employer contributions to NHS Pensions	**19,216**	**310**	**19,526**	18,224
Pension cost - employer contributions paid by NHSE on provider's behalf (6.3%)	**8,406**	**134**	**8,540**	7,722
Pension cost - other	**41**	**9**	**50**	60
Agency / contract staff	**-**	**8,542**	**8,542**	9,258
	201,509	**22,250**	**223,759**	213,663
Employee expenses recharged to other organisations	**(123)**	**-**	**(123)**	(282)
Employee expenses capitalised as part of assets	**(726)**	**-**	**(726)**	(452)
	200,660	**22,250**	**222,910**	212,929

7.2 Directors' remuneration

	Year Ended 31 March 2024 £ 000	Year Ended 31 March 2023 £ 000
Directors' remuneration	**1,064**	942
Employer contributions to NHS Pensions Agency	**103**	81
Benefits in kind	**2**	1
Defined benefit pension schemes	-	-

Further details on directors' remuneration are given in the remuneration report from page 54 of the Annual Report.

7.3 Average number of employees

	Year Ended 31 March 2024 Permanent Number	Other Number	Total Number	Year Ended 31 March 2023 Total Number
Medical and dental	**162**	**294**	**456**	455
Administration and estates	**1,027**	**128**	**1,154**	465
Healthcare assistants and other support staff	**664**	**242**	**906**	760
Nursing, midwifery and health visiting staff	**983**	**175**	**1,158**	1,778
Scientific, therapeutic and technical staff	**293**	**36**	**329**	447
	3,129	**875**	**4,003**	3,905
Of which number of employees engaged on capital projects	**13**	-	**13**	10

The comparative period ended 31 March 2023 contained some misclassifications between staff groups but did not cause an overall material difference so have not been restated. The primary difference was between Nursing and Midwifery staff and Administration and Estates staff numbers.

7.4 Staff exit packages

There have been no contractual staff exit packages during the year ended 31 March 2024 (Year ended 31 March 2023 none, £nil).

7.5 Retirements due to ill-health

During the year ending 31 March 2024 there were four (2022/23 - six) early retirements from the Trust agreed on the grounds of ill-health. The additional pension costs of these ill-health retirements (calculated on an average basis and borne by the NHS Pension Scheme) for 2023/24 was £176,000 (2022/23 - £486,000).

7.6 Reporting of other compensation schemes - exit packages

During the year ending 31 March 2024 there were ten (2022/23 - twenty-one) other departures agreed from the Trust. The costs of other departures agreed for 2023/24 was £35,000 (2022/23 - £182,000). Of the other departure costs ten were for contractual payments in lieu of notice (2022/23 twenty-one) and ten had an individual cost less than £10,000 (2022/23 fifteen with individual cost less than £10,000).

7.7 Retirement benefits

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 conducted annually by the scheme actuary (currently the Government Actuary’s Department) as at the end of the reporting period. This uses an actuarial assessment for the previous accounting period in conjunction with updated membership and financial data for the current reporting period and is accepted as providing suitably robust figures for financial reporting purposes. The valuation of the scheme liability as at 31 March 2024, is based on valuation data as 31 March 2023, updated to 31 March 2024 with summary global member and accounting data. In undertaking this actuarial assessment, the methodology prescribed in IAS 19, relevant FReM interpretations, and the discount rate prescribed by HM Treasury have also been used.

The latest assessment of the liabilities of the scheme is contained in the report of the scheme actuary, which forms part of the annual NHS Pension Scheme 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 (taking into account recent demographic experience), and to recommend contribution rates payable by employees and employers.

The latest actuarial valuation undertaken for the NHS Pension Scheme was completed as at 31 March 2020. The results of this valuation set the employer contribution rate payable from April 2024. The Department of Health and Social Care has recently laid Scheme Regulations confirming the employer contribution rate will increase to 23.7% of pensionable pay from 1 April 2024 (previously 20.6%). The core cost cap cost of the scheme was calculated to be outside of the 3% cost cap corridor as at 31 March 2020. However, when the wider economic situation was taken into account through the economic cost cap cost of the scheme, the cost cap corridor was not similarly breached. As a result, there was no impact on the member benefit structure or contribution rates.

	Year Ended 31 March 2024 £ 000	Year Ended 31 March 2023 £ 000
8 Finance income		
Interest on cash deposits	**1,133**	404
NHS Charitable funds: investment income	**75**	67
	1,208	471

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

9 Finance expense		
Interest expense:		
Finance leases	**79**	127
Interest on the late payment of commercial debt	**3**	-
Total interest expense	**82**	127
Unwinding of discount on provisions	**(26)**	(24)
Total finance costs	**56**	103

10 Impairment of assets recognised as operating expenses		
Operating expenses include net impairment costs due to:		
Changes in market price	**20,889**	2,796
	20,889	2,796

Including reversal of impairments previously charged to the income statement of £nil (2022/23 £47,000), there were £20,889,000 of net impairments recognised in operating expenses for the period ending 31st March 2024 (2022/23 £2,796,000)

11 Interests in Joint Operations

The James Paget University Hospitals NHS Foundation Trust has a 18% interest in a joint operation for the provision of pathology services in Norfolk known as Eastern Pathology Alliance (EPA). The arrangement has been effective from 1st November 2013 and has not involved the establishment of a separate entity.

In accordance with IFRS 11 the Trust has recognised a proportion of the net operating position for EPA. This means that included within income from activities in note 4.1 is £1,599,000 (2022/23 £1,257,000), and included within operating expenses in note 5 is £2,566,000 (2022/23 £3,330,000).

	Assets Under Construction £ 000	Software Licences £ 000	Other £ 000	Total £ 000
12 Intangible assets				
12.1 Intangible assets 2023/24				
Cost or valuation at 1 April 2023	3,062	8,035	61	**11,158**
Additions - purchased	577	1,150	-	**1,727**
Reclassifications	(2,300)	2,300	-	**-**
Cost or Valuation at 31 March 2024	**1,339**	**11,485**	**61**	**12,885**
Amortisation at 1 April 2023	-	5,486	46	**5,532**
Provided during the year	-	1,022	7	**1,029**
Amortisation at 31 March 2024	**-**	**6,508**	**53**	**6,561**
Opening net book value at 1 April 2023				
Purchased	3,062	2,534	15	5,611
Finance leases	-	-	-	-
Donated	-	12	-	12
Government granted	-	4	-	4
Total NBV at 1 April 2023	3,062	2,550	15	5,627
Closing net book value at 31 March 2024				
Purchased	1,339	4,971	8	**6,318**
Donated	-	6	-	**6**
Government granted	-	-	-	**-**
Total NBV at 31 March 2024	**1,339**	**4,977**	**8**	**6,324**
12.2 Intangible assets 2022/23				
Cost or valuation at 1 April 2022	2,577	7,314	61	**9,952**
Reclassification of existing finance leased assets to right of use assets on 1 April 2022	-	(520)	-	**(520)**
Additions - purchased	1,297	429	-	**1,726**
Reclassifications	(812)	812	-	**-**
Disposals	-	-	-	**-**
Cost or Valuation at 31 March 2023	**3,062**	**8,035**	**61**	**11,158**
Amortisation at 1 April 2022	-	5,138	40	**5,178**
Reclassification of existing finance leased assets to right of use assets on 1 April 2022	-	(405)	-	**(405)**
Provided during the year	-	753	6	**759**
Disposals	-	-	-	**-**
Amortisation at 31 March 2023	**-**	**5,486**	**46**	**5,532**
Opening net book value at 1 April 2022				
Purchased	2,577	2,035	21	4,633
Finance leases	-	114	-	114
Donated	-	18	-	18
Government granted	-	9	-	9
Total NBV at 1 April 2022	2,577	2,176	21	4,774
Closing net book value at 31 March 2023				
Purchased	3,062	2,534	15	**5,611**
Finance leases	-	-	-	**-**
Donated	-	12	-	**12**
Government granted	-	4	-	**4**
Total NBV at 31 March 2023	**3,062**	**2,550**	**15**	**5,627**

continued

13 Property, plant and equipment

13.1 Property, plant and equipment 2023/24

	Land	Buildings (excluding dwellings)	Dwellings	Assets under construction	Plant and Machinery	Transport Equipment	Information Technology	Furniture and Fittings	Total Trust
	£ 000	£ 000	£ 000	£ 000	£ 000	£ 000	£ 000	£ 000	£ 000
Cost or valuation at 1 April 2023	3,007	38,179	2,299	32,491	23,901	417	11,462	1,689	**113,445**
Additions - purchased	-	-	-	46,370	1,449	-	220	66	**48,105**
Additions - donated	-	-	-	58	-	-	-	-	**58**
Reclassifications	-	27,076	-	(30,389)	1,265	-	1,823	225	**0**
Impairments	(304)	(25,357)	(709)	-	-	-	-	-	**(26,370)**
Revaluations	40	165	-	-	-	-	-	-	**205**
Disposals	-	-	-	-	(577)	-	-	(3)	**(580)**
Cost or Valuation at 31 March 2024	**2,743**	**40,063**	**1,590**	**48,530**	**26,038**	**417**	**13,505**	**1,977**	134,863
Accumulated depreciation at 1 April 2023	-	-	-	-	13,960	277	7,920	1,024	**23,181**
Provided during the year	-	4,790	76	-	1,898	21	1,122	102	**8,009**
Impairments	-	(4,686)	(76)	-	-	-	-	-	**(4,762)**
Reclassifications	-	-	-	-	-	-	-	-	**-**
Revaluations	-	(104)	-	-	-	-	-	-	**(104)**
Disposals / Derecognition	-	-	-	-	(503)	-	-	(3)	**(506)**
Accumulated depreciation at 31 March 2024	**-**	**-**	**-**	**-**	**15,355**	**298**	**9,042**	**1,123**	25,818
Opening net book value at 1 April 2023									
Purchased	3,007	35,076	2,299	32,444	9,065	140	3,470	600	86,101
Government granted	-	3,103	-	47	521	-	72	65	3,808
Donated	-	-	-	-	355	-	-	-	355
Total NBV at 1 April 2023	3,007	38,179	2,299	32,491	9,941	140	3,542	665	90,264
Closing net book value at 31 March 2024									
Purchased	2,743	37,376	1,589	48,460	10,091	119	4,411	806	**105,596**
Owned - donated / granted	-	2,687	-	70	593	-	52	47	**3,449**

Total NBV at 31 March 2024	**2,743**	**40,063**	**1,589**	**48,530**	**10,684**	**119**	**4,463**	**853**	**109,045**

13.2 Property, plant and equipment 2022/23

	Land	Buildings (excluding dwellings)	Dwellings	Assets under construction	Plant and Machinery	Transport Equipment	Information Technology	Furniture and Fittings	Total Trust
	£ 000	£ 000	£ 000	£ 000	£ 000	£ 000	£ 000	£ 000	£ 000
Cost or valuation at 1 April 2022	2,832	35,047	1,897	15,019	29,216	417	14,024	1,443	**99,895**
Reclassification of existing finance leased assets to right of use assets on 1 April	-	-	-	-	(6,230)	-	(3,557)	-	**(9,787)**
Additions - purchased	-	-	-	28,644	1,194	-	330	-	**30,168**
Additions - donated	-	-	-	56	5	-	18	-	**79**
Reclassifications	-	9,857	-	(11,228)	478	-	647	246	**(0)**
Impairments	-	(6,840)	47	-	-	-	-	-	**(6,793)**
Revaluations	175	115	355	-	-	-	-	-	**645**
Disposals	-	-	-	-	(762)	-	-	-	**(762)**
Cost or Valuation at 31 March 2023	**3,007**	**38,179**	**2,299**	**32,491**	**23,901**	**417**	**11,462**	**1,689**	**113,446**
Accumulated depreciation at 1 April 2022	-	-	-	-	16,353	256	9,125	942	**26,676**
Reclassification of existing finance leased assets to right of use assets on 1 April	-	-	-	-	(3,266)	-	(2,120)	-	**(5,386)**
Provided during the year	-	4,091	61	-	1,635	21	915	82	**6,805**
Impairments	-	(3,997)	-	-	-	-	-	-	**(3,997)**
Reclassifications	-	-	-	-	-	-	-	-	**-**
Revaluations	-	(94)	(61)	-	-	-	-	-	**(155)**
Disposals	-	-	-	-	(762)	-	-	-	**(762)**
Accumulated depreciation at 31 March 2023	**-**	**-**	**-**	**-**	**13,960**	**277**	**7,920**	**1,024**	**23,181**
Opening net book value at 1 April 2022									
Purchased	2,832	33,190	1,897	14,963	8,730	161	3,384	426	65,583
Finance leased	-	-	-	-	2,964	-	1,436	-	4,400
Government granted	-	1,857	-	56	747	-	79	75	2,814
Donated	-	-	-	-	422	-	-	-	422
Total NBV at 1 April 2022	2,832	35,047	1,897	15,019	12,863	161	4,899	501	73,219
Closing net book value at 31 March 2023									
Purchased	3,007	35,076	2,299	32,444	9,065	140	3,470	600	**86,101**
Finance leased	-	-	-	-	-	-	-	-	**-**
Government granted	-	3,103	-	47	521	-	72	65	**3,808**
Donated	-	-	-	-	355	-	-	-	**355**

Total NBV at 31 March 2023	**3,007**	**38,179**	**2,299**	**32,491**	**9,941**	**140**	**3,542**	**665**	**90,264**

13 Property, plant and equipment

13.3 Right of use assets - 2023/24 - Total

	Property (land and buildings) £ 000	Plant and Machinery £ 000	Transport Equipment £ 000	Information Technology £ 000	Furniture and Fittings £ 000	Intangible assets £ 000	Total Trust £ 000
Cost or valuation at 1 April 2023	251	6,320	92	3,556	-	520	**10,739**
Additions - lease liability	46	431	45	551	-	-	**1,073**
Disposals	-	(873)	-	-	-	-	**(873)**
Cost or Valuation at 31 March 2024	**297**	**5,878**	**137**	**4,107**	**-**	**520**	**10,939**
Accumulated depreciation at 1 April 2023	49	4,216	25	2,664	-	463	**7,417**
Provided during the year - RoU Asset	150	789	25	540	-	57	**1,561**
Disposals / Derecognition	-	(874)	-	-	-	-	**(874)**
Accumulated depreciation at 31 March 2024	**199**	**4,131**	**50**	**3,204**	**-**	**520**	**8,104**
Closing net book value at 31 March 2024							
RoU Asset	98	1,747	87	903	-	0	**2,835**
Total NBV at 31 March 2024	**98**	**1,747**	**87**	**903**	**-**	**0**	**2,835**

Of the right of use assets net book value, £51,000 is leased with Local Authorities for land and buildings, all other right of use assets are leased from bodies external to government (2022/23 £76,000 leased with local authorities).

13.4 Right of use assets - 2022/23 - Total

Cost or valuation at 1 April 2022	-	-	-	-	-	-	**-**
Reclassification of existing finance leased assets to right of use assets on 1 April	-	6,229	-	3,556	-	520	**10,305**
Recognition of right of use assets for existing operating leases on initial application of IFRS 16 on 1 April 2022	251	91	29	-	-	-	**371**
Additions - lease liability	-	-	63	-	-	-	**63**
Cost or Valuation at 31 March 2023	**251**	**6,320**	**92**	**3,556**	**-**	**520**	**10,739**
Accumulated depreciation at 1 April 2022	-	-	-	-	-	-	**-**
Reclassification of existing finance leased assets to right of use assets on 1 April	-	3,266	-	2,120	-	405	**5,791**
Provided during the year - RoU Asset	49	950	26	543	-	58	**1,626**
Accumulated depreciation at 31 March 2023	**49**	**4,216**	**26**	**2,663**	**-**	**463**	**7,417**
Closing net book value at 31 March 2023							
RoU Asset	202	2,104	66	893	-	57	**3,322**

Total NBV at 31 March 2023	**202**	**2,104**	**66**	**893**	**-**	**57**	**3,322**

13.5 Analysis of property, plant and equipment

Land, building and dwelling assets were subject to a desktop valuation conducted by the Trust's externally appointed independent valuers on an alternate site basis as at 31st March 2024.

Of £21,607,000 net impairments (2022/23 £2,796,000), £20,889,000 (2022/23 - £2,796,000) has been recognised in operating expenses and £718,000 (2022/23 - £nil) has been recognised directly in equity during the period.

13.6 Analysis of revalued property, plant and equipment

	Land	Buildings (excluding dwellings)	Dwellings	Total
	£ 000	£ 000	£ 000	£ 000
Net book value of PPE in the revaluation reserve				
As at 1 April 2023	**1,294**	**1,547**	**415**	**3,256**
Movement in year	**(264)**	**270**	**(415)**	**(409)**
As at 31 March 2024	**1,030**	**1,817**	**-**	**2,847**
As at 1 April 2022	1,119	1,337	-	2,456
Movement in year	175	210	415	800
As at 31 March 2023	1,294	1,547	415	3,256

13.7 Other Investments

	Year Ended 31 March 2024 £ 000	Year Ended 31 March 2023 £ 000
NHS Charitable funds: Other investments		
Carrying value at 1 April	**2,465**	2,591
Acquisitions in year - other	**1,683**	529
Movement in fair value of Available-for-sale financial assets recognised in Other Comprehensive Income	**128**	(177)
Disposals	**(1,633)**	(478)
Carrying value at 31 March	**2,643**	2,465

14 Inventories

14.1 Inventories recognised in current assets

	Total as at 31 March 2024 £ 000	Total as at 31 March 2023 £ 000
Drugs	**1,565**	1,229
Consumables	**1,857**	1,584
Consumables donated from DHSC group bodies	**20**	60
Energy	**27**	5
	3,469	2,878

14.2 Inventory Movements

Carrying Value at 1 April	**2,878**	3,182
Additions (purchased)	**40,387**	37,232
Additions (donated) - from DHSC	**146**	579
Inventories consumed (recognised in expenses)	**(39,810)**	(37,980)
Write down of inventories recognised as an expense	**(132)**	(135)
	3,469	2,878

At 31st March 2024 the Charitable Funds held inventories of £nil (31st March 2023 £nil)

	Total as at 31 March 2024 £ 000	Total as at 31 March 2023 £ 000
15 Trade and other receivables		
15.1 Current trade and other receivables		
Contract receivables	**8,465**	16,852
Allowance for impaired contract receivables / assets	**(423)**	(436)
Prepayments	**2,191**	1,963
Interest receivable	**170**	39
Operating lease receivables	**7**	-
PDC dividend receivable	**543**	732
VAT receivable	**1,628**	642
Other receivables - revenue	**1,192**	621
NHS Charitable funds: Trade and other receivables	**36**	45
	13,809	20,458

On consolidation the balance of receivables from Charity of £250,000 (31 March 2023 £257,000) is eliminated and replaced with Charity receivables balance £36,000 (31 March 2023 £45,000). Excluding Charitable Funds, the Trust Current receivable balance is £14,024,000 (31 March 2023 £20,520,000).

15.2 Non-current trade and other receivables		
Contract receivables	**446**	381
Allowance for impaired contract receivables / assets	**(103)**	(91)
Prepayments	**323**	182
	666	473

15.3 Allowances for credit losses		
Allowances as at 1 April - brought forward	**527**	417
New allowances arising	**516**	277
Changes in existing allowances	**11**	-
Reversals of allowances	**(359)**	(89)
Amounts utilised	**(169)**	(78)
Provision at 31 March	**526**	527

16 Cash and cash equivalents

	Trust Total 2024 £ 000	Charitable Funds Total 2024 £ 000	Trust Total 2023 £ 000	Charitable Funds Total 2023 £ 000
At 1 April	**8,419**	**517**	27,397	831
Net change in year	**26,152**	**(236)**	(18,978)	(314)
At 31 March	**34,571**	**281**	8,419	517
Broken down into:				
Cash at commercial banks and in hand	**40**	**281**	27	517
Cash with the Government Banking Service	**34,531**	**-**	8,392	-
Cash and cash equivalents as in SoFP	**34,571**	**281**	8,419	517
At 31 March	**34,571**	**281**	8,419	517

Total cash and cash equivalents for the group as at 31 March 2024 are £34,851,000 (31 March 2022 - £8,936,000).

17 Trade and other payables

17.1 Current trade and other payables

	Total as at 31 March 2024 £ 000	Total as at 31 March 2023 £ 000
NHS trade payables - revenue	**3,912**	2,522
Amounts due to other related parties - revenue	**3,396**	2,511
Trade payables - capital	**26,876**	12,062
Other trade payables	**3,485**	7,534
Social security costs payable	**2,252**	2,128
Other taxes payable	**2,209**	1,893
Other payables	**6,742**	16,121
Accruals	**8,047**	10,200
NHS Charitable funds	**-**	155
	56,919	55,127

17.2 Non-current trade and other payables

Other payables	**-**	-
	-	-

17.3 Other liabilities - current

Deferred income: contract liabilities	**1,879**	1,585
	1,879	1,585

18 Movements in the carrying value of lease liabilities

	Finance Leases	Total
Carrying value at 1 April 2023	3,932	**3,932**
Cash movements:		
Financing cash flows - payments and receipts of principal	(1,860)	**(1,860)**
Financing cash flows - payments of interest	(79)	**(79)**
Non-cash movements:		
Additions	1,073	**1,073**
Interest charge arising in year	79	**79**
Carrying value at 31 March 2024	**3,145**	**3,145**

The incremental borrowing rate applied to lease liabilities on during 2023 was the HM Treasury rate of 3.51%. The rate applicable from 1 Jan 2024 is 4.72%

19 Borrowings

19.1 Current borrowings

		Total as at 31 March 2024 £ 000	Total as at 31 March 2023 £ 000
Obligations under finance leases	Note 20	**1,575**	1,681
		1,575	1,681

19.2 Non-current borrowings

		Total as at 31 March 2024 £ 000	Total as at 31 March 2023 £ 000
Obligations under finance leases	Note 20	**1,571**	2,252
		1,571	2,252

20 Lease liabilities - maturity analysis

	Total as at 31 March 2024 £ 000	Total as at 31 March 2023 £ 000
Obligations under finance leases where the trust is the lessee		
Minimum finance lease payments due:		
no later than one year	**1,683**	1,806
later than one year and no later than five years	**1,668**	2,377
later than five years	**-**	-
Gross finance lease liabilities	**3,351**	4,183
Finance charges allocated to future periods	**(205)**	(250)
Net finance lease liabilities	**3,146**	3,933
Net finance lease liabilities are due:		
no later than one year	**1,575**	1,681
later than one year and no later than five years	**1,571**	2,252
later than five years	**-**	-
	3,146	3,933

21 Provisions

21.1 Provision for liabilities and charges

	Pensions - Early Retirement	Pensions - injury benefits	Other Legal Claims	Other	Total as at 31 March 2024	Total as at 31 March 2023
	£ 000	£ 000	£ 000	£ 000	£ 000	£ 000
At 1 April	530	560	63	337	**1,490**	1,819
Change in the discount rate	(4)	(3)	-	-	**(7)**	(260)
Arising during the year	76	55	34	17	**182**	350
Used during the year	(68)	(39)	(36)	(103)	**(246)**	(130)
Reversed unused	-	(128)	(4)	(173)	**(305)**	(265)
Unwinding of discount	(13)	(14)	-	-	**(27)**	(24)
At 31 March	**521**	**431**	**57**	**78**	**1,087**	1,490
Expected timing of cash flows						
Within 1 year	66	33	57	78	**234**	506
Between 1 and 5 years	265	127	-	-	**392**	413
After 5 years	190	271	-	-	**461**	571
Total	**521**	**431**	**57**	**78**	**1,087**	1,490

Pensions provisions covers liabilities in respect of former staff members. Due to the nature of the obligation (pension related) there is uncertainty over the expected timing of cash flows, duration and magnitude

Legal claims include Employer's Liability and Public Liability claims. Incidents occurring after 1 April 1999 are covered by the NHS Litigation Authority Liabilities to Third Parties Scheme

Other provisions include contractual challenges, there are no individual provisions greater than £1m.

21.2 Current provisions

	Total as at 31 March 2024	Total as at 31 March 2023
	£ 000	£ 000
Pensions - other staff	**66**	62
Pensions - injury benefit	**33**	44
Other legal claims	**57**	63
Other	**78**	337
At 31 March	**234**	506

21.3 Non-current provisions

Pensions - other staff	**455**	468
Pensions - injury benefit	**398**	516
At 31 March	**853**	984

21.4 Clinical negligence liabilities

£101,236,000 is included in the provisions of the NHS Litigation Authority at 31 March 2024 (31 March 2023 - £123,759,000) in respect of clinical negligence liabilities of the Foundation Trust.

21.5 Contingent liabilities

The Trust has £7,000 of contingent liabilities at 31 March 2024 (31 March 2023 - £11,000) in respect of potential excess payments for NHS Litigation Authority claims for Public and Employer Liability claims outstanding where timing is expected to be within the next 12 months.

22 Revaluation reserve

	Property, plant and equipment 2024 £ 000	Total 2024 £ 000	Property, plant and equipment 2023 £ 000	Total 2023 £ 000
At 1 April	**3,256**	**3,256**	2,456	2,456
Impairments	**(719)**	**(719)**	-	-
Revaluations	**310**	**310**	800	800
At 31 March	**2,847**	**2,847**	3,256	3,256

23 Financial instruments

23.1 Analysis of financial assets and liabilities by category

	Held at amortised cost £ 000	Held at fair value through I&E £ 000	Total £ 000
Carrying values of financial assets as at 31 March 2023			
Trade and other receivables excluding non-Financial assets	**9,754**	**-**	**9,754**
Cash and cash equivalents	**34,571**	**-**	**34,571**
Consolidated NHS Charitable fund financial assets	**317**	**2,643**	**2,960**
Total financial assets as at 31 March 2024	**44,641**	**2,643**	**47,284**
Carrying values of financial assets as at 31 March 2022			
Trade and other receivables excluding non-financial assets	17,363	-	17,363
Cash and cash equivalents	8,419	-	8,419
Consolidated NHS Charitable fund financial assets	563	2,464	3,027
Total financial assets as at 31 March 2023	26,345	2,464	28,809

£168,000 of impairment loss on loans and receivables (31 March 2023 - £188,000 loss) has been recognised within operating expenses during the year under the increase in provision for impairment of receivables within note 5.

	Held at amortised cost £ 000	Held at fair value through I&E £ 000	Total book value £ 000
Liabilities as per Statement of Financial Position			
Carrying values of financial liabilities as at 31 March 2024			
Obligations under finance leases	**3,146**	**-**	**3,146**
Trade and other payables excluding non-financial liabilities	**43,736**	**-**	**43,736**
IAS 37 provisions which are financial liabilities	**950**	**-**	**950**
NHS Charitable funds	**-**	**-**	**-**
Total financial liabilities as at 31 March 2024	**47,832**	**-**	**47,832**
Carrying values of financial liabilities as at 31 March 2023			
Obligations under finance leases	3,933	-	3,933
Trade and other payables excluding non-financial liabilities	50,673	-	50,673
IAS 37 provisions which are financial liabilities	1,090	-	1,090
NHS Charitable funds	154	-	154
Total financial liabilities as at 31 March 2023	55,850	-	55,850

	As at 31 March 2024 £ 000	As at 31 March 2023 £ 000
23.2 Maturity of financial liabilities		
Financial liabilities maturing in		
one year or less	**45,518**	52,739
In more than one year but not more than five years	**2,060**	2,789
more than five years	**459**	572
	48,037	56,100

	Book value as at 31 March 2024 £ 000	Fair value as at 31 March 2024 £ 000
23.3 Fair value of financial assets and liabilities		
Financial assets		
Consolidated NHS Charitable funds	**2,643**	**2,643**
Total	**2,643**	**2,643**

The fair value of financial assets and liabilities for the James Paget University Hospitals NHS Foundation Trust is not significantly different from the book value. The assets of the NHS Charity are held in listed securities and as such the market value can fluctuate causing variances between the book value and the fair value. The carrying values of other short-term receivables and payables are a reasonable approximation of the fair value.

The Trust has limited exposure to interest rate risk, currency risk, credit risk, liquidity risk, and other specific price risks, and therefore does not actively seek to manage risk in these areas.

24 Third party assets

The Foundation Trust held £3,000 cash at bank and in hand at 31 March 2024 (31 March 2023 - £4,000) which relates to monies held on behalf of patients. This has been excluded from the cash at bank and in hand figure reported in the accounts. Gross inflows and outflows during the reporting period are £1,000 and £nil respectively (2022/23 - £nil and £nil).

25 Financial commitments

25.1 Capital commitments

The Foundation Trust has £11,535,000 of contractual capital commitments as at 31 March 2024 mainly related to intangible assets and building schemes in progress (31 March 2023 - £7,959,000 mainly related to intangible assets and building schemes in progress).

25.2 Other financial commitments

The Trust is committed to making payments under non-cancellable contracts (which are not leases, PFI contracts or other service concession arrangements) during 2023/24 as follows, analysed by the period during which the commitment expires:

	As at 31 March 2024 £ 000	As at 31 March 2023 £ 000
Expiry in less than one year	**1,945**	1,086
Expiry in more than one year but less than five years	**11**	437
Expiry in more than five years	**-**	-
Total	**1,956**	1,523

26 Related party transactions

	Year Ended 31st March 2024 £ 000	Year Ended 31st March 2023 £ 000
26.1 Key management personnel compensation		
Salaries and other short-term benefits	**1,066**	944
Post employment benefits	**103**	81
Total	**1,169**	1,025

Key management personnel has been interpreted as all the executive, non-executive and non-voting directors of the Trust.

26.2 Related party payments, receipts and balances

During the year none of the Department of Health and Social Care Ministers, Board members or members of the key management staff, or parties related to them, have undertaken any material transactions (other than employment benefits) with the James Paget University Hospitals NHS Foundation Trust.

All bodies within the scope of the Whole Government Accounts (WGA), including the James Paget University Hospitals NHS Foundation Trust are considered to be under the common control of the UK government, and are therefore considered to be related parties. Within the group structure of WGA, the immediate parent of the Trust is the Department of Health. The James Paget University Hospitals NHS Foundation Trust also acts as the corporate Trustee of the James Paget University Hospitals Charitable Fund and in accordance with the charity's declaration of trust, members of the Foundation Trust's Board of Directors act as ex-officio Trustees of the Charitable Funds. In accordance with note 1.2 the Charitable Fund has been consolidated into these group accounts and is therefore no longer reported as a related party. The values of transactions with these entities are detailed below:

Value of transactions with other related parties Non-consolidated subsidiaries and associates / joint ventures

Paragraph 25 of IAS 24 allows entities which are related parties because they are under the same government control to reduce the volume of the detailed disclosures. The GAM interprets this such that DHSC group bodies must disclose the Department of Health and Social Care as the parent department and provide a note of the main entities within the public sector with which the body has had dealings, but that no information needs to be given about these transactions.
In line with this, these related parties notes only collect details of transactions and balances with bodies or persons outside of the whole of government accounts boundary.

Notes to the Accounts

continued

27 Losses and special payments

	31 March 2024 Total no of cases Number	31 March 2024 Total value of cases £000's	31 March 2023 Total no of cases Number	31 March 2023 Total value of cases £000's
Losses:				
Theft, fraud, etc.	**-**	**-**	-	-
overpayment of salaries etc.	**-**	**-**	-	-
Losses of cash	**-**	**-**	-	-
Fruitless payments and constructive losses	**-**	**-**	-	-
Bad debts and claims abandoned	**6**	**-**	3	-
Damage to buildings, property etc. (including stores losses).	**2**	**1**	8	63
Total Losses	**8**	**1**	11	63
Special Payments:				
Extra contractual to contractors	**-**	**-**	-	-
Ex gratia payments	**21**	**8**	14	4
Total Special Payments	**21**	**8**	14	4
Total losses and special payments	**29**	**9**	25	67

28 Charitable Funds summary statements 2023/24

28.1 Summary Statement of Financial Activities

	IFRS Year Ended 31 March 2024 £ 000	Charity Consolidation Eliminations *	Year Ended 31 March 2024 £ 000
Incoming Resources: excluding investment income	**273**	-	**273**
Total operating income	**273**	-	**273**
Employee benefits:			
- expended with the Foundation Trust	**(72)**	72	**-**
Other resources expended			
- with the Foundation Trust	**(235)**	235	**-**
- with bodies outside the NHS	**(210)**	-	**(210)**
- audit fee (payable to the external auditor)	**(13)**	-	**(13)**
Total operating expenditure	**(530)**	307	**(223)**
Incoming Resources: investment income	**75**	-	**75**
Net (outgoing) / incoming resources before other recognised gains and losses	**(182)**	307	**125**
Fair value gains / (losses) on investment assets	**128**	-	**128**
Net Movement in funds	**(54)**	307	**253**

28.2 Summary Balance Sheet

Non-current assets			
Other Investments	**2,643**	-	**2,643**
Total non-current assets	**2,643**	-	**2,643**
Current assets			
Trade and other receivables	**36**	-	**36**
Cash and cash equivalents	**281**	-	**281**
Total current assets	**317**	-	**317**
Current liabilities			
Trade and other payables	**(250)**	250	**-**
Total current liabilities	**(250)**	250	**-**
Net assets	**2,710**	250	**2,960**
Funds of the charity			
Restricted funds:	**216**	-	**216**
Unrestricted funds:			
Unrestricted income funds	**2,304**	250	**2,554**
Revaluation reserve	**190**	-	**190**
Total Charitable Funds	**2,710**	**250**	**2,960**

Charitable Funds are presented under UK GAAP and are consistent with SORP 2015. In restating the charity accounts to be consistent with the IFRS based accounting policies of the Foundation Trust, the commitments accrual of £235,000 (2022/23 £385,000) reported under UK GAAP has been removed. The separate accounts of the Charity can be found on the Charity Commission website.

* Consolidation eliminations illustrate the impact on the balances of the group accounts, and do not impact on the underlying performance of the Charitable Fund which retains a movement in funds of £54,000 (2022/23 £496,000), and net assets of £2,710,000 (2022/23 £2,378,000).

29 Charitable Funds summary statements 2022/23

29.1 Summary Statement of Financial Activities

	IFRS Year Ended 31 March 2023 £ 000	Charity Consolidation Eliminations *	Year Ended 31 March 2023 £ 000
Incoming Resources: excluding investment income	**187**	-	**187**
Total operating income	**187**	-	**187**
Employee benefits:			
- expended with the Foundation Trust	**(188)**	188	**-**
Other resources expended			
- with the Foundation Trust	**(308)**	308	**-**
- with bodies outside the NHS	**(110)**	-	**(110)**
- audit fee (payable to the external auditor)	**(7)**	-	**(7)**
Total operating expenditure	**(613)**	496	**(117)**
Incoming Resources: investment income	**67**	-	**67**
Net (outgoing) / incoming resources before other recognised gains and losses	**(359)**	496	**137**
Fair value gains / (losses) on investment assets	**(177)**	-	**(177)**
Net Movement in funds	**(536)**	496	**(40)**

29.2 Summary Balance Sheet

Non-current assets			
Other Investments	**2,464**	-	**2,464**
Total non-current assets	**2,464**	-	**2,464**
Current assets			
Trade and other receivables	**45**	-	**45**
Cash and cash equivalents	**517**	-	**517**
Total current assets	**562**	-	**562**
Current liabilities			
Trade and other payables	**(263)**	109	**(154)**
Total current liabilities	**(263)**	109	**(154)**
Net assets	**2,763**	109	**2,872**
Funds of the charity			
Restricted funds:	**405**	-	**405**
Unrestricted funds:			
Unrestricted income funds	**2,008**	109	**2,117**
Revaluation reserve	**350**	-	**350**
Total Charitable Funds	**2,763**	109	**2,872**

Charitable Funds are presented under UK GAAP and are consistent with SORP 2015. In restating the charity accounts to be consistent with the IFRS based accounting policies of the Foundation Trust, the commitments accrual of £385,000 (2021/22 £509,000) reported under UK GAAP has been removed. The separate accounts of the Charity can be found on the Charity Commission website.

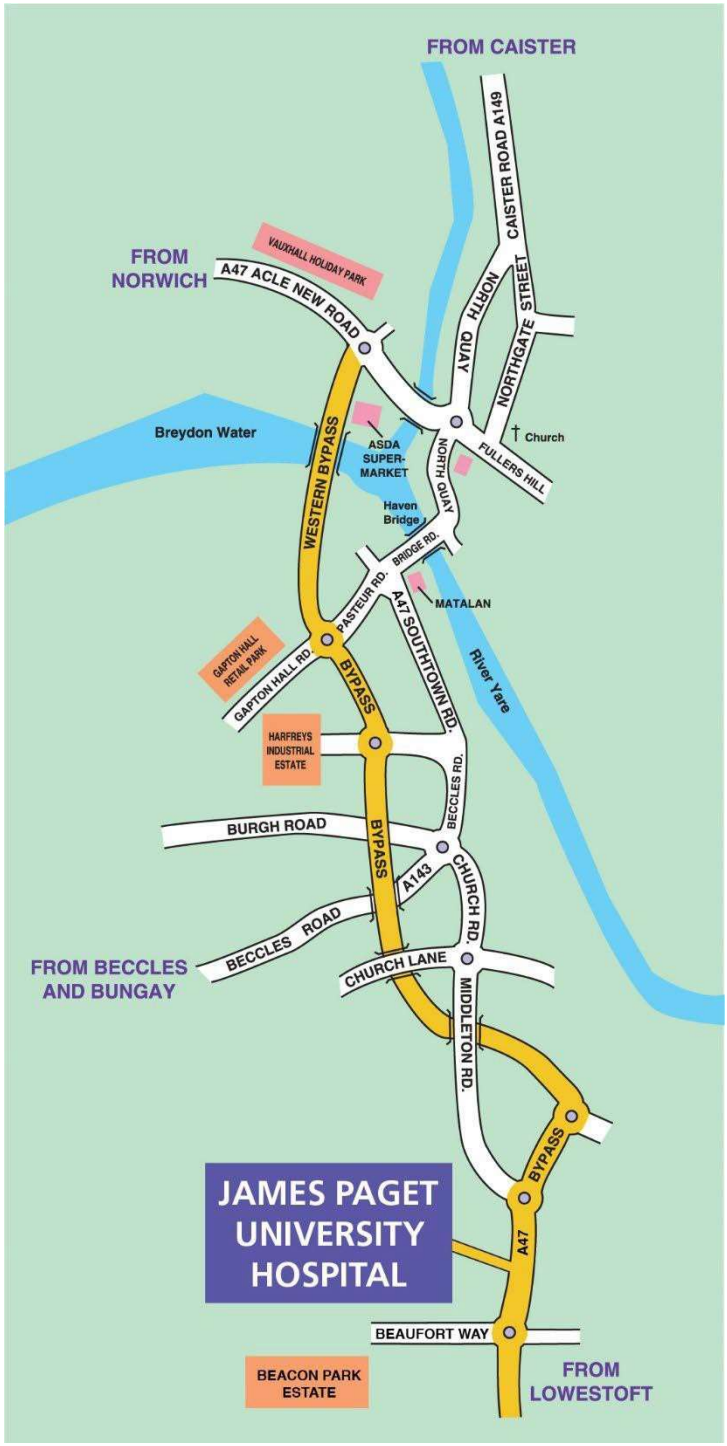
* Consolidation eliminations illustrate the impact on the balances of the group accounts, and do not impact on the underlying performance of the Charitable Fund which retains a movement in funds of £496,000 (2021/22 £481,000), and net assets of £2,378,000 (2021/22 £2,790,000).

Glossary and Key to Abbreviations

AHP	Allied Health Professional
Acute	Rapid onset, severe symptoms, and brief duration
Audit	A continuous process of assessment, evaluation, and
adjustment BAF	Board Assurance Framework
CHP	Sustainability – combined heat and power
CQC	Care Quality Commission
Capital	Spending on land and premises and provision, adaptation, renewal, replacement or demolition of buildings, equipment, and vehicles
CiC	Committees in Common
EADU	Emergency Assessment and Discharge Unit
ED	Emergency Department
EDI	Equality, diversity, and inclusion
ENT	Ear, Nose and Throat services
ERB	Elective Recovery Board
ERIC	Estates Returns Information Collection – NHS Digital
FTSU	Freedom to Speak Up
HMB	Hospital Management Board
HASU	Hyper Acute Stroke Unit
Inpatient	A patient admitted to hospital for a period of treatment or to undergo an operation, staying in hospital for 24 hours or longer
ICS	Integrated Care System
JPUH	James Paget University Hospitals NHS Foundation Trust
KLOEs	Key Lines of Enquiry
KPIs	Key Performance Indicators
N&R	Nomination and Remuneration
N&W	Norfolk and Waveney
N&WHG	Norfolk and Waveney Hospitals Group – the three acute Trusts
NED	Non-executive Director
NHP	New Hospitals Programme
NHSE/I	NHS England/NHS Improvement leads the NHS in England. They have been working together since April 2019 to better support the NHS to deliver improved care for patients
NNUH	Norfolk and Norwich University Hospitals NHS Foundation Trust
Outpatient	Provided on an appointment basis without the need to be admitted

	to or stay in hospital
PDC	Public Dividend Capital
QEH	The Queen Elizabeth Hospital King's Lynn NHS Foundation Trust
RAAC	Reinforced Aerated Autoclaved Concrete roof panels
REGO	Renewable energy electric contract
RTT	Referral to Treatment
SFIs	Standing Financial Instructions – part of corporate governance framework
SOC	Strategic Outline Case
UoR	Use of Resources
UEA	University of East Anglia
UEC	Urgent and Emergency Care
VCSE	Voluntary, community and social enterprise sectors
VSM	Very Senior Manager
WRES/WDES	Equality – Workforce Race and Disability Equality Standards
WTE/FTE	Whole time/full time equivalent (staffing)

Useful contacts and how to get to the hospital



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