

Proud
of the
Paget

NHS

**James Paget
University Hospitals**
NHS Foundation Trust

ANNUAL REPORT AND ACCOUNTS 2025/26



James Paget University Hospitals NHS Foundation Trust

Annual Report and Accounts 2025/26

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

Contents

Table of Contents

Forewords by the Group Chair, Chief Executive and James Paget Hospital Executive Managing Director.....	6
Our history and purpose	9
Performance	10
Activity and performance overview	11
Sustainability	25
Overseas operations.....	29
Going concern.....	29
Directors' Report.....	31
Governance Architecture Schematic.....	34
The Council of Governors	45
Statement of Compliance with the Code of Governance for NHS Provider Trusts	48
The Care Quality Commission Well-Led Framework	48
Care Quality Commission ratings	50
Service improvements	51
Financial disclosures	56
Remuneration Report	60
Statement of Accounting Officer's Responsibilities	80
Auditor's Report	82
Annual Governance Statement	88
Staff report.....	95
Equity, diversity, and human rights.....	96
Freedom to Speak Up	99
Data and policies	100
Staff engagement and the NHS Staff Survey	103
Other disclosures	107
Glossary and Key to Abbreviations	110
Useful contacts and how to get to the hospital	112
Financial Statements and notes to the Accounts	114

Forewords by the Group Chair, Chief Executive and James Paget Hospital Executive Managing Director

David Roberts, Group Chair, Norfolk and Waveney University Hospitals Group



*David Roberts,
Group Chair*

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

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

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

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

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

We aim to ensure all three Trusts deliver consistently the standard of care our patients and our population deserves, and that our staff want to provide. Our priorities are to:

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

Facing Challenges and Pursuing Improvement

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

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

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

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

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

Acknowledgements and Gratitude

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

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

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

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

- Hospital to community
- Analogue to digital systems
- Treatment to prevention

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

Professor Lesley Dwyer, Group Chief Executive, Norfolk and Waveney University Hospitals Group, and Jonathan Gardner, Executive Managing Director (From 12th January 2026)



*Professor
Lesley Dwyer,
Group Chief
Executive*

There's never a quiet time in healthcare and the past year has been characterised as a period of change for our hospitals.

I want to start by saying how proud I am of everyone's effort and achievements over the last year as we continue to live with rising demand for our services as well as continuing pressure on our finances.

We live in a world that is constantly evolving and adapting with advances in technology and AI, which also represents a challenge and an opportunity for all leaders in the NHS to adapt and future-proof our services.



*Jonathan
Gardner,
Executive
Managing
Director*

This year, we have seen the formal creation of the Norfolk and Waveney University Hospitals Group (NWUHG) which brings three hospital trusts - James Paget University Hospital (JPUH), Norfolk and Norwich University Hospitals (NNUH) and the Queen Elizabeth Hospital (QEH), King's Lynn – under one Group.

I became Group Chief Executive for NWUHG on 6 May and, with the support of Interim Chair David Roberts, established a Board of Directors responsible for the strategic running of three distinct hospital trusts.

Each trust has its own very experienced Executive Managing Director and Hospital Leadership Team in place to manage the day-to-day running of our hospitals. I am pleased to have appointed Jonathan Gardner, Shane Gordon and Michelle Arrowsmith as Executive Managing Directors at JPUH, NNUH and QEH, respectively

The creation of the hospitals group marks a new chapter in collaboration between the three acute hospitals in Norfolk and Waveney by having a shared purpose and unified strategic approach to the complex challenges we all face.

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

We've all faced similar challenges - pressures on performance, resources and staff support, and working separately has limited our ability to address them. Coming together gives us strength and focus. This approach also aligns us with the NHS 10-year plan, which emphasises community-integrated care and sees the creation of new neighbourhood health hubs.

Looking forward, our focus for the next two years is around One Recovery, which is a programme to improve performance and recovery to provide a stable foundation for the future to build a world-class university hospital system that supports both patients and staff.

We are also developing a Group-wide clinical strategy and moving forward with the New Hospital Programme for QEH and JPUH.

I am also hugely excited by the opportunities to advance research and innovation in our hospitals and to bring together the efforts of all three acute Trusts to develop our full potential as places of research and learning.

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 are provided through the new Community Diagnostic Centres and The James Paget Orthopaedic Centre.

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 Trust 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.

STRATEGIC PRIORITIES



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 Executive Managing Director to achieve the outcomes expected. An annual delivery plan is agreed each year to ensure the Priorities and Ambitions are delivered over the term of the strategy.

A set of objectives was agreed by the Trust’s Hospital Management Group on 14 April 2026 setting site specific objectives for the James Paget and incorporating the emerging objectives from the Norfolk Hospitals Group – notably the delivery of the One Recovery Programme.

The objectives for 2026/27 are as follows, it is noted at the time of agreeing the objectives some of the KPIs that underpin delivery were being developed in the various One Recovery programmes.



Building a Healthier Future Together 2023-28
Objectives for 2026 - 2027



James Paget
University Hospitals
NHS Foundation Trust

 OUR PATIENTS 1. Deliver Our Quality Priorities 2. Improve the way patients contact & interact with us 3. Reduce the time patients spend in our hospital	 OUR PEOPLE 1. Improve Staff Engagement and Morale 2. Reduce the level of sickness absence 3. Reduce the occurrence and impact of violence and aggression faced by our staff
 OUR PARTNERS 1. Deliver effective ‘Neighbourhood Health’ through partnership working 2. Improve patient pathways across the Group and system partners 3. Redesign support services to meet the needs of the Group	 OUR PERFORMANCE 1. Reduce waiting times 2. Reduce the wait for cancer treatment 3. Deliver the Cost Improvement Programme

The Trust keeps track of the status of its Strategic Priorities, the Ambitions, and underpinning annual delivery plan through reporting to the relevant management committees and Hospital Management group.

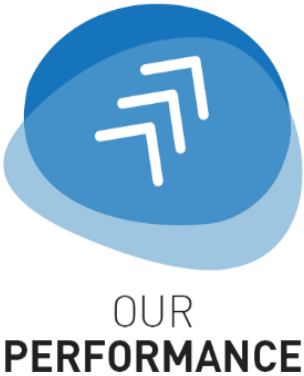
Good progress was made across all objectives in the 2025/26 Delivery Plan

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

With the launch of the Norfolk and Waveney University Hospitals Group, we have further developed collaborative partnerships throughout the Norfolk and Waveney System, supporting initiatives aimed at delivering improved outcomes and experiences for every individual who uses our services.

Throughout the year, we have faced persistent operational challenges but have advanced progress toward our key priorities and objectives. The ongoing demand for urgent and emergency care services across the Trust, coupled with periods of industrial action, has resulted in sustained pressure on all areas. We remain committed to addressing elective waiting lists, reducing procedure wait times,



improving cancer performance, and minimising patient stays within our Emergency Department and hospital beds to ensure individuals receive care in the most suitable environment for their health needs. These efforts are accompanied by an ongoing dedication to enhancing quality and safety.

The Trust's Emergency Department (Urgent and Emergency Care – UEC) has faced persistent challenges throughout the year. A resilience plan has been developed to address increased demand during winter and other periods. In collaboration with system partners, the Trust is actively identifying additional opportunities to improve patient experience and outcomes. Furthermore, plans are underway to establish an Urgent Treatment Centre on site to alleviate pressure on the Emergency Department and facilitate the timely release of ambulances from the hospital.

The number of patients not meeting the 'criteria to reside' has decreased compared to the previous year; however, it remains above the threshold necessary for the Trust to operate within its allocated bed numbers. This issue does not stem from a single cause but is system wide and includes challenges within the local community and social care market. To address this, the Trust continues to implement the 'virtual ward' strategy in conjunction with the use of escalation beds.

Our capacity to decrease waiting times for patients requiring elective procedures has been affected by ongoing emergency pressures and patient flow throughout the hospital. Additional elective recovery programs identified for the latter half of 2025/26 have resulted in reductions in waiting list sizes and wait times. These initiatives will continue through 2026/27 to support the Trust's key priority of further decreasing these wait times alongside wait times for patients waiting for cancer diagnosis and treatment.

The number of patients we treated over the last year is set out below, with comparisons to the two previous financial years.

Activity	2023/24	2024/25	2025/26
Elective Inpatients	4,350	6,087	6,138
Day Cases	33,656	36,346	38,123
Non-Elective Inpatients	29,929	29,104	28,882
Outpatients	270,194	288,113	280,941
A&E (Emergency Department)	97,623	105,443	106,917

The Trust employs a Performance and Accountability Framework to provide Group Board members and key Divisional staff with essential information required to understand, monitor, and evaluate the Trust's quality and performance. This enables timely interventions should there be any decline in performance relative to established targets. Structured reviews are conducted by the Finance and Performance, Quality Safety and Effectiveness, and People and Culture Management Groups.

Additionally, a monthly integrated performance report is presented to the Hospital Management Group, facilitating assessment across quality, safety, operational, workforce, and financial indicators. This process ensures robust assurance for the Norfolk and Waveney University Hospitals Group Executive team and Board.

The Key Performance Indicators are in line with NHS England's 2025/26 planning guidance which focused on elective recovery and additional measures to monitor how the Emergency Department was functioning to support patients.

National NHS objectives 2025/26	Threshold 2025/26	Actual 2025/26
UEC: Improve A&E waiting times, with a minimum of 78% of patients admitted, discharged and transferred from ED within 4 hours in March 2026 and a higher proportion of patients admitted, discharged and transferred from ED within 12 hours across 2025/26 compared to 2024/25	4 Hours: 78% 12 Hours: 6.9%	71.0% 8.3%
Elective Care: Improve the percentage of patients waiting no longer than 18 weeks for treatment to 65% nationally by March 2026, with every trust expected to deliver a minimum 5% point improvement	60.1%	55.1%
Elective Care: Improve the percentage of patients waiting no longer than 18 weeks for a first appointment to 72% nationally by March 2026, with every trust expected to deliver a minimum 5% point improvement	69.4%	62.9%
Elective Care: Reduce the proportion of people waiting over 52 weeks for treatment to less than 1% of the total waiting list by March 2026	1%	3.9%
Cancer: Improve performance against the headline 62-day cancer standard to 75% by March 2026	75%	69.5% (unvalidated)

Details of our service and quality improvements can be found within the Director's report at page 31 and within the Quality Account 2025/26 available on our website <https://www.jpaget.nhs.uk/about-us/publications-and-reports/>

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.

Five overarching quality priorities have been agreed for 2024-2027, each of which had a number of sub-priorities.

Quality Priority 1: We will implement and optimise our Patient Safety and learning Culture through the implementation of the Patient Incident Response Framework (PSIRF), quality and safety reporting through QSAFE and learning from incidents

Quality Priority Domain(s):

☒ Patient Safety ☒ Clinical Effectiveness ☒ Patient Experience

i	90% of our staff will be trained in Level one Patient Safety Syllabus	Achieved
ii	90% of clinical and governance staff will be trained in Level 2 Patient Safety Syllabus	Achieved
iii	For 100% of Patient Safety Incident Investigations (PSIIs), there will be evidence that staff, patients and relatives have been involved in the investigation process.	Achieved



iv	All level 1 and 2 investigations will be supported by an agreed PSIRF tool and be fully utilised across the organisation	Achieved
v	Monitor and see a reduction, year on year in complaints relating to any form of communication	Not Achieved

Quality Priority 2: Deliver Personalised, Safe Care for Maternity and Neonatal service users through our Maternity Delivery Plan (MIP)

Quality Priority Domain(s):

☒ Patient Safety ☒ Clinical Effectiveness ☐ Patient Experience

i	Ensuring the lessons learnt from Ockenden and Kirkup are monitored through robust action plans delivered through the MIP demonstrating sustained and embedded improvements in practice, culture, leadership and governance.	Achieved
ii	Annual reduction of preventable still births per 1000 live births	Not yet confirmed
iii	Annual reduction of preventable Neonatal deaths per 1000 live births	Achieved
iv	Smoking at time of delivery 6%	Not Achieved
v	Have 0 maternal deaths	Achieved

Quality Priority 3: Patients in our care do not come to avoidable harm by reducing the incidence of harm monitored by our quality matrix, including LFD, SJR, GIRFT, NICE recommendations

Quality Priority Domain(s):

☒ Patient Safety ☒ Clinical Effectiveness ☒ Patient Experience

i	5% year on year reduction in falls per 1000 bed days, based on the previous year's metric	Partially Achieved
ii	5% year on year reduction in Hospital Acquired Pressure Ulcers per 1000 bed days, based on the previous year's metric	Not Achieved
iii	10% year on year reduction in medication incidents, based on the previous year's metric	Not Achieved
iv	15% reduction year on year for nationally reportable Gram Negative Infection, based on the previous year's metric	Not Achieved
v	>90% compliance with MUST Nutrition assessment completion within 6 hours of admission, based on the previous year's baseline metric	Achieved
vi	10% reduction year on year with Sepsis– Delivery of Antibiotics (CCORT, Sepsis Audit)	Achieved
vii	Improvement in all of the End of Life Metric's year on year. (NACL Audit/MAD audit)	Achieved
viii	100% of clinical areas assessed for ward accreditation and have achieved and maintained at least good	Partially Achieved

Quality Priority 4: Embed and build on our patient and public engagement plan.

Quality Priority Domain(s):

☐ Patient Safety ☐ Clinical Effectiveness ☒ Patient Experience

i	Embed and build on our patient and public engagement plan.	Achieved
---	--	----------

Quality Priority 5: To deliver high standards of care and access to services for our Older Peoples Medicine (OPM)

Quality Priority Domain(s):

☒ Patient Safety ☒ Clinical Effectiveness ☒ Patient Experience

i	Establish an Older Peoples Medicine Multi-disciplinary team	Achieved
ii	Develop and enhance OPM pathways with bespoke services that avoid admission	Achieved
iii	(TBC) reduction in LOS - this will be confirmed once the system wide approach to OPM has been finalised, led by the ICB.	Metric Not Set
iv	(TBC) reduction in admission of people aged between 65 and 80 - this will be confirmed once the system wide approach to OPM has been finalised, led by the ICB.	Metric Not Set
v	Development in research into non-medical interventions and measuring impact	Achieved

- **Quality Priority 1:** 1 of 5 sub-priorities were achieved, and 1 was not achieved.
 - Monitor and see a reduction, year on year, in complaints relating to any form of communication. There was a 30% increase in complaints relating to communication.
- **Quality Priority 2:** 3 of 5 sub-priorities were achieved to date. One priority was not achieved, and one is awaiting confirmation of compliance. The sub-priorities which were not achieved or are currently not yet confirmed were:
 - Annual reduction of preventable still births per 1000 live births. Compliance with this sub-priority is currently not confirmed. There were 3 still births for 2025/26 against a baseline of 2 in 2024/25. One was deemed to be unavoidable, one demonstrated care issues which it was considered may have made a difference to the outcome for the baby, and one is still undergoing review (within timescale) and potential preventability is yet to be determined.
 - Smoking at time of delivery 6%. Compliance with the sub-priority was not achieved. (8.26% average for 2024/25, Q4 average compliance of 6%).
- **Quality Priority 3:** 3 of 8 sub-priorities achieved, 5 not achieved. The sub-priorities which were not achieved were:
 - 5% year on year reduction in falls per 1000 bed days, based on the previous year's metric - 5.19 Falls per 1000 bed days within 2025/26, against a 2024/25 baseline of 5.29, and target of 5.04.
 - 5% year on year reduction in Hospital Acquired Pressure Ulcers per 1000 bed days,

based on the previous year's metric – 0.79 Hospital Acquired pressure ulcers in 2025/26, against a 2024/25 baseline of 0.77, and target of 0.73.

- 10% year on year reduction in medication incidents, based on the previous year's metric - There were 700 medication incidents in 2025/26, against a baseline of 699 in 2024/25, and a target of 629.
- 15% reduction year on year for nationally reportable Gram Negative infection, based on the previous year's metric - . End of year total for gram negative infections within 2025/26 was 81, against a 2024/25 baseline of 80, and 2025/26 quality priority trajectory of 68.
- 100% of clinical areas assessed for ward accreditation and have achieved and maintained at least good - 100% of wards were assessed for ward accreditation, and 94% of wards achieved good or outstanding. 6% (1 ward) was assessed as requires improvement.

• **Quality Priority 4:** This quality priority was achieved for 2025/26.

• **Quality Priority 5:** 3 of 5 sub-priorities achieved for 2025/26 (however 2 sub-priorities metrics not yet confirmed).

The sub-priorities which have not yet been confirmed are:

- Reduction in length of stay – this target will be confirmed once the system wide approach to OPM has been finalised, led by Norfolk and Waveney Integrated Care Board
- Reduction in admission of those aged between 65 and 80 - this target will be confirmed once the system wide approach to OPM has been finalised, led by Norfolk and Waveney Integrated Care Board

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. 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 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. The workstreams within the Plan are focused on both patient care and workforce equalities with Delivery Groups in place to ensure that each workstream has a robust plan for delivery and is achieving its key outcomes.

In 2025-26, the Trust delivered a Respiratory Pilot in collaboration with Health Connect, aimed at reducing health inequalities in an area where deprivation contributes to significantly higher levels of respiratory disease. Within Great Yarmouth and Waveney, the Core20 population (the most deprived 20% of the population) accounts for 36% of Chronic Obstructive Pulmonary Disease cases, with 48% of these individuals identified as active smokers—compared with 16% and 23% respectively across the rest of Norfolk.

The pilot supported people discharged from James Paget University Hospital following respiratory related admissions, offering targeted navigation and interventions that address wider determinants of health. This included smoking cessation, pulmonary rehabilitation, self management support, healthy

lifestyle promotion, and warm home and damp/mold awareness.

Delivered through a broad Place Partnership—comprising East Coast Community Healthcare, local government, the ICB, acute services, public health, and the VCSE sector—the programme focused on improving quality of life and reducing, preventing, or delaying future health and care needs. Early evidence since its launch in January 2025 indicated improved wellbeing, and the 18 month evaluation is expected to demonstrate reduced acute activity and an increase in care delivered closer to home.

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 datasets that have been developed and shared as part of this section outline our patient population in relation to Index of Multiple Deprivation (IMD). IMD spans from 1 (most deprived) to 10 (least deprived) and is linked to a variety of factors and supports the Trust to understand where it needs to focus or improve its services to support more equitable access to treatment and support for patients.

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



Health Inequalities 2025/26 - Waiting List Analysis

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 remained stable from April 25 to March 26, and the ratio of male/female has remained static. Whilst not shown visually, the proportion of men and women waiting at the higher waits of 52 and 65 weeks is less in line with the proportion at over 18 weeks, indicating that there is a marginal increase in the percentage of men waiting in the longer wait brackets (52% to 59% for 65+ weeks).

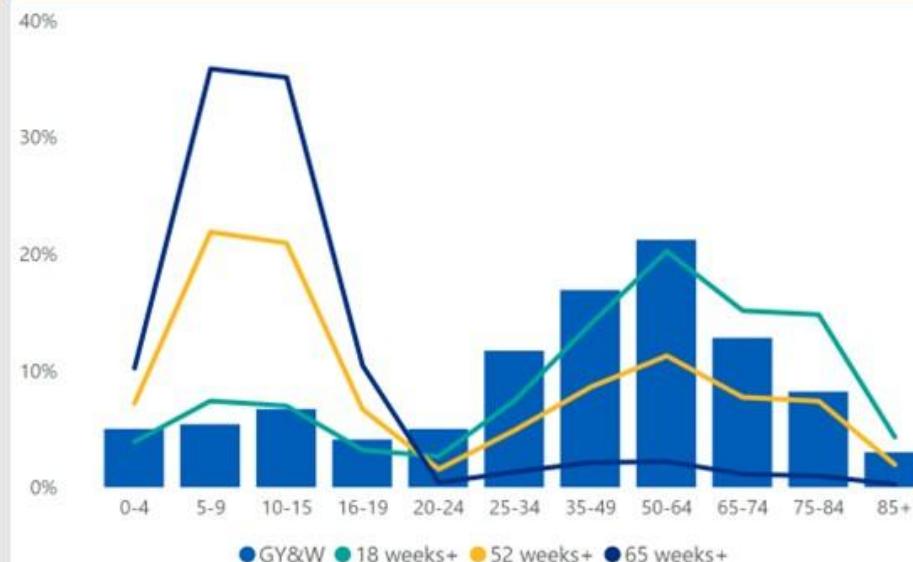
With regards to ethnic groups, the population of GY&W is an outlier compared to the national picture when it comes to the high percentage (94%) of White - British residents. This profile is closely mirrored in the waiting list profile and there are no changes to the profile for longer waits.

When comparing the age profile of the waiting list compared to the population of GY&W, there are some significant differences, with patients over 65 representing 34% of the list, whilst only making up 24% 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 due to Community Paediatrics waiting lists.

Waiting List Profile by Ethnicity and weeks waiting



Waiting List Profile by Age and weeks waiting



Health Inequalities 2025/26 - Elective Activity

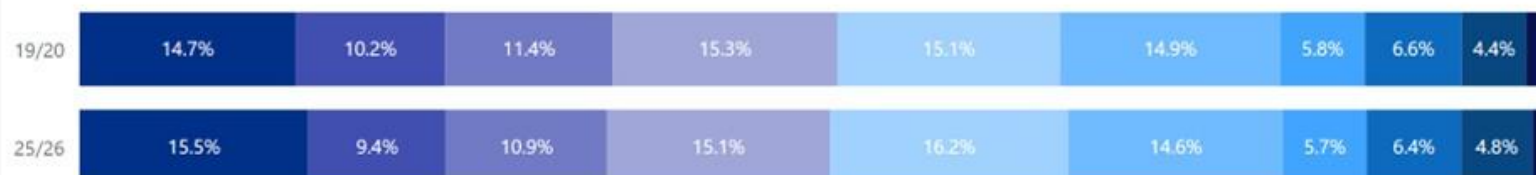
Elective Activity Profile pre-pandemic compared to 2025/26 - overall activity and profile by decile - split by under/over 18



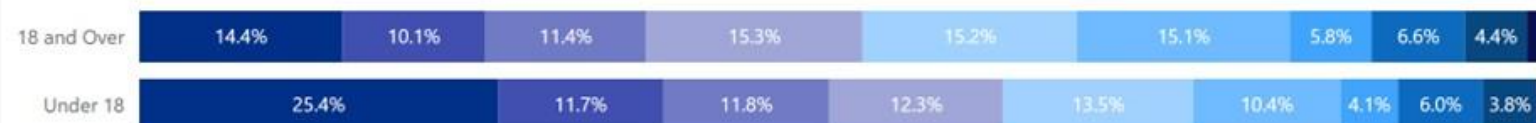
Elective Activity is higher overall in 2025/26 than pre-pandemic (2019/20) but there has not been a significant shift in the profile when looking at IMD groups (top right chart). The above profile suggests that there is an under-representation of the two lowest deciles in the activity profile compared 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.

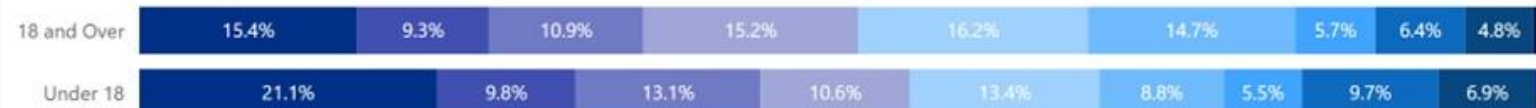
Pre-Pandemic vs 2025/26



2019/20

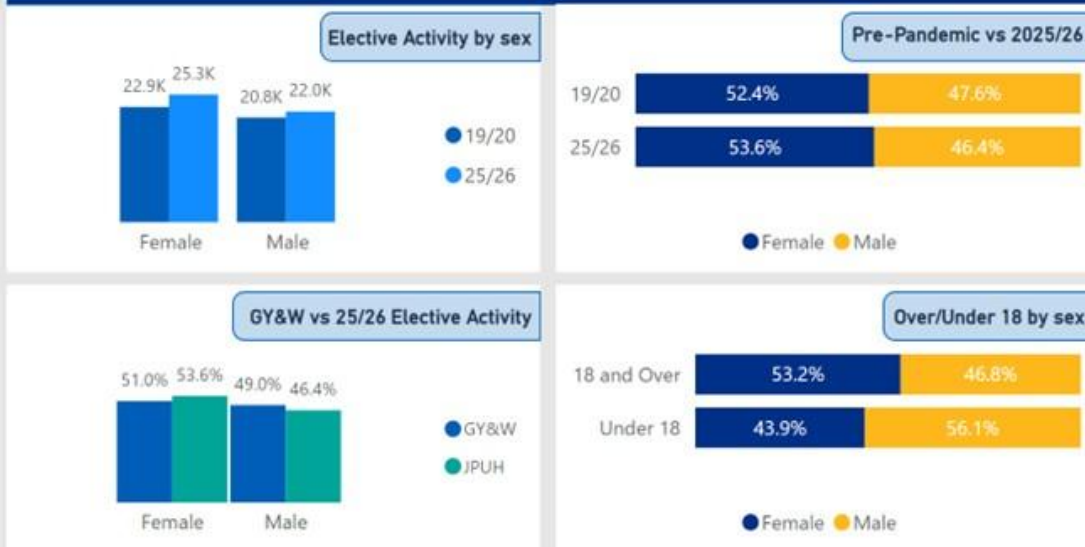


2025/26



Health Inequalities 2025/26 - Elective Activity

Elective Activity Profile pre-pandemic compared to 2025/26 - Sex profile



On the previous page, Elective Activity was shown to be higher in 2025/26 than pre-pandemic 2019/20 - when compared to the distribution of activity by sex, the increased percentage of female patients is approximately double that of additional male patients (10% increase versus 5% increase from 2019). 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.

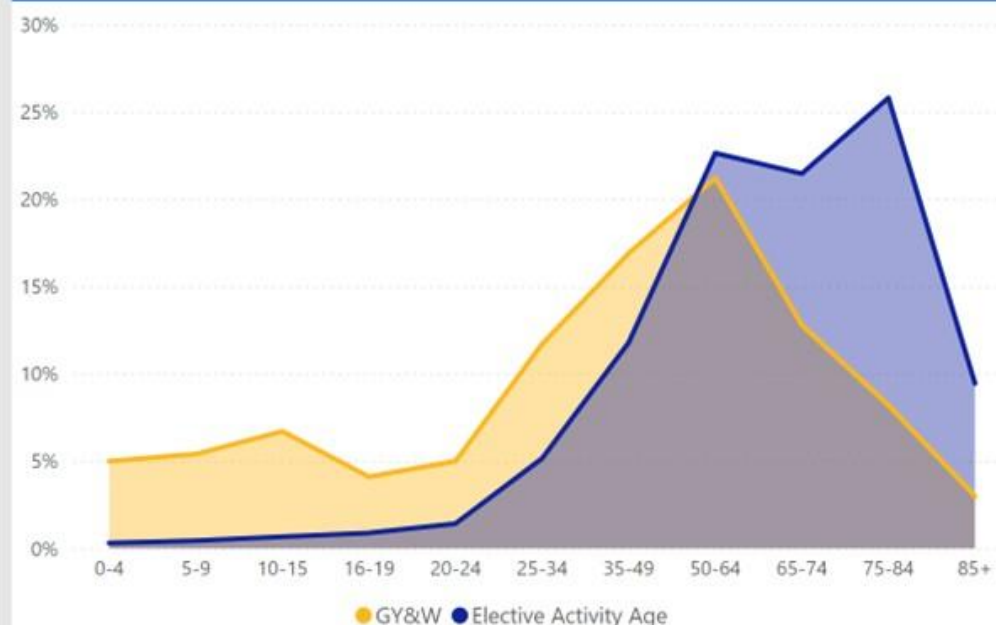
Ethnicity shows a largely consistent profile, with a marginal increase in the overall numbers from other ethnic groups alongside a larger increase in the numerically dominant white British grouping. Overall, the profile matches that for GY&W as a whole.

The chart to the right compares the profile of age bands across GY&W with the distribution of Elective Activity in 25/26. 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 2025/26 - Ethnicity profile



Elective Activity Age profile 2025/26



Non-Elective Activity Profile for under 18s

GY&W IMD vs 25/26 Non-Elective Activity



Non-Elective Activity split by Decile

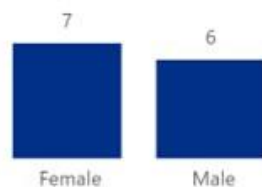


GY&W Age Band vs 25/26 Non-Elective



The metrics on this page concern children's health - to the left and above, the distribution of non-elective admissions for under 19 year olds in 25/26 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.

Tooth extractions for under 10s



Health Inequalities 2025/26 - Cancer Referrals

Referrals for Cancer Profile by IMD decile



IMD	Population	Patients
1	18.66%	14.13%
2	11.94%	8.62%
3	11.19%	10.22%
4	14.93%	17.23%
5	14.93%	17.45%
6	12.69%	13.80%
7	4.48%	6.11%
8	5.22%	6.83%
9	4.48%	4.14%
10	1.49%	1.48%

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 to 8th deciles. There was minimal variation between deciles when looking at average days between referral and diagnosis (21-24 days).

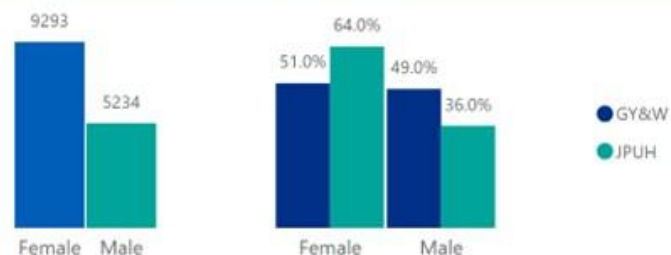
Splitting the referrals by sex reveals that a majority of referrals are for women, with the percentage split falling above the local demographic male/female split.

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.

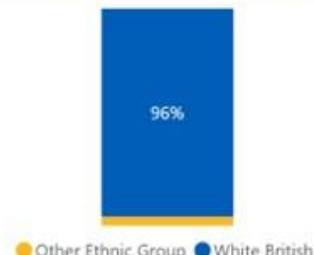
Av. Days Wait



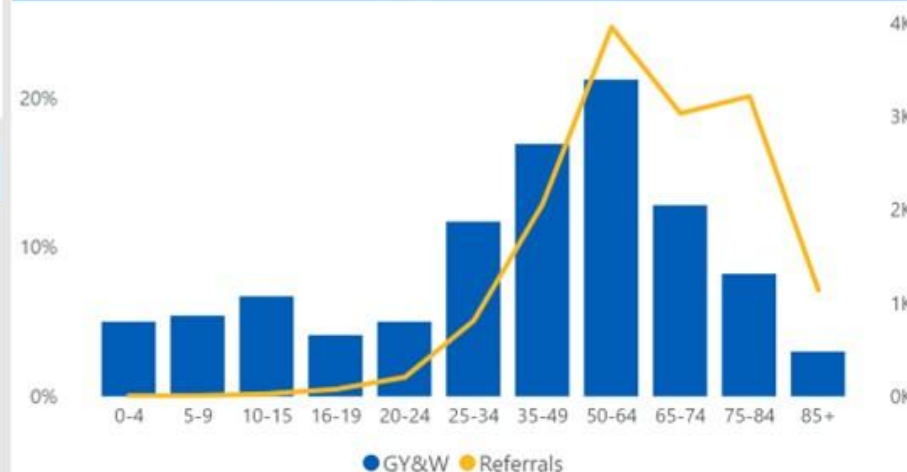
Treatment for Cancer Profile by Sex



Cancer Profile by Ethnicity



Referrals for Cancer Profile by Age Band



Health Inequalities 2025/26 - Cancer Treatment

Treatment for Cancer Profile by IMD decile



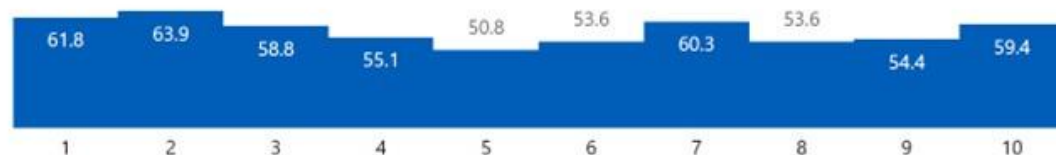
IMD	Population	Treated
1	18.66%	12.74%
2	11.94%	9.06%
3	11.19%	10.49%
4	14.93%	17.85%
5	14.93%	17.57%
6	12.69%	15.65%
7	4.48%	5.49%
8	5.22%	5.60%
9	4.48%	4.17%
10	1.49%	1.37%

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 (50 - 64 days) but does not correlate with referral volume and sits below the 62 day target on average.

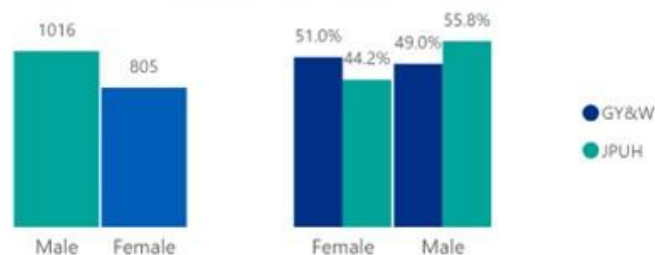
Sex profiles indicate that, although referrals for women are approaching double that for men, in terms of treatment, men outnumber women and the % profiles between GY&W and JPUH are more aligned.

Treatment by Ethnicity mirrors the referral percentages.

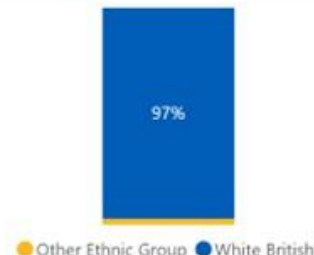
Av. Days Wait



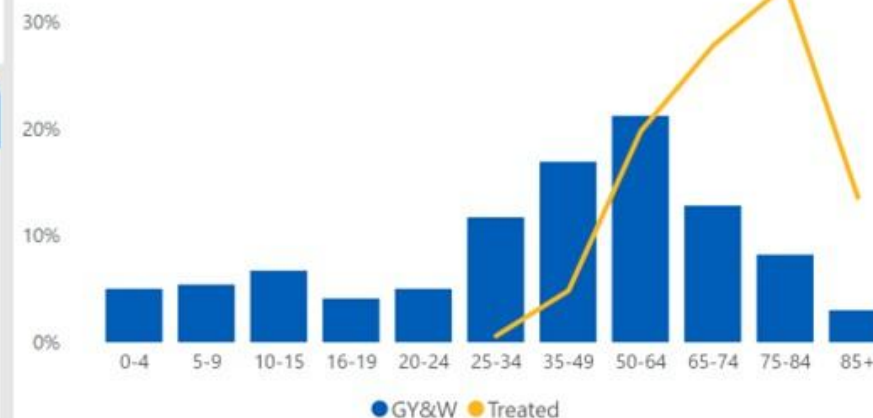
Treatment for Cancer Profile by Sex



Cancer Profile by Ethnicity



Treatment for Cancer Profile by Age Band



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 - are now part of the Norfolk Hospitals Group.

The Trust's Director of Strategy & Transformation chairs the Gt Yarmouth & Waveney Place Board which has representation from all key local stakeholders including local government, primary care, and community providers.

The Place Board is now developing clear plans to support the requirements to deliver Neighbourhood Health amongst other local priorities and to address the changes facing the wider system such as Local Government review and the formation of unitary councils. In addition, the commissioning landscape has changed with the formation of the Norfolk and Suffolk Integrated Care board.



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 annual reporting requirements for NHS bodies, stemming from HM Treasury's TCFD aligned disclosure guidance for public sector annual reports. TCFD recommended disclosures as interpreted and adapted for the public sector by the HM Treasury TCFD aligned disclosure application guidance, will be implemented in sustainability reporting requirements on a phased basis up to the 2025/26 financial year. Local NHS bodies are not required to disclose scope 1, 2 and 3 greenhouse gas emissions under TCFD requirements as these are computed nationally by NHS England.

Governance: Oversight, Assessment, and Management of Climate-related Issues

The Trust's commitment to addressing climate-related challenges is demonstrated through its continuous, proactive, and transparent approach, including:

- **Governance Structures:**
 - Annual sustainability report to the **Trust Board of Directors**
 - A nominated **Net Zero Executive Lead**.
 - Bi-Monthly **Sustainability Group** meeting to review and progress actions.
 - Sustainability Group update to the **Estates, Facilities and Health and Safety Group**, with escalation to the **Estates and Facilities Programme Delivery Group** and **Finance and Performance Group** as needed.

This robust governance framework ensures continuous, assessment, monitoring and accountability at all organisational levels.

Strategy

Climate related risks and responses are captured within an Adverse Weather Policy and are integrated into divisional and department business continuity plans.

A 2025 release of specific trust guidance linked to Climate Adaptation Plan's and Risk Assessment tools is being reviewed for implementation.

Sustainability Risk Management

The Board has overall responsibility for risk management, this is described in the previous sections on the Board and its committees.

Metrics and Targets

Significant steps have been taken to reduce carbon emissions across the estate of James Paget Hospital and this is monitored primarily through energy usage and reporting.

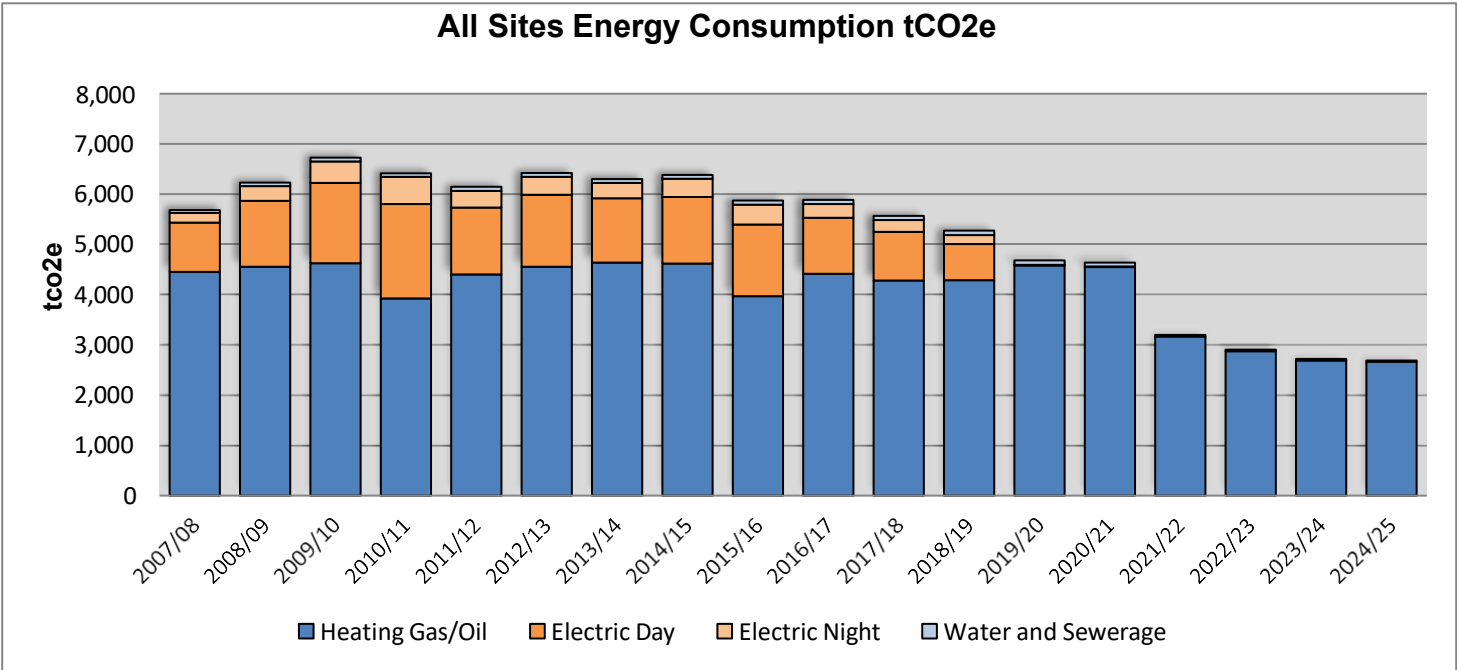
The Trust has continued to reduce tCO2e through energy consumption, with a 47.7% reduction since the Trust 2021 Green Plan, and a 1% reduction in 2024/25.

Since 2020 all the Trust’s electricity has been sourced from a renewable source. Total Grid Electric Day Rate kWh in 2024/25 is 65,384 lower than 2023/24.

These small improvements in 2024/25 have occurred during a phase where the footprint of hospital has expanded (Community Diagnostic Centre, Orthopaedic Theatres, Fracture Clinic).

The Trust has seen a reduction in gas consumption by 332,548 kWh in 2024/25 compared to the previous financial year.

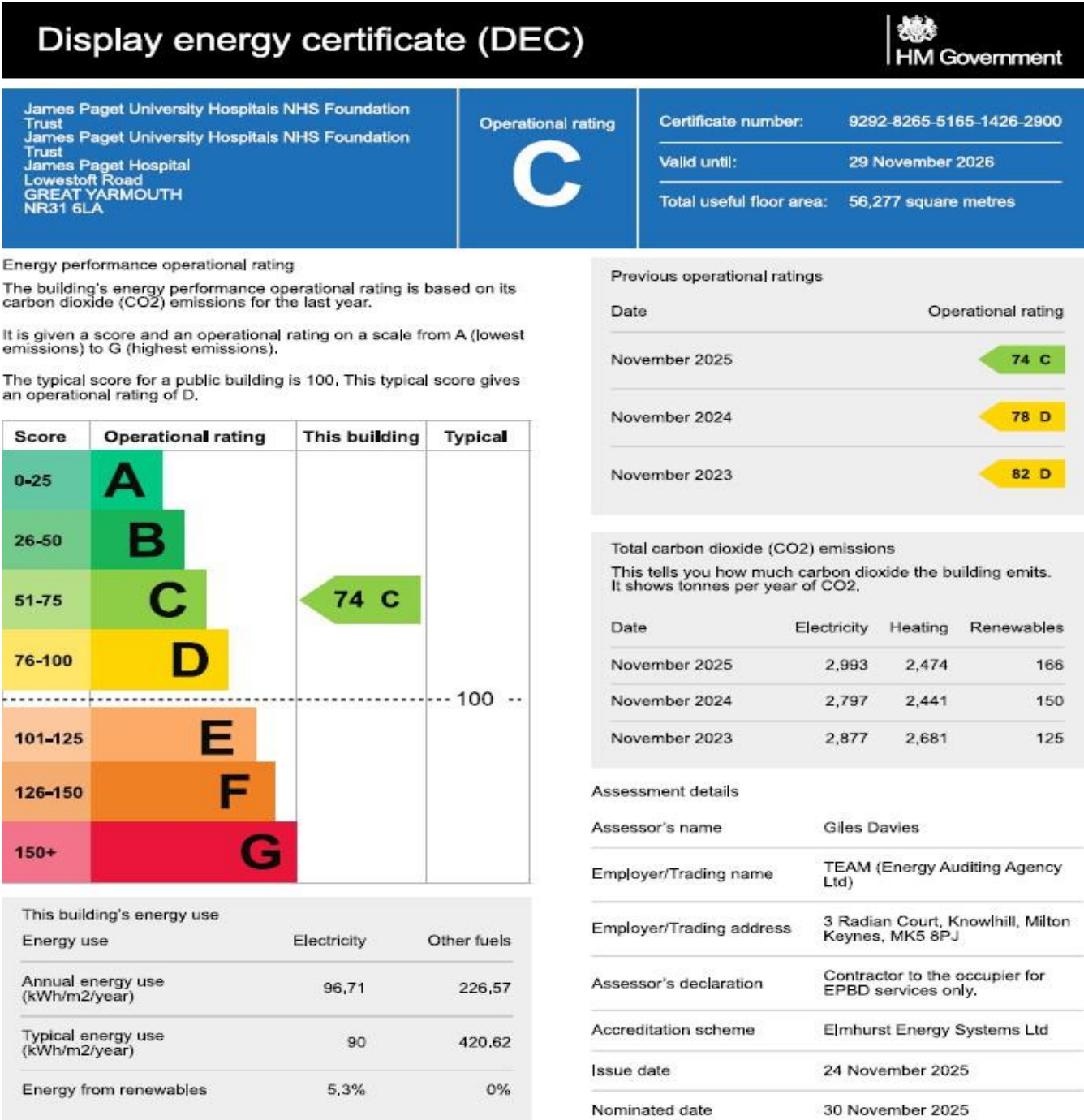
All Sites Energy Consumption tCO2e



Energy efficiencies have been positively reflected in our Energy Certificate operational rating which improved from D rating to C rating in 2025.

This is alongside the efficient rating of Louise Hamilton Centre (C rating) and GP Streaming Unit (B rating)

Key Performance Indicators



- Travel and Transport
- Estates and Facilities
- Food and Nutrition
- Supply Chain and Procurement
- Climate Adaptation

Our refreshed Green Plan aligns the Trust with national expectations for the next three-year cycle. It sets out **27 SMART targets** mapped to (but not limited to) the nine core focus areas, with progress monitored regularly through the **Sustainability Group**.

Key Components of the Green Plan

- **Energy and Carbon Emissions Update**
Tracking current performance and outlining steps to reduce emissions.
- **Summary of Key Achievements to Date**
Highlighting progress made since the previous plan.
- **Embedded Social Value and Collaborative Projects**
Showcasing partnerships and initiatives that strengthen social and environmental impact.
- **New Hospital Programme and Long-Term Proposals**
Integrating sustainability into future estate developments.
- **Short-Term Objectives and Opportunities for Acceleration**
Identifying areas where immediate action can deliver faster results.
- **Innovation from Staff and Partner Organisations**
Encouraging new ideas and pilot projects that support sustainable practice.
- **Green Spaces and Biodiversity Assessment**
Reviewing and enhancing natural assets across the estate.
- **Governance, Risks, and Communication**
Ensuring strong oversight, risk management, and clear communication pathways.

James Paget University Hospital (JPUH) New Hospital Update

The James Paget University Hospital is progressing with its plans for a new state-of-the-art hospital, part of the national New Hospital Programme.

The New Hospital Programme is the most significant planned capital infrastructure development in Norfolk and Waveney, developing new hospitals for both The Queen Elizabeth Hospital King's Lynn and James Paget Hospital, in Gorleston.

The two hospital schemes which were being managed separately, are being brought together into a single, unified programme that will deliver two state-of-the-art hospitals. This strategic integration strengthens oversight, ensures consistency in clinical strategy and service planning across the Norfolk and Waveney University Hospitals Group, and enables a more efficient use of shared expertise and resources.

Both QEH and JPUH remain part of Wave 1 of the Government's New Hospital Programme, and work continues at pace on both sites, including the development of Outline Business Cases and enabling works.

The Norfolk and Waveney University Hospitals Group's New Hospital Programme Board will oversee delivery of both hospitals, and will ensure alignment with Government requirements through the National New Hospital Programme, the priorities set out in the NHS 10-Year Plan, and the ongoing

clinical strategy work with system partners to define the future shape of acute healthcare based on population needs and evidence.

Key updates include:

- **Strategic Outline Case (SOC):** The SOC was conditionally approved in March 2026 by the Government.
- **Budget Allocation:** An indicative budget of **£1-1.5 billion** has been allocated for the project.
- **Future Paget Vision:** The new hospital will feature 100% single-patient rooms, and cutting-edge facilities to enhance patient care and public and staff experience.
- **Demand and Capacity Modelling:** Extensive modelling has been conducted to ensure the hospital meets the future healthcare needs of the local population.
- **Hospital Design Principles:** The design incorporates innovative principles from the **Hospital 2.0** standardised approach with which the hospital now has good alignment. The new hospital design also aims to achieve seamless integration with the landscape, maximising the opportunities of the new site, ensuring clinical services are near each other, full compliance with modern standards, and advanced digital infrastructure.
- **Net-Zero Feasibility Energy Study:** A comprehensive study is underway to evaluate energy solutions that align with the Trust's net-zero ambitions, including renewable energy sources and energy-efficient technologies.

Construction is expected to begin in **2027-28**, marking a significant milestone in delivering high-quality healthcare for the region.

Overseas operations

There were no overseas operations during 2025/26.

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 2026, 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 2025/26 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 2026/27 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 commissioners, 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.



Professor Lesley Dwyer

Chief Executive and Accounting Officer

25 June 2026

Director's Report

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

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

Board and Group Governance Framework

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

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

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

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

Chair, Vice Chair, and Senior Independent Director

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

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

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

Board Committees

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

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

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

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

Audit Committees in Common

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

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

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

External Audit Independence

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

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

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

of the Trust's position.

Nomination and Remuneration Committees in Common

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

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

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

Hospital Operating Model and Management Arrangements

The Hospital Operating Model forms part of the management arrangements supporting the Group governance model. It is designed to balance unified strategic oversight with responsive, safe, and effective operational control at each hospital site.

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

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

The specialist management groups include:

People and Culture Management Group, responsible for workforce planning, staff experience, cultural development, safe staffing controls, employment-related compliance, and implementation of risk management in relation to workforce, culture, and people-related controls.

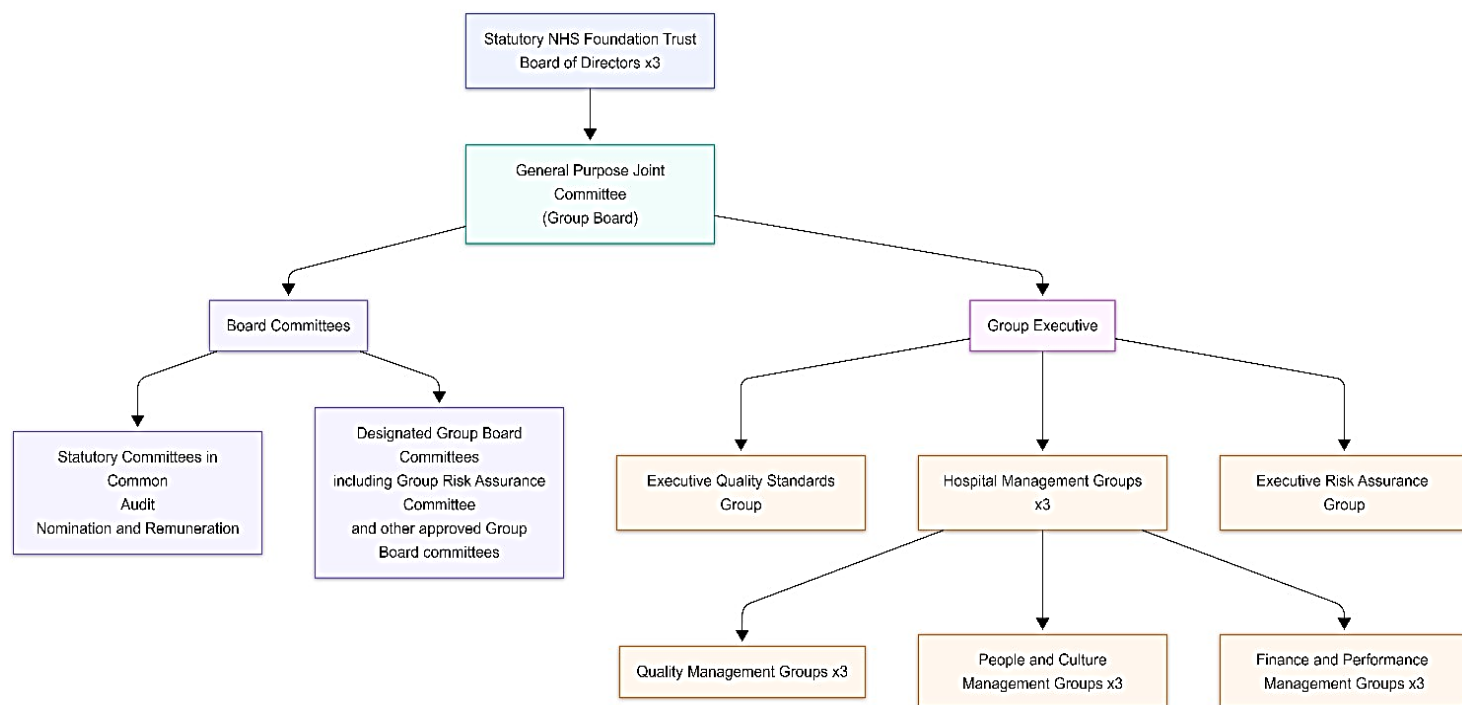
Finance and Performance Management Group, responsible for internal financial control, operational performance monitoring, efficiency, alignment with Group strategic priorities, and implementation of risk management in relation to finance, performance, productivity, and operational recovery.

Quality Management Group, responsible for clinical effectiveness, patient safety, care quality standards, patient outcomes, quality improvement oversight, and implementation of risk management in relation to quality, safety, clinical effectiveness, and patient experience.

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

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

Governance Architecture Schematic



Board Composition, Succession, Appointment, and Development

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

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

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

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

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

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

arrangements, risk and internal control, the Annual Governance Statement, and the role of the Council of Governors.

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

Board Effectiveness and Evaluation

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

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

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

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

Members of the Trust Board of Directors

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

The Board of Directors are as follows:

Interim Group Chair	David Roberts (Appointed October 2025)
Group Chief Executive	Professor Lesley Dwyer (Appointed May 2025)
Group Chief Delivery Officer	Jo Segasby (Appointed May 2025)
Group Chief Medical Officer	Rob Sherwin (Appointed December 2025)
Group Chief Nurse	Rachael Cocker (Appointed December 2025)

Chief Finance Officer	Marcus Thorman (Appointed May 2025)
Executive Managing Director of Norfolk and Norwich University Hospitals	Shane Gordon (Appointed December 2025)
Executive Managing Director for The Queen Elizabeth Hospital King's Lynn	Michelle Arrowsmith (Appointed January 2026)
Executive Managing Director for the James Paget University Hospital	Jonathan Gardner (Appointed January 2026)

Non-voting members of the Board

Interim Group Director of Governance	Ian Walker (Appointed November 2025)
Group Digital Director	Ed Prosser-Snelling (Appointed September 2025)

Non-executive Directors

William Van't Hoff	Appointed December 2025
Sally Collier (and Senior Independent Director)	Appointed December 2025
Phillip Baker	Appointed December 2025
Jack Bowman	Appointed December 2025
Jo Churchill	Appointed December 2025
Nikki Gray	Appointed December 2025
Stephen Javes	Appointed December 2025

James Paget Site Leadership Team changes during the year

Through the above transition to the formal collaborative Group model across 2025-26, James Paget University Hospitals is led at Trust level by its Site Leadership Team. The current Site Leadership Team is as follows:

Executive Managing Director	Jonathan Gardner (Appointed January 2026)
Chief Finance Officer	James Taylor (Appointed March 2026)
Chief Operating Officer	Charlotte Dillaway (Appointed May 2024)
Chief Medical Officer	Dr Robert Major (Appointed January 2026)

Chief Nurse	Jacky Copping (Appointed April 2025)
Chief Finance Officer	James Taylor (Appointed March 2026)
Director of People and Culture	Deborah O'Hara (Appointed March 2026)
Director of Strategy and Transformation	Jonathan Barber (Appointed February 2018)

Changes to James Paget Hospital Board of Directors during the year

Mark Friend was Chair of the James Paget Hospital Board of Directors until April 2025, before taking up the role as Interim Chair of the Norfolk and Waveney University Hospitals Group.

Stephen Javes, Dr Sarah Whiteman, Caitlin Notley, Sally Collier, John Hennessey, and Susanne Lindqvist ended their roles as Non-Executive Directors through the formation of the Norfolk and Waveney University Hospitals Group in October 2025.

Site Leadership changes during the year

Dr Shane Gordon joined James Paget Hospital as Executive Managing Director in May 2025, and left this role in December 2025.

Jonathan Barber acted as Interim Executive Managing Director between December 2025 and January 2026.

Jonathan Gardner joined James Paget Hospital as Executive Managing Director in January 2026.

Alison Stace joined James Paget Hospital as Chief Delivery Officer in October 2025.

Vivek Chitre left the role of Chief Medical Officer in December 2025.

Paul Morris left the role of Chief Nurse in April 2025.

Ed Taylor left the role of Chief Finance Officer in January 2026.

Mark Flynn left the role of Director of Strategic Projects in December 2025.

Sarah Goldie left the role of Director of People and Culture in February 2026.

Director's Interests and Independence

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

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

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

Trust-specific disclosures on Non-Executive Director independence, including names, appointment dates, tenure, and any relevant declarations, are set out below.

Director's Interests

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

Non-Executive Director Independence

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

Board and Committee Attendance

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

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

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

JPUH Board of Directors attendance (May – September 2025)

Member Name	Title	30 May 2025	25 July 2025	26 September 2025
Mark Friend	Chair	Y	Y	Y
Sally Collier	Non-Executive Director and Senior Independent Director	N	Y	Y
Andrea Finegan	Non-Executive Director	Y	N	Y
John Hennessey	Non-Executive Director	N	Y	Y
Stephen Javes	Non-Executive Director and Senior Independent Director	Y	Y	Y
Susanne Lindqvist	Non-Executive Director	Y	Y	Y
Caitlin Notley	Non- Executive Director	Y	N	N

Jason Selvarajah	Non-Executive Director	N	Y	N
Sarah Whiteman	Non-Executive Director	Y	Y	N
Jonathan Barber	Director of Strategy & Transformation	Y	Y	Y
Vivek Chitre	Chief Medical Officer	Y	Y	Y
Jacqueline Copping	Chief Nurse	Y	Y	Y
Charlotte Dillaway	Chief Operating Officer	Y	Y	Y
Lesley Dwyer	Group Chief Executive	Y	Y	Y
Mark Flynn	Director of Strategic Projects	N	Y	Y
Sarah Goldie	Director of People & Culture	Y	N	Y
Shane Gordon	Executive Managing Director	Y	Y	Y
Edmund Taylor	Chief Finance Officer	Y	Y	Y
Isobel Le Grice	Deputy Director of People & Culture	N	Y	N

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

Name	Group Board Role	17 Dec 2025 (Public)	17 Dec 2025 (Private)
David Roberts	Interim Group Chair	Present	Present
Sally Collier	Group Non-Executive Director	Present	Present
Stephen Javes	Group Non-Executive Director	Present	Present
Professor Philip Baker	Group Non-Executive Director	Present	Present
Jack Bowman	Group Non-Executive Director	Present	Present
Johanna (Jo) Churchill	Group Non-Executive Director	Present	Present

William Va't Hoff	Group Non-Executive Director	Present	Present
Nikki Gray	Group Non-Executive Director	Absent	Absent
Professor Lesley Dwyer	Group Chief Executive Officer	Present	Present
Jo Segasby	Group Chief Delivery Officer	Present	Present
Marcus Thorman	Group Chief Finance Officer	Present	Present
Dr Rob Sherwin	Group Chief Medical Officer	Present	Present
Rachael Cocker	Interim Group Chief Nurse	Present	Present
Dr Shane Gordon	Executive Managing Director, NNUH	Present	Present
Chris Bown	Interim Executive Managing Director, QEHL	Present	Present
Jonathan Barber	Interim Executive Managing Director, JPUH	Present	Present
Dr Ed Prosser-Snelling	Group Director of Digital (Non-voting)	In Attendance	In Attendance
Ian Walker	Interim Group Director of Governance (Non-voting)	In Attendance	In Attendance
Jo Hannam	Group Communications Lead (Non-voting)	In Attendance	In Attendance
Charlie Helps	Group Secretary (Non-voting)	In Attendance	In Attendance

Committee Activity During the Year

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

The statutory Committees in Common remained accountable to their respective statutory Trust Boards while considering common business together where appropriate. Designated Group Board committees

supported the Group Board in relation to delegated Joint Functions within their approved terms of reference.

Audit Committees in Common

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

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

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

Nomination and Remuneration Committees in Common

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

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

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

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

Group Risk Assurance Committee

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

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

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

The Committee sought and scrutinised assurance on the effectiveness of controls, the adequacy of

mitigations, the consistency of escalation, the quality of evidence supporting reported risk positions, and the actions required where assurance gaps, control weaknesses, or matters outside risk appetite were identified. Its scrutiny supported the Group Board's oversight of the Board Assurance Report or Board Assurance Framework reporting in use during the year, significant control issues, and the further embedding of risk-based assurance across the Group.

Board Effectiveness, Induction, Appraisal, and Development

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

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

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

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

Council of Governors

The Council of Governors continued to discharge its statutory role during 2025/26. The Council of Governors is responsible for holding the Non-Executive Directors, individually and collectively, to account for the performance of the Board of Directors. It also has statutory responsibilities in relation to the appointment and removal of the Chair and Non-Executive Directors, approval of the appointment of the Chief Executive, appointment or removal of the external auditor, and other matters set out in the NHS Act 2006 and the Trust Constitution.

During the transition to the Group model, the Council of Governors retained its statutory role for the Trust. The establishment of the Norfolk and Waveney University Hospitals Group did not remove or transfer the statutory responsibilities of the Council of Governors.

The Trust continued to support communication between the Board of Directors and the Council of Governors, including through the Chair, Lead Governor arrangements, Governor meetings, reporting, and engagement on relevant statutory matters. Trust-specific information on the Council of Governors, membership, meetings, attendance, and activity during the year is set out below.

Relationship Between the Board of Directors and the Council of Governors

The Board of Directors and Council of Governors have distinct statutory roles. The Board of Directors

is responsible for governing the Trust and for the Trust's strategy, performance, risk, internal control, and statutory compliance. The Council of Governors holds the Non-Executive Directors to account for the performance of the Board of Directors and represents the interests of members and the public.

The Chair has a key role in supporting effective communication between the Board of Directors and the Council of Governors, while preserving the distinct responsibilities of each body. The Senior Independent Director and Lead Governor arrangements provide additional routes for dialogue where required.

During 2025/26, the relationship between the Board of Directors and Council of Governors was particularly important because of the transition to the Group model. Governors were engaged in the statutory elements of the transition, including matters relating to Chair and Non-Executive Director appointments and the approval of the Group Chief Executive appointment where required.

Trust-specific details of Governor engagement, meetings, and statutory decisions are set out below.

Foundation Trust Membership

The Trust remains accountable to its members and the wider public through its Foundation Trust membership and Council of Governors. Members are drawn from public and staff constituencies in accordance with the Trust Constitution.

During 2025/26, the Trust continued to maintain arrangements for membership engagement, communication, and Governor representation. Trust-specific membership numbers, constituencies, recruitment activity, engagement activity, and any material changes during the year are set out below.

Code of Governance for NHS Provider Trusts Disclosures

The Trust has applied the Code of Governance for NHS Provider Trusts during 2025/26. The Code supports effective Board leadership, accountability, composition, succession, evaluation, audit, risk, internal control, and stakeholder engagement.

The Trust's application of the Code should be read in the context of the transition to the Norfolk and Waveney University Hospitals Group. During the year, the Trusts redesigned Board composition and governance arrangements to support the GPJC model, while preserving the statutory role of each Trust Board and Council of Governors.

Where the Trust has applied the Code, this is reflected in the relevant sections of this Directors' Report, the Annual Governance Statement, the Remuneration Report, the Staff Report, and the Code disclosure schedule. Any Trust-specific explanation, exception, or transitional disclosure is set out below.

Directors' Responsibility for the Annual Report and Accounts

The Directors are responsible for preparing the Annual Report and Accounts. The Board has reviewed the Annual Report and Accounts and considers that, taken as a whole, they are fair, balanced, and understandable, and provide the information necessary for patients, staff, Governors, members, regulators, and other stakeholders to assess the Trust's performance, business model, governance, and strategy.

In reaching this conclusion, the Board considered the content of the Performance Report, Accountability Report, Remuneration Report, Staff Report, Annual Governance Statement, financial statements, audit findings, regulatory context, significant internal control issues, and the Trust's position within the Norfolk and Waveney University Hospitals Group.

The Board also considered the need to distinguish between the shared Group governance model and the continuing statutory accountability of each Trust. The Annual Report and Accounts therefore describe the Group model, the role of the General Purpose Joint Committee, and the Trust's retained statutory responsibilities.

Statutory Statements and Other Directors' Report Disclosures

The following sections include the Trust-specific statutory statements and other disclosures required for the Directors' Report, including matters relating to the Trust's provider licence, cost allocation and charging, political and charitable donations, better payment practice, income disclosures, overseas operations where relevant, modern slavery, anti-bribery arrangements, and any other Trust-specific disclosures required by the Annual Reporting Manual or applicable guidance.

The Council of Governors

The Council of Governors is chaired by the Chair of the Trust, who also serves as Chair of the Board of Directors, thereby ensuring alignment and continuity between the Trust's unitary Board and its wider accountability structures.



The role of the Council is defined in the Trust Constitution, which sets out the statutory duties of Governors and the mechanisms through which they are consulted, supported, and kept informed. Processes are in place to ensure Governors receive timely information and are actively engaged in strategic matters.

The Council of Governors represents the interests of the Trust's members, staff, patients, and the wider community. It provides a vital channel of communication between the public—through elected and appointed Governors—and the Board of Directors, both formally and informally. The Council does not manage the Trust but plays a key role in its governance and accountability.

Governors receive a formal induction at the beginning of their term of office, designed to familiarise them with the role, statutory duties, and governance framework of the Trust. Further training is provided periodically to support continued development and enable Governors to engage effectively with strategic and operational matters.

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.

A Council of Governors' Code of Conduct is in place, which outlines the expectations of behaviour and responsibilities of the role, including adherence to the Seven Principles of Public Life (the Nolan Principles). All Governors are required to sign and abide by the Code either on election or upon appointment. The Code also includes provisions for declaring gifts, hospitality, and conflicts of interest, and supports the ethical and transparent conduct of Council business.

Statutory Duties of the Council of Governors

In accordance with the NHS Act 2006 and the Trust Constitution, the Council of Governors is responsible for:

- **Appointment and Removal of Non-executive Directors:** Including the Chair of the Board, and determining their terms and conditions, including remuneration.
- **Holding the Non-executive Directors to Account:** Governors hold the Non-executive Directors individually and collectively to account for the performance of the Board of Directors.
- **Approval of Significant Transactions:** The Council must approve certain specified transactions, such as mergers, acquisitions, and other material changes, and any proposed amendments to the Constitution.
- **Strategic Planning:** While the Board sets the strategy, the Council is consulted on strategic plans and forward-looking priorities. The Board takes into account the views of the Council when finalising the Trust's strategy.
- **Appointment and Oversight of the External Auditor:** Including the appointment, removal, and terms of engagement.

- **Receipt of the Annual Report and Accounts:** Governors formally receive the Trust's audited Annual Report and Accounts, and the auditor's report, at a public meeting.

Through these duties, the Council helps ensure transparency, accountability, and public involvement in the Trust's governance.

Engagement and Operation

Members of the Site Leadership Team attend meetings of the Council of Governors throughout the year. The Director of Strategy and Transformation regularly attends to support strategic engagement with Governors, including discussion on service development, Trust priorities, and the wider work of the Norfolk and Waveney Health and Care Partnership.

Non-executive Directors present reports at each Council meeting, providing updates on the work of the Committees they chair. These reports are valued by Governors and provide opportunities for constructive dialogue, clarification, and scrutiny of Board-level decisions.

The Chair and Trust Secretary meet monthly with the Lead Governor to plan governor development, engagement activities, and governance matters.

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 2026, the staff membership is 4,372, with the public membership at 5,764, giving a total of 10,152. This is a reduction from last year's figure of 10,927.

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. Over 2024-25, the Trust's Council of Governors have led engagement with the Membership and wider community on helping to co-design the hospital's Engagement Principles, outlining how and when the Trust conducts engagement and consultation with patients and communities on service changes or hospital development, underpinning delivery of the Patient Experience and Engagement Plan.

The Council of Governors have also supported the development of engagement materials about the James Paget's vision for its new hospital, and helped design the process of engagement with membership and communities aligned to the new Engagement Principles. The outcomes of this engagement have been reported to and discussed by the Board of Directors.

Membership of the Council of Governors

The Council consists of 15 Governors, four appointed, eight elected by the public membership, and three 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.

Changes in year

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

- Samantha Chenery-Morris – July 2025

New elected and Appointed Governors

- None

Council of Governors meetings

Name	Title	16/5/2025	10/07/2025
Mark Friend	Trust Chair	Y	Y
Stephen Javes	Senior Independent Director	Y	Y
Ian Clayton	Lead Governor	Y	Y
Tony Goldson	Public Governor	Y	Y
Luis Tavares	Public Governor	Y	N
Stuart Everett	Public Governor	Y	N
Jose Bamonde	Public Governor	Y	N
Peter Hargrave	Public Governor	N	Y
Maria Grimmer	Public Governor	Y	Y
Kevin Jordan	Public Governor	Y	Y
Harry Hicks	Staff Governor	Y	N
Gary Walker	Staff Governor	N	Y
Robert Watson	Staff Governor	Y	Y
Emma Flaxman- Taylor	Appointed Governor	Y	N
James Reeder	Appointed Governor	Y	N
David Beaven	Appointed Governor	Y	N
Samantha Chenery-Morris	Appointed Governor	Y	N

Governor's Nomination and Remuneration Committee meetings

Member Name	Title	08/05/2025	02/07/2025
Mark Friend	Trust Chair	Y	N
John Hennessey	Non Executive Director	N	Y
Ian Clayton	Lead Governor	Y	Y
James Reeder	Appointed Governor	Y	Y
Emma Flaxman-Taylor	Appointed Governor	Y	N
Kevin Jordan	Public Governor	Y	N
Luis Tavares	Public Governor	Y	Y
Tony Goldson	Public Governor	Y	Y
Peter Hargrave	Public Governor	Y	N
Harry Hicks	Staff Governor	Y	Y
Gary Walker	Staff Governor	N	Y

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

The Board of Directors of James Paget University Hospitals NHS Foundation Trust has applied the principles of the NHS England Code of Governance for NHS Provider Trusts on a 'comply or explain' basis.

For the financial year 1 April 2025 to 31 March 2026, the Board of Directors considers that it was fully compliant with the main principles, supporting principles, and detailed provisions of the Code of Governance. There are no departures or non-compliant exceptions to declare for this reporting period.

During 2025/26, the Trust transitioned to a formal group operating model alongside Norfolk and Norwich University Hospitals NHS Foundation Trust and The Queen Elizabeth Hospital King's Lynn, forming the Norfolk and Waveney University Hospitals Group (NWUHG). The principles of the Code of Governance have been explicitly embedded within the new Group Governance Framework, the Provider Collaboration Agreement, and the Terms of Reference for the General Purpose Joint Committee (the Group Board). The Board is satisfied that these collaborative arrangements preserve the statutory independence of the Trust while upholding the highest standards of corporate governance, accountability, and board effectiveness expected of an NHS Foundation Trust.

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

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

The Care Quality Commission Well-Led Framework

The most recent Well-led inspection by the Care Quality Commission (CQC) took place in September 2025. Further information on the Trust's CQC ratings and regulatory status can be found on page 49 of this report.

As part of the Trust's commitment to continuous improvement and high standards of governance, an independent review of corporate governance was commissioned in 2023/24. The review, conducted by the Good Governance Institute, confirmed that the Trust had in place a robust system of risk management and internal control, with several areas of exemplary practice highlighted. The findings were closely aligned with the eight domains of the CQC's Well-Led Framework, which continues to inform and shape the Trust's governance and leadership agenda.

The Trust's performance against each domain of the Well-Led Framework is summarised below:

Leadership Capacity and Capability

Leadership development remains a strategic priority. Structured programmes have been introduced to support leaders at all levels, supported by a strengthened recruitment process to ensure the appointment of individuals with the skills, values, and integrity required. Strategic succession planning for Board and senior roles is in place.

Vision and Strategy

The Trust's strategic ambitions were reviewed and updated during 2023/24 to reflect the evolving

needs of our population and healthcare system. These priorities have been clearly communicated to staff and stakeholders and are reviewed regularly to ensure continued relevance and impact.

Culture

The Trust continues to promote an inclusive, respectful, and open culture. Targeted initiatives have supported staff wellbeing and reinforced professional behaviours. Policies to address bullying, harassment, and discrimination are in place and actively upheld, with a strong emphasis on dignity and compassion in all aspects of care and working life.

Governance and Management

Governance structures have been reviewed and enhanced to support clear decision-making and accountability. The Board and its Committees operate under defined terms of reference, with systematic reporting, regular evaluation, and clear escalation pathways. An integrated assurance framework is in place to monitor performance and risk across all domains of the Trust's work.

Managing Risks, Issues, and Performance

The Trust has established clear and proactive processes for identifying, escalating, and managing risks. Performance is monitored through the Board Assurance Framework, Integrated Performance Report, and audit mechanisms. Findings from audits and reviews are acted upon promptly, with appropriate follow-up and assurance testing.

Engaging with People Who Use Services

Patient experience remains central to quality improvement. Mechanisms for capturing feedback from patients, families, and carers have been enhanced, and their insights inform both individual care and service planning. Engagement includes formal forums and direct conversations through 'ward-to-board' initiatives.

Staff Engagement

The Trust has strengthened its engagement with staff through structured feedback loops, staff surveys, listening events, and ongoing involvement in decision-making. Staff engagement is monitored through the People and Culture Committee, and outcomes inform both operational improvements and organisational development priorities.

Continuous Improvement and Innovation

A culture of continuous improvement is embedded throughout the organisation. Learning from incidents, near misses, and best practice is actively shared. Innovation is supported at both clinical and organisational levels, including through quality improvement methodologies, research activity, and staff-led service redesign.

The Trust remains committed to maintaining and improving standards in line with the CQC's Well-Led Framework and is actively applying the findings of both internal self-assessments and external assurance to shape its ongoing development as a safe, effective, and well-led organisation.

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



OUR
PATIENTS

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

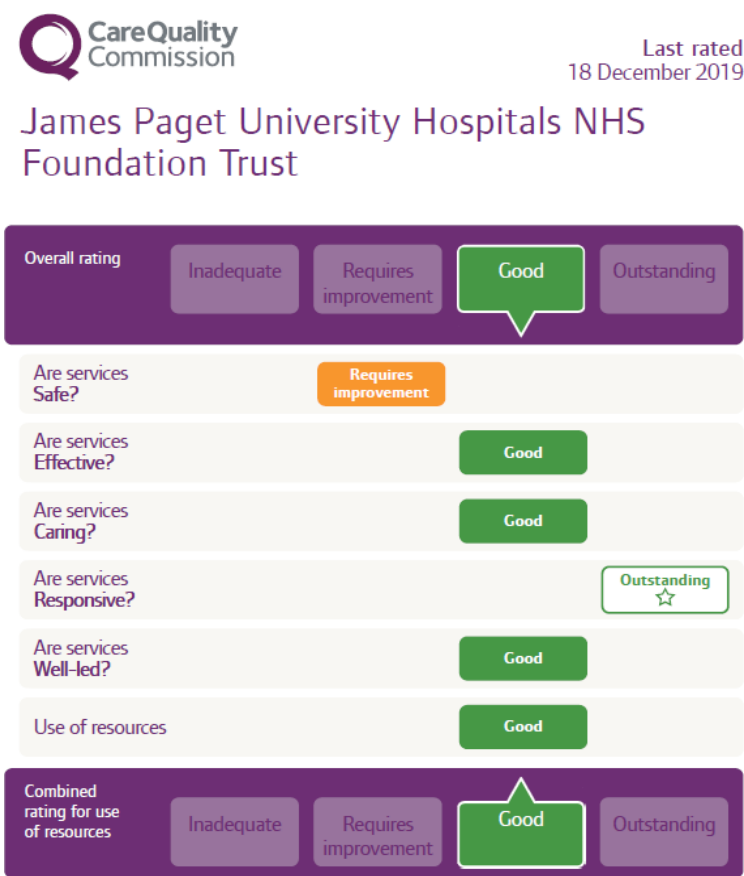
The Trust's most recent inspection from the Care Quality Commission (CQC) was of the hospital's maternity services, which took place on 16 September 2025. The outcome of this inspection was published on the 1st April 2026 with an improved rating of maternity services at our hospital from 'inadequate' to 'requires improvement'. Because of this outcome, the rating of the hospital overall has also been upgraded from 'requires improvement' to 'good'.

This inspection of maternity services came following an inspection in January 2023 where we were rated as inadequate and issued a warning notice, with the requirement of taking immediate actions to improve maternity services and reduce the risk of harm to mothers and babies. Since the outcome of the CQC's inspection, our hospital has worked hard to implement the immediate requirements following the warning notice, as well as the actions and recommendations from the full CQC report.

To achieve changes and rapid improvement to services, we implemented a comprehensive programme of improvement actions and its implementation has continued since the inspection. The monitoring and oversight of the progress and effectiveness of the improvement programme continues being undertaken by an Executive Maternity Improvement Group led by the Executive Managing Director.

The outcomes from this inspection demonstrate the commitment our staff have towards the needs of people giving birth and their babies at our hospital.

Trust Level Ratings



Core Service Level Ratings



Last rated
1 April 2026

James Paget University Hospitals NHS Foundation Trust

James Paget Hospital



Are services

Safe?	Requires improvement
Effective?	Good
Caring?	Good
Responsive?	Outstanding ☆
Well-led?	Good

	Safe	Effective	Caring	Responsive	Well-led	Overall
Medical care (including older people's care)	Requires improvement	Good	Good	Good	Good	Good
Services for children & young people	Good	Good	Good	Outstanding ☆	Good	Good
Critical care	Good	Good	Good	Good	Good	Good
End of life care	Good	Good	Outstanding ☆	Good	Good	Good
Maternity	Requires improvement	Good	Good	Outstanding ☆	Requires improvement	Requires improvement
Outpatients	Good	Not rated	Good	Outstanding ☆	Good	Good
Surgery	Good	Good	Good	Good	Good	Good
Urgent and emergency services	Good	Good	Good	Good	Good	Good

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:

James Paget celebrates fundraising and first operations through new surgical system – The hospital celebrated the arrival of a new robotic-assisted surgical system, following a successful fundraising campaign to raise £1.2m to purchase the robot led by the James Paget Hospital Charity. Funds were raised for a da Vinci X surgical system provided by Intuitive, which uses robotic-assisted technology to help surgeons perform a range of procedures, alongside a low temperature sterilizing unit and training to help the James Paget's surgical theatre team use the robot.



Same Day Emergency Care Unit opens - The Trust opened its new Same Day Emergency Care unit in October 2025, which saw over 450 patients in its first week of operation. SDEC is a service that provides emergency medical care and treatment to patients without the need for hospital admission, allowing them to be assessed, diagnosed, and treated on the same day they arrive. The SDEC unit was opened by Lady Dannatt, Lord Lieutenant of Norfolk, with colleagues from the Trust's Executive and Divisional leadership and operational staff in attendance, as well as representatives from partner organisations in Norfolk and Waveney's Integrated Care System

Northgate CDC opens and is praised for impressive delivery of services - A Community Diagnostic Centre (CDC) opened by the James Paget in 2025 has been praised by NHS England for its 'impressive' service – and highlighted as a model for other CDCs to follow. Leaders from the NHS' Community Diagnostic Centres programme team visited our Northgate CDC in Great Yarmouth last month as part of a national programme to identify best practice. Northgate welcomed its first patients in April 2025, operating in a renovated NHS hospital building based in the heart of a local community.





James Paget Nurse receives special recognition from national charity - Mickey Cox, Heart Failure Specialist Nurse at James Paget Hospital, has been awarded a 'Special Recognition' Award by Pumping Marvellous, the UK's heart failure charity. The award celebrates Mickey's hard work in working with Pumping Marvellous to coordinate a series of outreach events in Great Yarmouth and Lowestoft, aimed at identifying cases of heart failure, high blood pressure and atrial fibrillation.

A Roof over your Health event - James Paget Hospital was part of a community event for the local homeless community that was held at The Hive in Great Yarmouth Library. 'A Roof Over Your Health' was coordinated by James Paget University Hospitals Research and Evaluation Associate Emma Stimpson and Mandalay CIC, with the aim of connecting individuals experiencing homelessness to essential health and wellbeing services and information in a supportive, welcoming setting. The event brought together diverse organisations and specialists to provide accessible health advice and practical support for those in need.



Research

- **Team praised for contribution to research study**



A team from the James Paget have been recognised for their 'outstanding contribution' to a research project exploring the use of Artificial Intelligence (AI) to help detect pre-cancerous growths in the bowel.

Four senior clinicians from the hospital's Endoscopy Department were involved in a national study looking to see whether AI can help improve the detection rate for adenoma during a colonoscopy, a diagnostic procedure to examine the inside of the bowel using a thin, flexible tube with a camera.

Our hospital was one of 25 sites across the country to complete the study, with organisers highlighting the Paget's 'outstanding contribution', with recognition for the team's recruitment of patients to time and target, responsiveness and quality of data.

- **Paget reaches 1000 participants in national diabetes study**

The James Paget is one of 17 hospitals across the country taking part INGRID2, a maternity study which screens newborn babies with the aim of identifying those that are genetically 'high

risk' of developing type 1 diabetes, which affects 1 in every 250 children born in the UK every year.

Our research team celebrated reaching their recruitment target of 1000 participants to the study, and also offers parents the chance to get involved in further research aimed at reducing the chance of their baby developing Type 1 diabetes or delaying its onset.



Patient and 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 23k people
- The Trust **X (formerly Twitter)** account (@JamesPagetNHS) has 5.8k Followers
- James Paget's **LinkedIn** page (<https://www.linkedin.com/company/james-paget-hospital/>) has 8.4k Followers
- The Trust's **Instagram** account (<https://www.instagram.com/jamespagethospital/>) has 2k Followers.

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

Complaints handling

Complaints received by the Trust continue to be managed in accordance with the NHS Complaints Procedure. All complaints are acknowledged within three working days, followed by early contact with the complainant to clarify the concerns raised and agree an appropriate response timescale: 45 working days for non complex cases and 60 working days for complex cases.

Meeting these agreed timeframes has remained a significant challenge during the year, resulting in complaints performance being recorded as an extreme organisational risk. Oversight meetings chaired by the Chief Nurse, alongside a detailed recovery plan, are in place and are beginning to demonstrate gradual improvement in performance.

The Trust monitors five complaint related Key Performance Indicators, which are reported monthly to the Quality, Safety and Effectiveness Management Group.

During 2025/26, the Trust received 209 formal complaints, an increase from 161 in the previous year.

PALS - Patient Advice and Liaison Service

This service provides support to patients, relatives, carers, members of the public and staff who require information or guidance about the healthcare system. PALS is available to assist with a wide range of enquiries, including:

- Identifying and providing the information needed to answer questions
- Offering details about the services available within the hospital
- Helping to resolve concerns by directing individuals to the appropriate teams or staff

members

- Explaining the steps to take if a concern cannot be resolved
- Supporting staff in achieving timely and effective resolution of enquiries
- Recording and sharing compliments received

The number of PALS enquiries received during 2025/26 increased to 2,911, representing a 23.56% rise compared with the previous year (n=2,356). It is encouraging to note that compliments continue to represent the largest proportion of enquiries, accounting for 25.86% of all contacts.

The PALS service has recently been relocated to a patient facing accessible service in the main foyer of the hospital.

Stakeholder relations

Over the last year, we have taken an active role in supporting discussions around the development of the Integrated Care System 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 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 meets bi monthly to provide service users with a structured forum to review feedback and contribute to patient centred quality improvement initiatives.

Members have engaged and provided feedback specifically related to the Community Diagnostic Centres and the Same Day Emergency Care Unit.

The Together Against Cancer Group offers valuable insight into cancer related services, enabling

members to share feedback and help drive improvements that enhance the experiences of patients and their families.

We continue to work collaboratively with the Health Overview and Scrutiny Committees in Norfolk and Suffolk, seeking their guidance on future areas of focus and providing information and support to inform their discussions.

Monthly Maternity Voices Partnership listening events are held online to support continued improvements in care for local people.

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 2025/26 or 2024/25.

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 %
2025/26	24,587	13,713	56%	195,931	160,928	82%	220,518	174,641	79%
2024/25	16,658	12,900	77%	223,056	191,096	86%	239,713	203,996	85%

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 %
2025/26	1,155	716	62%	56,443	49,970	89%	57,598	50,686	88%
2024/25	1,056	803	76%	56,756	49,557	87%	57,812	50,360	87%

Liability to pay interest

There was no liability to pay interest, by virtue of failing to pay invoices within the 30-day period where obligated to do so (2024/25 £nil).

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 £7.3m for 2025/26 (2024/25 deficit: £16.3m). This position includes within operating expenses an impairment charge of £10.1m (2024/25 charge: £16.0m) which, when excluded, leaves a surplus excluding impairments of £2.8m (2023/24 deficit: £0.3m). On a control total basis for 2025/26 the Trust reported a surplus of £1.6m (2023/24 breakeven).

Capital investments

Capital investments of **£47.7m** were made during 2025/26 as shown in the table below.

Capital Investments 2025/26	£'000	PDC funded £'000
NHP	11,351	11,351
RAAC	12,244	11,792
EPR	5,140	5,140
Digital Health Investments	3,563	149
CDC	3,052	1,800
Equipment replacement	2,831	1,364
SDEC	2,616	2,252
Estates Work	1,961	332
Critical Infrastructure Risk	1,412	1,410
Theatres Robot	1,360	0
Leases	1,238	0
Urgent Treatment Centre	896	880
Total	47,664	36,470

Cash and financing

The Trust's non-consolidated cash position increased by £4.9m during 2025/26, with cash and cash equivalents of £44.3m held at 31 March 2026. Of the £47.7m of capital expenditure, £36.5m 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 New Hospital Programme (NHP), RAAC, Community Diagnostics Centre (CDC) and the Same Day Emergency Care facility (SDEC). The SDEC and CDC are multi-year schemes which were completed during 2025/26. The EPR scheme is a multi-year scheme which commenced in 2020/21 with total PDC funded spend to 31 March 2026 of £15.0m. The RAAC scheme is a multi-year scheme which commenced in 2020/21 with total PDC funded spend to 31 March 2026 of £49.6m. The NHP is a multi-year scheme which commenced during 2020/21 with spend to 31 March 2026 of £32.4m of which £31.1m has been funded through PDC.

The Trust has £1.8m of finance lease liabilities. The largest contracts include the lease of the fracture clinic building recorded in the accounts as a right of use asset with a net liability of £1.0m as at 31 March 2026. The Trust also has finance lease contracts in place for Fluoroscopy equipment of £0.1m in total. There were new right of use asset entered into during 2025/26 of £1.6m, the largest of which was for the fracture clinic building £1.2m.

Efficiencies and transformation

In 2025/26 the Trust's financial plan included an efficiency savings target of £25.9m. The Trust achieved savings during 2025/26 of £28.9m, of which £7.8m was non-recurrent and £21.1m was recurrent. The total of £28.9m represents 7.2% of the Trust's expenditure before efficiencies.

NHS Oversight Framework

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

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

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

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

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

Segmentation

During the entire year 2025/26 the Trust has been classified as in segment 4 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 4 in the most recently published information as at 18 March 2026.

This segmentation information is the trust's position as at 17 February 2025. Current segmentation information for NHS trusts and foundation trusts is published on the NHS England website:

<https://www.england.nhs.uk/nhs-oversight-framework/segmentation-and-league-tables/>

Finance and use of resources (UoR)

The Trust was not subject to a CQC UoR assessment during 2025/26. 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.

A handwritten signature in black ink, appearing to be 'LD' with a long, sweeping horizontal stroke extending to the right.

Professor Lesley Dwyer
Chief Executive and Accounting Officer
25 June 2026

Remuneration Report

Annual Statement on Remuneration

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

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

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

Major decisions on senior managers' remuneration

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

The Nominations and Remuneration Committee determined that Trust staff on the VSM pay scale should receive a consolidated pay award of 3.25%.

The Medical Director in addition to their managerial duties also maintains a clinical practice and solely received the Medical and Dental pay award of 4% from 1st April 2025. The Medical Director is also entitled under the consultant contract for Clinical Impact Awards (CIA), formerly Clinical Excellence Awards (CEA), in 2025/26.

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

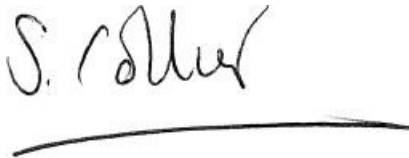
The Trust's strategy and business planning process sets key business objectives which in turn inform individual objectives for senior managers. Performance is closely monitored and discussed through both an annual and ongoing appraisal process.

Senior managers are employed on contracts of service and are substantive employees of the Trust. Their contracts are open-ended employment contracts which can be terminated by either party with six months' notice. All executive directors are subject to periodic appraisal and are accountable to the Board of Directors for performance in those areas to which they provide executive leadership. The Trust's normal disciplinary policies apply to senior managers, including the sanction of summary dismissal without notice for gross misconduct. The Trust's redundancy

policy is consistent with NHS redundancy terms for all staff.

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

During 2025/26, one director (Group Chief Medical Director) received part of their remuneration via a bonus scheme. No other substantial changes to senior managers' remuneration were made during 2025/26.

A handwritten signature in black ink, appearing to read 'S. Collier', is positioned above a horizontal line.

Signed by Chair of Remuneration Committee on 25 June 2026

Group Non-Executive Director and the Senior Independent Director - Sally Collier

Senior Managers' Remuneration Policy

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

Remuneration component	Applicable to	Jurisdiction	Relevance to Trust's long- and short-term objectives	Amount payable
Basic salary	All senior managers	Nominations and Remuneration Committee	Recommendations in respect of basic salary are made to the Nominations and Remuneration Committee by the Chief Executive (for executive directors) and the Chairman (for the Chief Executive) on the basis of assessment of performance at annual appraisal, and specifically achievement of agreed personal objectives that reflect the long- and short-term objectives of the Trust.	Any increases are agreed with reference to the NHS VSM Pay Framework and advice as required.
Pension	All senior managers	Terms of membership as specified by the NHS Pension Scheme administered by the NHS Pensions Agency	N/A	Determined by the NHS Pensions Agency.
Clinical Impact Award (formerly Clinical Excellence Award) Scheme	Group Chief Medical Director only	Determined by Local Awards Committee in accordance with medical and dental employment contract; not awarded by Nominations and Remuneration Committee. The Scheme ended on 1 st April 2024. Existing awards granted prior to 1 st April 2018 remain in place.	Awards are determined by the Local Awards Committee in accordance with an agreed scheme that recognises clinical excellence across five domains. Analysis of the scheme demonstrates a linkage to the Trust's strategic objectives including the leadership and delivery of clinical services, teaching, training and research.	Level nine award is the maximum that can be awarded locally.
10% Bonus	Group Chief Medical Director and Executive Managing Director	Nominations and Remuneration Committee & Regional Medical Director	A separate cash payment of 10% of an employee's basic salary where a bonus payment has been agreed.	Payment is made at 10% of gross basic pay.

Accompanying notes:

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

- (3) With the exception of the bonus scheme, there are no significant differences between the remuneration policy for senior managers and the general policy for employees' remuneration

Annual Report on Remuneration

Service Contracts

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

Name & Title	Date of Commencement	End Date	Unexpired Term at 31 st March 2026	Notice Period
Group Executive Directors:				
L Dwyer, Group Chief Executive Officer	04/05/2025	Ongoing	N/A	6 Months
J Segasby, Group Chief Delivery Officer ⁴	01/11/2025	Ongoing	N/A	6 Months
J Segasby, Acting Group Chief Nurse	01/11/2025	14/12/2025	N/A	6 Months
M Thorman, Group Chief Finance Officer	01/11/2025	Ongoing	N/A	6 Months
S Gordon, Executive Managing Director	01/11/2025	07/12/2025	N/A	6 Months
J Gardner, Executive Managing Director	12/01/2025	Ongoing	N/A	6 Months
J Sherwin, Group Chief Medical Director	01/12/2025	Ongoing	N/A	6 Months
B Brett, Acting Group Chief Medical Director (NNUH) ¹	01/11/2025	30/11/2025	N/A	6 Months
V Chitre, Acting Group Chief Medical Director (JPUH) ¹	01/11/2025	30/11/2025	N/A	6 Months
R Martin, Acting Group Chief Medical Director (QEHL) ¹	01/11/2025	30/11/2025	N/A	6 Months
R Cocker, Interim Group Chief Nurse	15/12/2025	15/12/2026	N/A	6 Months
JPUH Trust Executive Directors prior to Group:				
J Segasby, Trust Chief Executive Officer	25/04/2022	11/05/2025	N/A	6 Months
S Gordon, Executive Managing Director ²	13/05/2025	31/10/2025	N/A	6 Months
E Taylor, Trust Chief Finance Officer	01/07/2019	31/10/2025	N/A	6 Months
C Dillaway, Trust Chief Operating Officer	12/01/2024	31/10/2025	N/A	6 Months
V Chitre, Trust Chief Medical Officer	01/08/2022	31/10/2025	N/A	6 Months
P Morris, Trust Chief Nurse	01/04/2020	25/04/2025	N/A	6 Months
J Copping, Trust Chief Nurse	28/04/2025	31/10/2025	N/A	6 Months
J Barber, Trust Deputy Chief Executive	12/02/2018	31/10/2025	N/A	6 Months
A Stace, Trust Chief Delivery Officer ³	06/10/2025	31/10/2025	N/A	6 Months
M Flynn, Trust Director of Strategic Projects	01/07/2019	31/10/2025	N/A	6 Months
S Goldie, Trust Director of People & Culture	02/11/2022	31/10/2025	N/A	6 Months

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

² – S Gordon was employed by the East Suffolk & North Essex NHS Foundation Trust with the cost to the Trust being recharged.

³ – A Stace was employed by the East Suffolk & North Essex NHS Foundation Trust with the cost to the Trust being recharged.

⁴ – J Segasby was the JPUH CEO until 10th May and subsequently the group delivery officer from 1 November. Between 11th May & 1 November she had no voting rights and therefore is not considered a member of senior management during this period.

Group Non-Executive Directors:	Date of Commencement	End Date	Unexpired Term at 31 st March 2026	Notice Period
D Roberts, Interim Group Chairman	01/11/2025	31/10/2026	6 Months	3 Months
W Van't Hoff, Group Non-Executive Director	10/12/2025	09/12/2027	20 Months	3 Months
S Collier, Group Non-Executive Director	10/12/2025	09/12/2028	32 Months	3 Months
P Baker, Group Non-Executive Director	10/12/2025	09/12/2028	32 Months	3 Months
J Bowman, Group Non-Executive Director	10/12/2025	09/12/2028	32 Months	3 Months
J Churchill, Group Non-Executive Director	10/12/2025	09/12/2028	32 Months	3 Months
N Gray, Group Non-Executive Director	22/12/2025	21/12/2028	32 Months	3 Months
S Javes, Group Non-Executive Director	22/12/2025	21/12/2027	20 Months	3 Months
Trust Non-Executive Directors:				
M Friend, Trust Chairman	02/10/2023	06/04/2025	N/A	3 Months
S Collier, Trust Non-Executive Director	04/07/2023	31/10/2025	N/A	3 Months
J Hennessey, Trust Non-Executive Director	08/04/2021	30/09/2025	N/A	3 Months
S Javes, Trust Non-Executive Director	01/01/2019	31/10/2025	N/A	3 Months
S Lindqvist, Trust Non-Executive Director	01/02/2023	31/10/2025	N/A	3 Months
C Notley, Trust Non-Executive Director	17/10/2022	31/10/2025	N/A	3 Months
S Whiteman, Trust Non-Executive Director	01/10/2023	31/10/2025	N/A	3 Months

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

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

Nominations and Remuneration Committee

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

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

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

The remuneration and expenses for the Trust Chairman and non-executive directors are determined by the Council of Governors informed by information issued by organisations such as NHS Providers.

Disclosures required by the Health and Social Care Act

Prior to the formation of the N&WUH Group in November 2025, there were a total of twelve executive directors in office at the JPUH during the period (filling nine roles) and seven non-executive directors, including the Chairman (filling seven roles). Following the formation of the N&WUH Group in November 2025, there were a total of ten executive directors in office during the period (filling six roles) and eight non-executive directors, including the Chairman (filling nine roles).

In 2024/25, 16 directors had been in office, being nine executive directors (filling eight roles) and seven non-executive directors (filling seven roles).

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

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

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

The Governor role is unpaid. When the Council of Governors was established, it was agreed that governors were entitled to claim travel expenses for attending meetings. In 2025/26 there were 15 governors (eight public governors, three staff governors and four partner governor). In 2024/25 there were 20 governors (ten public governors, six staff governors and four partner governors).

Table of disclosure Governors	2025/26	2024/25
The total number of governors in office	15	20
The number of governors receiving expenses in the reporting period	0	0
The aggregate sum of expenses paid to governors in the reporting	£ 0	£ 0

period		
Directors		
The total number of directors in office	25	16
The number of directors receiving expenses in the reporting period	5	8
The aggregate sum of expenses paid to directors in the reporting period	£ 1,460	£ 2,914

Single total figure remuneration table (the figures incorporated within the note below are subject to audit)

Name and title (Chairman and Executive Directors)	12 months ended 31st March 2026				
	Salary	All Taxable Benefits	Annual & Long-term Performance Related Bonuses	Pension Related Benefits	Total
	(bands of £5,000)	Rounded to the nearest £100	(bands of £5,000)	(bands of £2,500)	(bands of £5,000)
	£'000	£	£'000	£'000	£'000
J Segasby, JPUH Chief Executive until 11/05/25, then Group Chief Delivery Officer from 01/11/25	235-240	0	0	360-362.5	595 – 600
S Gordon, JPUH Executive Managing Director from 13/05/25 until 07/12/25	175-180	0	0	0	175-180
J Gardner, JPUH Executive Managing Director from 12/01/26	40-45	0	0	12.5-15	55-60
E Taylor, JPUH Chief Finance Officer until group formed on 01/11/25	85-90	0	0	62.5 – 65	325 - 330
C Dillaway, JPUH Chief Operating Officer until group formed on 01/11/25	80-85	0	0	22.5 – 25	105 – 110
N Kee, JPUH Chief Operating Officer until 30/04/24	0	0	0	0	0
V Chitre, JPUH Chief Medical Officer until group formed on 01/11/25, then Acting Group Medical Officer until 30/11/25	115-120	0	0	167.5-170	285-290
P Morris, JPUH Chief Nurse until 25/04/25	5-10	0	0	7.5-10	15-20
J Copping, JPUH Chief Nurse from 28/04/25 until group formed on 01/11/25	60-65	0	0	12.5-15	75-80
J Barber, JPUH Deputy Chief Executive until group formed on 01/11/25	90-95	0	0	27.5-30	115-120
A Stace, JPUH Chief Delivery Officer from 06/10/25 until group formed on 01/11/25	10-15	0	0	0	10-15
M Flynn, JPUH Director of Strategic Projects until group formed on 01/11/25	75-80	0	0	57.5-60	135-140
S Goldie, JPUH Director of People and Culture until group formed on 01/11/25	70-75	0	0	75-77.5	145-150

12 months ended 31st March 2025				
Salary	All Taxable Benefits	Annual & Long-term Performance Related Bonuses	Pension Related Benefits	Total
(bands of £5,000)	Rounded to the nearest £100	(bands of £5,000)	(bands of £2,500)	(bands of £5,000)
£'000	£	£'000	£'000	£'000
195-200	0	0	47.5-50	245-250
0	0	0	0	0
0	0	0	0	0
140-145	0	0	35-37.5	180-185
115-1250	0	0	30-32.5	150-155
10-15	0	0	0	10-15
200-205	0	0	0	200-205
135-140	0	0	257.5-260	390-395
0	0	0	0	0
145-150	0	0	85-87.5	230.235
0	0	0	0	0
125-130	0	0	0	125-130
120-125	0	0	25-27.5	145-150

	12 months ended 31st March 2026				
	Salary	All Taxable Benefits	Annual & Long-term Performance Related Bonuses	Pension Related Benefits	Total
	(bands of £5,000)	Rounded to the nearest £100	(bands of £5,000)	(bands of £2,500)	(bands of £5,000)
Name and title (Non-Executive Directors)	£'000	£	£'000	£'000	£'000
M Friend, JPUH Chair until 06/04/25 then NNUH Chair until group formed on 01/11/25	30-35	0	0	0	30-35
S Collier, JPUH Non Executive Director until group formed on 01/11/25	5-10	0	0	0	5-10
J Hennessey, JPUH Non Executive Director until 30/09/25	5-10	0	0	0	5-10
S Javes, JPUH Non Executive Director until group formed on 01/11/25	15-20	100	0	0	15-20
S Lindqvist, JPUH Non Executive Director until group formed on 01/11/25	5-10	400	0	0	5-10
C Notley, JPUH Non Executive Director until group formed on 01/11/25	5-10	0	0	0	5-10
S Whiteman, JPUH Non Executive Director until group formed on 01/11/25	5-10	0	0	0	5-10

12 months ended 31st March 2025				
Salary	All Taxable Benefits	Annual & Long-term Performance Related Bonuses	Pension Related Benefits	Total
(bands of £5,000)	Rounded to the nearest £100	(bands of £5,000)	(bands of £2,500)	(bands of £5,000)
£'000	£	£'000	£'000	£'000
45-50	0	0	0	45-50
10-15	100	0	0	10-15
10-15	0	0	0	10-15
10-15	100	0	0	10-15
10-15	700	0	0	10-15
10-15	0	0	0	10-15
10-15	1200	0	0	10-15

Definitions:

Senior Managers

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

Salary

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

Expense Payments

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

Pension related benefits

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

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

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

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

Benefits in Kind

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

Bonus

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

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

Remuneration Split

				Total Earnings	Pension Related Benefits	Earning Less Pension Adjustment			
				(bands of £5,000)	(bands of £2,500)	(bands of £5,000)	NNUH Contribution (Based on Earnings less Pension)	JPUH Contribution (Based on Earnings less Pension)	QEHKL Contribution (Based on Earnings less Pension)
Dates				(bands of £5,000)	(bands of £2,500)	(bands of £5,000)	(bands of £5,000)	(bands of £5,000)	(bands of £5,000)
Name	Position	Appointed	End	£'000	£'000	£'000	£'000	£'000	£'000
D Roberts	Interim Group Chair	01/11/2025	Ongoing	35 – 40	0	35 – 40	10 – 15	10 – 15	10 – 15
L Dwyer	Group Chief Executive Officer (NNUH Chief Executive Officer until 31 Oct 2025)	04/05/2025	Ongoing	295 – 300	57.5 – 60	235 – 240	75 – 80	75 – 80	75 – 80
M Thorman	Group Chief Financial Officer (NNUH Interim Chief Financial Officer from 24 Mar 25 to 31 Oct 25)	01/11/2025	Ongoing	150 – 155	42.5 – 45	105 – 110	30 – 35	35 – 40	35 – 40
J Sherwin	Group Chief Medical Director	01/12/2025	Ongoing	135 – 140	62.5 – 65	75 – 80	25 – 30	25 – 30	25 – 30
B Brett	Acting Group Medical Director (NNUH)	01/11/2025	30/11/2025	35 – 40	12.5 – 15	20 – 25	5 – 10	5 – 10	5 – 10
R Martin	Acting Group Chief Medical Director (QEHKL)	01/11/2025	30/11/2025	25 – 30	5 – 7.5	15 – 20	5 – 10	5 – 10	5 – 10
R Cocker	Interim Group Chief Nurse (from 15 Dec 25)	15/12/2025	Ongoing	60 – 65	7.5 – 10	50 – 55	15 – 20	15 – 20	15 – 20
P Baker	Group Non-Executive Director	10/12/2025	Ongoing	0 – 5	0	0 – 5	0 – 5	0 – 5	0 – 5
J Bowman	Group Non-Executive Director	10/12/2025	Ongoing	5 – 10	0	5 – 10	0 - 5	0 - 5	0 - 5
J Churchill	Group Non-Executive Director	10/12/2025	Ongoing	5 – 10	0	5 – 10	0 - 5	0 - 5	0 - 5
S Collier	Group Non-Executive Director	10/12/2025	Ongoing	5 – 10	0	5 – 10	0 - 5	0 - 5	0 - 5
N Gray	Group Non-Executive Director	22/12/2025	Ongoing	0 – 5	0	0 – 5	0 – 5	0 – 5	0 – 5
S Javes	Group Non-Executive Director	22/12/2025	Ongoing	0 – 5	0	0 – 5	0 – 5	0 – 5	0 – 5
W Van't Hoff	Group Non-Executive Director	10/12/2025	Ongoing	5 – 10	0	5 – 10	0 - 5	0 - 5	0 - 5
J Segasby	Group Delivery Officer (JPUH Chief Executive until 11/05/25 then Group Chief	25/04/2022	Ongoing	310-315	190 -192.5	120-125	35-40	55-60	35-40

	Delivery Officer from 01/11/25)								
S Gordon	JPUH Executive Managing Director from 13/05/25 until 07/12/25	13/05/2025	07/12/2025	175-180	0	175-180	0	175-180	0
J Gardner	JPUH Executive Managing Director from 12/01/26	12/01/2026	Ongoing	55-60	12.5-15	40-45	0	55-60	0
E Taylor	JPUH Chief Finance Officer until group formed on 01/11/25	01/07/2019	31/10/2025	85-90	0	85-90	0	85-90	0
C Dillaway	JPUH Chief Operating Officer until group formed on 01/11/25	12/01/2024	31/10/2025	105-110	22.5-25	85-90	0	105-110	0
V Chitre	Acting Group Chief Medical Director (JPUH) (Prev. JPUH Medical Director)	01/11/2025	30/11/2025	285-290	167.5-170	115-120	0-5	105-110	0-5
P Morris	JPUH Chief Nurse until 25/04/25	01/04/2020	25/04/2025	15-20	7.5-10	5-10	0	15-20	0
J Copping	JPUH Chief Nurse from 28/04/25 until group formed on 01/11/25	28/04/2025	30/10/2025	75-80	12.5-15	60-65	0	75-80	0
J Barber	JPUH Deputy Chief Executive until group formed on 01/11/25	12/02/2018	30/10/2025	115-120	27.5-30	90-95	0	115-120	0
A Stace	JPUH Chief Delivery Officer from 06/10/25 until group formed on 01/11/25	06/10/2025	30/10/2025	10-15	0	10-15	0	10-15	0
M Flynn	JPUH Director of Strategic Projects until group formed on 01/11/25	01/07/2019	30/10/2025	135-140	57.5-60	75-80	0	135-140	0
S Goldie	JPUH Director of People and Culture until group formed on 01/11/25	02/11/2022	30/10/2025	145-150	75.77.5	70-75	0	145-150	0
M Friend	JPUH Chair until 06/04/25 then NNUH Chair until group formed on 01/11/25	02/10/2023	06/04/2025	35-40	0	35-40	35-40	0	0
S Collier	JPUH Non Executive Director until group formed on 01/11/25	04/07/2023	31/10/2025	5-10	0	5-10	0	5-10	0
J Hennessey	JPUH Non Executive Director until 30/09/25	08/04/2021	30/09/2025	5-10	0	5-10	0	5-10	0
S Javes	JPUH Non Executive Director until group formed on 01/11/25	01/01/2019	31/10/2025	15-20	0	15-20	0	15-20	0
S Lindqvist	JPUH Non Executive Director until group formed on 01/11/25	01/02/2023	31/10/2025	5-10	0	5-10	0	5-10	0
C Notley	JPUH Non Executive	17/10/2022	31/10/2025	5-10	0	5-10	0	5-10	0

	Director until group formed on 01/11/25									
S Whiteman	JPUH Non Executive Director until group formed on 01/11/25	01/10/2023	31/10/2025	5-10	0	5-10		0	5-10	0

Notes:

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

Pensions entitlement table

2025/26 Name and title	Real increase in pension at age 60 (bands of £2,500) £'000	Real increase in pension lump sum at age 60 (bands of £2,500) £'000	Total accrued pension at age 60 at 31 March 2026 (bands of £5,000) £'000	Lump sum at age 60 related to accrued pensions at 31 March 2026 (bands of £5,000) £'000	Cash Equivalent Transfer Value at 1 April 2025 £'000	Real increase in Cash Equivalent Transfer Value £'000	Cash Equivalent Transfer Value at 31 March 2026 £'000
L Dwyer, Group Chief Executive ²	2.5 – 5	0	10 – 15	0 – 5	99	0	0
M Thorman, Group Chief Financial Officer	5 – 7.5	2.5 – 5	85 – 90	225 – 230	1,816	109	1,988
J Sherwin, Group Chief Medical Director	2.5 – 5	5 – 7.5	60 – 65	150 – 155	1,225	71	1,487
R Martin, Acting Group Chief Medical Director (QEHL)	2.5 – 5	2.5 – 5	70 – 75	175 – 180	1,579	60	1,719
R Cocker, Interim Group Chief Nurse	2.5 – 5	0	70 – 75	180 – 185	1,555	42	1,645
J Segasby, JPUH Chief Executive until 11/05/25 then Group Chief Delivery Officer	7.5 – 10	20 – 22.5	95 – 100	265 – 270	1,831	200	2,271
S Gordon, JPUH Executive Managing Director from 13/05/25 until 07/12/25	0	0	0	0	0	0	0
J Gardner, JPUH Executive Managing Director from 12/01/26	0 – 2.5	0	40 – 45	0	544	11	631
E Taylor, JPUH Chief Finance Officer until group formed on 01/11/25	0	0	0	0	0	0	0
C Dillaway, JPUH Chief Operating Officer until group formed on 01/11/25	0 – 2.5	0	10 – 15	0	201	20	242
V Chitre, JPUH Chief Medical Officer until group formed on 01/11/25, then Acting Group Medical Officer until 30/11/25	7.5 – 10	10 – 12.5	90 – 95	215 – 220	200	53	301
P Morris, JPUH Chief Nurse until 25/04/25	0 – 2.5	0 – 2.5	35 – 40	105 – 110	616	9	771
J Copping, JPUH Chief Nurse from 28/04/25 until group formed on 01/11/25	0 – 2.5	0	0 – 5	0	95	20	133
J Barber, JPUH Deputy Chief Executive until group formed on 01/11/25	0 – 2.5	0	20 – 25	0	511	42	580

A Stace, JPUH Chief Delivery Officer from 06/10/25 until group formed on 01/11/25	0	0	0	0	0	0	0
M Flynn, JPUH Director of Strategic Projects until group formed on 01/11/25	2.5 – 5	0 – 2.5	30 – 35	60 – 65	696	59	803
S Goldie, JPUH Director of People and Culture until group formed on 01/11/25	2.5 – 5	5.0 - 7.5	30 – 35	75 – 80	882	115	1,040

Notes:

1. L Dwyer – for the 2015 scheme a CETV as at 31 March 2026 is not available via a Greenbury request and therefore a “zero” value has been entered.
2. S Gordon and A Stace were not employed directly so no Greenbury reports were able to be provided.
3. E Taylor chose not to be covered by the pension arrangements during the reporting year.
4. For individuals which are shared between the three Trusts which form part of the N&WUH Group, the full CETV is disclosed for those individuals within each set of accounts and it has not been apportioned between the Trusts.
5. Negative values are not disclosed in this table but are substituted with a “zero”.
6. As non-executive members do not receive pensionable remuneration there will be no entries in respect of pensions for non-executive members.

Cash equivalent transfer value (CETV) figures are calculated using the guidance on discount rates for calculating unfunded public service contribution rates that was extant on 31 March 2026. HM Treasury published updated guidance on 27 April 2023; this guidance was used in the calculation of 2025/26 CETV figures.

2024/25 Name and title	Real increase in pension at age 60 (bands of £2,500) £'000	Real increase in pension lump sum at age 60 (bands of £2,500) £'000	Total accrued pension at age 60 at 31 March 2025 (bands of £5,000) £'000	Lump sum at age 60 related to accrued pensions at 31 March 2025 (bands of £5,000) £'000	Cash Equivalent Transfer Value at 1 April 2024 £'000	Real increase in Cash Equivalent Transfer Value £'000	Cash Equivalent Transfer Value at 31 March 2025 £'000
J Segasby, JPUH Chief Executive	2.5 – 5	0 – 2.5	80 – 85	220 – 225	1,642	56	1,831
E Taylor, JPUH Chief Finance Officer	2.5 – 5	0 – 2.5	45 – 50	115 – 120	879	35	992
C Dillaway, JPUH Chief Operating Officer from 28/05/24	0 – 2.5	0	15 – 20	0 – 5	155	15	201

N Kee, JPUH Chief Operating Officer until 30/04/24	0 – 2.5	0 – 2.5	55 – 60	150 – 155	302	0	0
V Chitre, JPUH Chief Medical Officer	0	0	75 – 80	195 – 200	120	46	200
P Morris, JPUH Chief Nurse	10 – 12.5	27.5 – 30	30 – 35	80 – 85	354	223	616
J Barber, JPUH Deputy Chief Executive	5 – 7.5	0	30 – 35	0 – 5	395	72	511
M Flynn, JPUH Director of Strategic Projects	0 – 2.5	0	30 – 35	75 – 80	645	0	696
S Goldie, JPUH Director of People and Culture	0 – 2.5	0	40 – 45	110 – 115	789	25	882

Lump Sum

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

Cash Equivalent Transfer Values

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

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

Real Increase in CETV

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

Compensation on early retirement or for loss of office

There were no directors paid for early retirement nor loss of office by the Trust in both 2025/26 and 2024/25.

Payments to past directors

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

Fair pay disclosure

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

Total remuneration comprises basic salary and allowances, non-consolidated performance-related pay and all taxable benefits. It does not include any severance payments, benefits in kind, employer pension contributions and the cash equivalent transfer value of pensions.

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

The banded remuneration of the highest paid director in the organisation in the financial year 2025-26 was £215k-£220k (2024/25: £195k-£200k). The relationship to the remuneration of the organisation's workforce is disclosed in the table below.

Pay ratio information table

2025/26	25th percentile	Median	75th percentile
'All staff' remuneration based on annualised, full-time equivalent remuneration of all staff (including temporary and agency staff) (£)	27,958	37,818	50,485
Salary component of 'all staff' remuneration based on annualised, full-time equivalent remuneration of all staff (including temporary and agency staff) (£)	27,753	37,802	50,273
'All staff' remuneration based on annualised, full-time equivalent remuneration of all staff (including temporary and agency staff): mid-point of band of highest paid director (£)	7.78	6.43	4.31
2024/25	25th percentile	Median	75th percentile
'All staff' remuneration based on annualised, full-time equivalent remuneration of all staff (including temporary and agency staff) (£)	31,890	42,003	52,651
Salary component of 'all staff' remuneration based on annualised, full-time equivalent remuneration of all staff (including temporary and agency staff) (£)	31,890	42,003	52,651
'All staff' remuneration based on annualised, full-time equivalent remuneration of all staff (including temporary and agency staff): mid-point of band of highest paid director (£)	8.23	6.25	4.99

Percentage change in remuneration of highest paid director

The Group Chief Delivery Officer was the highest paid director for the James Paget University Hospitals NHS Foundation Trust in the financial year 2025/26 at £215k-£220k. In 2024/25 the Chief Medical Officer was the highest paid director at £195k-£200k. The 2025/26 cost is the full salary and does not reflect the shared cost arrangement with N&WUHG agreed as part of the Group.

2025/26	% 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)	4.40	N/A
2024/25	% 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)	-9.20	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)	8.60	N/A

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

	2025/26	2024/25
Band of highest paid director's total remuneration (£'000)	215 – 220	195 – 200
Midpoint of band	217,500	197,500
25 th percentile (£)	26,598	25,674
Median total (£)	33,487	32,324
75 th percentile (£)	46,580	44,692
Remuneration ratio	6.50	6.11

Employee Remuneration Range

	2025/26	2024/25
Band of highest paid employee (£'000)	280 – 285	360 – 365
Band of lowest paid employee (£'000)	20 – 25	20 – 25

In 2025/26, eleven (2024/25: twenty nine) employees received remuneration in excess of the highest paid director. Remuneration ranged from £22.5k to £284.0k (2024/25: £22.5k to £360.5k).

The percentage change in average employee remuneration (based on total for all employees on an annualised basis divided by full-time equivalent number of employees) between years was 4.40%.

The highest paid director's remuneration was 6.50 times (2024/25: 6.11 times) the median remuneration of the workforce which was £33,487 (2024/25: £32,324).



Professor Lesley Dwyer
Chief Executive and
Accounting Officer
25 June 2026

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 the James Paget University Hospitals 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 James Paget University Hospitals 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.

A handwritten signature in black ink, appearing to be 'LD' with a long, sweeping horizontal stroke extending to the right.

Lesley Dwyer

Group Chief Executive

25 June 2026

INDEPENDENT AUDITOR'S REPORT TO THE COUNCIL OF GOVERNORS OF JAMES PAGET UNIVERSITY HOSPITALS NHS FOUNDATION TRUST

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 2026 which comprise the Statement of Comprehensive Income, Statement of Financial Position, Statement of Changes in Taxpayers' Equity and Statement of Cash Flows, and the related notes, including the accounting policies in note 1.

In our opinion the financial statements:

- give a true and fair view of the financial position of the Trust as at 31 March 2026 and of the its income and expenditure for the year then ended; and
- have been properly prepared in accordance with the accounting policies directed by NHS England with the consent of the Secretary of State in February 2026 as being relevant to NHS Foundation Trusts and included in the Department of Health and Social Care Group Accounting Manual 2025/26; and
- have been prepared in accordance with the requirements of the National Health Service Act 2006 (as amended).

Basis for opinion

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

Going concern

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

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

Our conclusions based on this work:

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

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

Fraud and breaches of laws and regulations – ability to detect

Identifying and responding to risks of material misstatement due to fraud

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

- Enquiring of management, the Audit Committee and internal audit as to the 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 Trust management may be in a position to make inappropriate accounting entries. On this audit we did not identify a fraud risk related to revenue recognition due to the block nature of the funding provided to the Trust during the year. We therefore assessed that there was limited opportunity for the Trust to manipulate the income that was reported.

We also identified a fraud risk related to the cut off of non-pay, non-depreciation expenditure in response to incentives to manipulate the results of the Trust 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.

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 incentive to carry expenditure forward.

We did not identify any additional fraud risks.

We also performed procedures including:

- Identifying journal entries to test based on risk criteria and comparing the identified entries to supporting documentation. These included entries which move expenditure to capital in M9 and M12, and using AI transaction scoring we use journal entries with unusual characteristics compared to the total journal population.
- 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 accounting period.
- Inspecting a sample of payments made post year end, to determine whether the in-year expenditure and associated liabilities are complete;

Identifying and responding to risks of material misstatement related to compliance with laws and regulations

We identified areas of laws and regulations that could reasonably be expected to have a material effect

on the financial statements from our general sector experience and through discussion with the Accounting Officer and other management (as required by auditing standards), and discussed with the Accounting Officer and other management the policies and procedures regarding compliance with laws and regulations.

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

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

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

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

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

Other information in the Annual Report

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

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

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

Remuneration and Staff Reports

In our opinion the parts of the Remuneration and Staff Reports subject to audit have been properly prepared, in all material respects, in accordance with the NHS Foundation Trust Annual Reporting Manual 2025/26.

Accounting Officer's and Audit Committee's responsibilities

As explained more fully in the statement set out on page 80, the Accounting Officer is responsible for the preparation of financial statements that give a true and fair view. They are also responsible for: such internal control as they determine is necessary to enable the preparation of financial statements that are free from material misstatement, whether due to fraud or error; assessing the Trust's ability to continue as a going concern, disclosing, as applicable, matters related to going concern; and using the going concern basis of accounting unless they have been informed by the relevant national body of the intention to either cease the services provided by the Trust or dissolve the Trust without the transfer of its services to another public sector entity.

The Audit Committee is responsible for overseeing the Trust's financial reporting process.

Auditor's responsibilities

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

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

REPORT ON OTHER LEGAL AND REGULATORY MATTERS

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

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

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 80, the Accounting Officer is responsible for ensuring that the Trust has put in place proper arrangements for securing economy, efficiency and effectiveness in its use of resources.

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

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

during the year.

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

Statutory reporting matters

We are required by Schedule 2 to the Code of Audit Practice to report to you if:

- we issue a report in the public interest under paragraph 3 of Schedule 10 of the National Health Service Act 2006; or
- we make a referral to the Regulator under paragraph 6 of Schedule 10 of the National Health Service Act 2006 because we have reason to believe that the Trust, or a director or officer of the Trust, is about to make, or has made, a decision which involves or would involve the incurring of expenditure which is unlawful, or is about to take, or has taken, a course of action which, if pursued to its conclusion, would be unlawful and likely to cause a loss or deficiency.

We have nothing to report in these respects.

THE PURPOSE OF OUR AUDIT WORK AND TO WHOM WE OWE OUR RESPONSIBILITIES

This report is made solely to the Council of Governors of the Trust, as a body, in accordance with Schedule 10 of the National Health Service Act 2006. Our audit work has been undertaken so that we might state to the Council of Governors of the Trust, as a body, those matters we are required to state to them in an auditor's report and for no other purpose. To the fullest extent permitted by law, we do not accept or assume responsibility to anyone other than the Council of Governors of the Trust, as a body, for our audit work, for this report, or for the opinions we have formed.

DELAY IN CERTIFICATION OF COMPLETION OF THE AUDIT

As at the date of this audit report, we are unable to confirm that we have completed our work in respect of the trust accounts consolidation pack of the Trust for the year ended 31 March 2026 because we have not received confirmation from the NAO that the NAO's audit of the Department of Health and Social Care accounts is complete.

Until we have completed this work, we are unable to certify that we have completed the audit of James Paget University Hospitals NHS Foundation Trust for the year ended 31 March 2026 in accordance with the requirements of Schedule 10 of the National Health Service Act 2006 and the NAO Code of Audit Practice.

Emma Larcombe

Emma Larcombe

for and on behalf of KPMG LLP

Chartered Accountants

20 Station Road,

Cambridge

CB1 2JD

26 June 2026

Annual Governance Statement

Scope of responsibility

As Accounting Officer, I have responsibility for maintaining a sound system of internal control that supports the achievement of James Paget University Hospitals 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 James Paget University Hospitals 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 2026 and up to the date of approval of the annual report and accounts.

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

Capacity to handle risk

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

Leadership of risk management during 2025/26 was exercised through the Trust Board and, within management, through the Executive Managing Director, the Hospital Management Group, and its specialist management groups for quality, people and culture, and finance and performance. The Board's Audit Committee (from November 2025 constituted as a Group Audit Committees in Common) scrutinised the adequacy and effectiveness of the Trust's risk management and internal control arrangements. Each division and corporate department was required to identify, assess, manage, and escalate risks in line with the risk management framework. Staff were supported through mandatory and role-specific training, policy guidance available on the Trust intranet, divisional induction, and support from dedicated risk and governance leads. Learning from incidents, clinical audit, internal audit, external review, and regulatory engagement was used to strengthen risk management practice.

The risk and control framework

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

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

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

The Group Board Assurance Framework Report, which identifies principal risks to the achievement of the Group's strategic objectives, is also reviewed monthly by ERAG and GRAC. It is received by the Group Board three times a year. Each BAF Report risk has a clearly identified Group Executive as the risk lead and sets out the controls in place to manage the risk and the sources of assurance on the effectiveness of the controls. The BAF Report also identifies any gaps in control or assurance and the actions being taken to address those and reduce the risk score in line with its trajectory.

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

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

Quality arrangements formed a central part of the risk and control framework. Group Aim A1 defined Quality as patient safety, patient experience, and clinical effectiveness. Associated principal risks included variation in quality standards, maternity services improvement, Electronic Patient Record dependent change, and new hospital programme transformation risk. Controls and review routes recorded in the March 2026 Group Board Assurance Framework Report included Trust-level Quality Management Groups, Hospital Management Groups, monthly Executive Performance Reviews, management escalation through ERAG, Board-level scrutiny through GRAC, and external review through NHS England oversight, Care Quality Commission inspection, and accreditation visits. The assurance position was active but not yet complete: the controls provided structured routes for oversight, escalation, and intervention, but were not yet sufficient to demonstrate that all quality variation, maternity improvement, and access risks had been reduced to target. Identified gaps included the need for a Group-wide quality framework, a Group-wide quality improvement programme, more consistent real-time quality data, and enhanced Board-level oversight of quality and outcomes. These actions will continue during 2026/27, with progress monitored through Trust management structures, ERAG, GRAC and the Group Board.

Group Aim A4 and Principal Risk 4 established the strategic framework for financial sustainability and value. The March 2026 Board Assurance Framework recorded limited assurance over financial sustainability, with key controls including the Board-approved Medium-term Plan, Cost Improvement Programme (CIP) development, bank and agency controls, and capital planning. Assurance sources included monthly Executive Performance Reviews, escalation through ERAG and GRAC, monthly reporting to NHS England, internal audit opinion, and external audit value for money findings once completed. The controls were operating and provided a defined route for oversight, grip, and escalation, but were not yet fully effective in reducing the financial sustainability risk to target. Gaps remained in relation to finalisation and delivery of 2026/27 CIP programmes, recurrent deficit reduction, and the need for deeper assurance over delivery trajectories, run-rate improvement, and the recurrent effect of savings.

Access, flow, and productivity remained a material operational risk during 2025/26, including elective waiting list pressures, long-wait pathways, theatre productivity, and the Trust's low relative position within the NHS Oversight Framework. Controls included integrated performance reporting, daily and weekly Patient Tracking List review, elective access validation, cancer and long-wait oversight, specialty recovery planning, Executive Performance Reviews, and escalation through HMG, ERAG, GRAC and Board reporting. Assurance was available over the existence and operation of these controls, including the Q1 and Q4 validation sprints and treatment or validation of over 4,300 patients, but controls had not yet delivered the required level of sustained recovery. Further assurance will be sought through the planned 2026/27 Group-wide Internal Audit review of Waiting List Management and through continued scrutiny of recovery trajectories, clinical harm review processes, and data quality controls.

During 2025/26, the Group identified digital capability and data readiness as a principal risk because insufficient digital maturity, data quality assurance, and analytics capability could inhibit modern clinical practice, transformation, and confident decision-making. Risks to data security were managed through digital and cyber controls including Data Protection and Security Toolkit improvement planning, cyber action plans, layered technical controls, user education, internal audit coverage, Cyber Assessment Framework work, and business case development for cyber and infrastructure investment. Cyber security and information governance were treated as a major principal risk, with further work required on resources, infrastructure refresh, governance alignment, and compliance capability across the Group.

The Trust's principal risks to compliance with the NHS provider licence section 4 on governance during the year related to the effectiveness and completeness of the evolving Group governance arrangements, clarity of responsibilities between the Trust Board, the Group Board, Committees in Common, and executive management structures, the sufficiency of Non-Executive Director scrutiny within the new model, the evidential standards required for lawful and informed decision-making, and the need to complete and embed the aligned governance instrument set. These matters were reflected in Group Principal Risk relating to corporate governance.

The Trust's review of governance effectiveness also drew explicitly on the Care Quality Commission and NHS England Well-Led Framework. This informed consideration of Board leadership, culture, strategy, risk management, information quality, learning, accountability, and the effectiveness of the developing Group governance and operating model. The Trust's Well-led arrangements were reviewed alongside NHS England oversight, CQC intelligence, internal audit, external audit, Board and committee reporting, and the work undertaken to complete and embed the Group governance instrument set.

Risk management was embedded in the activity of the organisation through integrated performance reporting, incident reporting, escalation processes, finance and performance review, quality review mechanisms, workforce planning, management group oversight, committee scrutiny, and use of the

BAF Report. Equality, diversity, human rights, and wider regulatory obligations were addressed through the Trust's established policies, operational controls, and decision-making processes. Public stakeholders remained engaged through the continuing constitutional role of the Trust's Council of Governors, patient and public involvement arrangements, patient feedback and complaints systems, and the Group's stated intention to strengthen stakeholder engagement and confidence through transparent communication and visible leadership. Group Aim A6 explicitly required proactive public and stakeholder engagement to build and maintain confidence in Group services.

The Trust continued to ensure that short, medium, and long-term workforce strategies and staffing systems were in place to support safe, sustainable, and effective staffing. In accordance with Developing Workforce Safeguards, the Board's approach to staffing assurance drew on evidence-based tools, professional judgement, and patient safety, quality, finance, workforce, and outcome indicators. The Group Aims and BAF Report identified workforce capacity, capability, retention, safe staffing, wellbeing, engagement, inclusion, and workforce pipeline as central priorities. The March 2026 Board Assurance Framework recorded controls including Trust-level workforce plans, establishment control, acuity-based rostering, temporary staffing controls, sickness absence plans, and staff survey improvement planning, while also identifying gaps in relation to shortage specialties, sickness rates, and staff engagement. Where staffing indicators were outside tolerance, actions were overseen through the People and Culture Management Group, Hospital Management Group, Executive Performance Reviews and Group assurance routes.

Maternity services demonstrated significant progress, improving its Care Quality Commission (CQC) rating from Inadequate to Requires Improvement (based on a September 2025 inspection), alongside the formal removal of the historic section 29A Warning Notice. The improvement was supported by an agreed maternity improvement plan, strengthened leadership oversight, quality and safety reporting, executive review, and continuing engagement with external oversight. However, the Trust recognised that the improvement controls required continued evidence of sustained embedding during 2026/27, particularly in relation to culture, staffing, learning, clinical standards, and measurable outcomes.

The People and Culture Management Group oversees safe staffing and red-flag processes. Highest sickness absence rates were addressed through Group-supported interventions, People Promise actions, strengthened management support, and monitoring of absence, retention, engagement, and workforce controls through local and Group reporting routes.

The principal estate risk is that the materially Reinforced Autoclaved Aerated Concrete (RAAC)-affected estate, with 86% RAAC coverage, could compromise patient and staff safety, service continuity and operational resilience. Controls included structural inspections, propping, monitoring, estates risk assessment, risk-register escalation, business continuity planning, capital planning, and reporting through local and Group governance routes. Assurance was taken from the continuing operation of the mitigation regime, professional estates advice, programme reporting, and oversight of the New Hospitals Programme. The residual risk remained significant because mitigation depends on continued monitoring, effective maintenance of temporary measures, clarity over the New Hospitals Programme timetable, and delivery of enabling work. During 2026/27, assurance will focus on the continuing safety of the mitigated estate, escalation of any deterioration, and the delivery confidence, timeline, cost, and operational continuity assumptions within the New Hospitals Programme.

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

The Trust has published on its website an up-to-date register of interests, including gifts and hospitality, for decision-making staff (as defined by the Trust with reference to the guidance) within the past twelve months as required by the Managing Conflicts of Interest in the NHS guidance.

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

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

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

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

The Trust's arrangements for reviewing the economy, efficiency, and effectiveness of the use of resources included oversight by the Board of Directors, the Audit Committee, executive finance and performance review processes, internal audit, external audit, and the Group and local assurance structures. The Board monitored delivery of the financial plan, cost improvement requirements, workforce controls, capital expenditure, and value for money considerations within a period of continuing financial pressure and transformation demand.

Information governance

At Group level, information governance and cyber security were recognised as a principal risk. Controls included Data Protection and Security Toolkit improvement planning, cyber action planning, technical controls, annual audit, internal audit coverage, and strategic work to align information governance and cyber security governance across the Group. This wider context informed the Trust's own information governance control environment during the year.

No material personal data breaches or major Data Security Incident Reporting Tool incidents were reported in 2025/26. Local remediation and controls are managed via Inphase and Caldicott processes, overseen locally by the Quality Management Group.

Data quality and governance

The Trust maintained arrangements to provide the Board with confidence that appropriate controls were in place to ensure the accuracy of performance and operational data.

During 2025/26, the Group identified digital capability and data readiness as a principal risk because insufficient digital maturity, data quality assurance, and analytics capability could inhibit modern clinical practice, transformation, and confident decision-making. The BAF Report recorded the need for a costed digital roadmap, improved data analytics capability, and a Group-wide business intelligence, analytics, and data quality function.

The Trust ensures the accuracy of elective waiting time data through a dedicated 18-week pathway validation team, weekly Patient Tracking List meetings led by the Elective Access Manager, and daily oversight of long-wait and cancer pathways.

The site leadership team manages significant local data risks impacting the accuracy of the Patient Tracking List, caused by the incorrect application of RTT codes, and open referrals not attached to an active waiting list, mitigated via a Data Quality Form to risk-stratify referrals.

Where patient pathway errors are identified or patients experience excessively high waiting times, clinical harm reviews are mandated and managed through the Safety Action and Assurance Group.

In 2025/26, Q1 and Q4 validation sprints delivered the validation and treatment of over 4,300 patients.

A Group-wide Internal Audit review of Waiting List Management is planned for 2026/27 and will provide further assurance over elective pathway controls and data quality.

Review of effectiveness

As Accounting Officer, I have responsibility for reviewing the effectiveness of the system of internal control. My review of the effectiveness of the system of internal control is informed by the work of the internal auditors, clinical audit and the executive managers and clinical leads within the Trust who have responsibility for the development and maintenance of the internal control framework. I have drawn on performance information available to me. My review is also informed by comments made by the external auditors in their management letter and other reports.

I have been advised on the implications of the result of my review of the effectiveness of the system of internal control by the board and the audit committee and a plan to address weaknesses and ensure continuous improvement of the system is in place.

The process applied in maintaining and reviewing the effectiveness of the system of internal control during 2025/26 included review by the Trust Board and Audit Committee, supported by internal audit, external audit, clinical audit, integrated performance reporting, and management review through the Trust's established executive and management group structure.

Where functions had been lawfully delegated for joint exercise, relevant matters were also scrutinised through the Group governance framework, including Board-level scrutiny through GRAC and management escalation through the Group Executive and ERAG.

The Head of Internal Audit opinion for 2025/26 has concluded that the organisation has an adequate and effective framework for risk management, governance and internal control. However, the internal auditors' work has identified further enhancements to the framework of risk management, governance and internal control to ensure that it remains adequate and effective.

The effectiveness review also drew on development of the Group Governance Framework itself. The March 2026 Board Assurance Framework report recorded an assurance rating of 'reasonable' for Principal Risk 14, corporate governance, while also identifying that elements of the Group governance structure remained to be fully implemented and embedded, that the risk management framework remained in development, and that Non-Executive Director vacancies remained to be filled. Planned actions included establishment of remaining Board committees, finalisation and embedding of Constitutions, Standing Orders and Standing Financial Instructions, further population, and review of the BAF Report, and agreement of a revised Group risk appetite statement.

In February 2025, NHS England completed a leadership and governance review of the proposed Group model. This resulted in an Amber rating, meaning that the Group could proceed as planned with moderate support and monitoring. A follow-up review, conducted by the NHS England team in November 2025, formed part of the evidence base for the review of effectiveness. It recognised timely progress in development of the governance framework and operating model, while also identifying a continuing need to keep the sufficiency of non-executive scrutiny under review, to evaluate the governance and operating model as it embedded, and to maintain focus on benefits realisation and governance effectiveness.

The review of effectiveness was further informed by completion of the statutory governance instrument set recorded in April 2026, with legal review confirming that the Provider Collaboration Agreement, Constitutions, Standing Orders, Standing Financial Instructions, and Scheme of Reservation and Delegation together formed a coherent and lawful governance framework for the Group model.

The review identified material operational risks requiring continued management action, most notably in relation to quality and safety metrics, maternity improvement, elective access and waiting list controls, financial sustainability, cyber security resilience, and estate risk arising from RAAC mitigations. These matters were actively escalated and tracked through the Trust's management groups, Executive Performance Reviews, ERAG, GRAC, Audit Committee and Board reporting arrangements.

The review concluded that controls were present and active, but in several areas had not yet delivered the required level of sustained improvement or assurance strength by year end. This reflected the need for continued strengthening in control execution, recovery discipline, and evidential demonstration of sustained improvement, rather than the absence of an overall control framework.

The Audit Committee has reviewed the overall framework for internal control and has recommended this statement to the Board of Directors.

Significant internal control issues

The Trust identified no significant internal control issues in 2025/26 that, in the judgement of the Board, met the threshold for separate disclosure as material control failures.

The Board nevertheless recognised material risks and assurance limitations in relation to quality variation, maternity improvement, elective access and waiting list controls, financial sustainability, cyber security resilience, and the RAAC-affected estate. These matters required strengthened management action, tighter application of controls, and continued assurance during 2026/27, but were not assessed as evidencing a breakdown of the overall system of internal control.

Conclusion

Overall, the Board's conclusion on the system of internal control is informed by the Head of Internal Audit opinion, external audit findings, management review, and the evidence set out in this statement. The Board recognises that controls were present and active across the principal risk areas described above, but that assurance was limited in relation to financial sustainability and not yet fully mature in relation to quality variation, maternity improvement, elective access, waiting list controls, and the RAAC-affected estate. These matters require stronger and more consistent application of the system of internal control during 2026/27 but were not judged at year end to constitute a significant failure of internal control.

Signatory



Professor Lesley Dwyer
Chief Executive
James Paget University Hospitals NHS Foundation Trust

Date: 25 June 2026

Staff Report

Our People Plan

Paget's People is our People Plan for 2023-28. It is aligned to the NHS People Plan, NHS People Promise and NHS Long Term Plan.



OUR
PEOPLE

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 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 Management Group receives updates on progress with the delivery of the plan and reviews the plan annually. We have continued to have a focus over the last year on embedding Paget CARES, our Values and Behaviours Framework and have implemented a Kindness and Respect toolkit, with associated training, to support with this. Work has progressed on Fair Recruitment with a review of recruitment materials.

Learning Reviews have been introduced as part of our Just and Learning Culture work. We have had an independent review undertaken on the prevention and management of violence and aggression towards staff and have established a Programme Board to oversee the implementation of associated plans.

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 vacancy rate continues to be well managed and is lower than the acute average.

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 be innovative in considering skills requirements, role design, ways of working and the 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 which supports the attraction and retention of 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 2025. We saw more than 800 nominations from both patients and staff and over 200 guests attended the ceremony to celebrate everyone nominated and our winners.



Additionally, we run an Employee of the Month Scheme. Nominations can be shared with the Executive Managing Director by patients, visitors and colleagues for 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 Executive Managing Director and celebrated through our staff communication forums. We were also delighted to celebrate our staff who have reached 10, 20, 30 and 40 years with the Trust, with those with the longest service being invited to a tea party with the Director of People and Culture.

Equity, 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 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 more work to do towards improving the experience of all staff working at the Trust, we are making positive progress and are pleased to see this reflected in several of the Workforce Race and Disability Equality Standards (WRES/WDES) as well as progress with the Equality Delivery System domains and improvement with areas of our Gender Pay Gap. We have also this year further embedded the NHS' Six Equality High Impact Actions.

Our staff networks (ethnically diverse, LGBTQ+, Ability and Women's Health) are key partners and we thank them for their openness, honesty, and collaboration in developing and delivering plans to improve staff experience.

As usual, we celebrated Pride month, including the raising of our rainbow flag and other activities. Our Therapies Team held a wonderful International Celebration sharing their cultures and traditions. Our staff also hosted a fantastic Women's Day event within the local community on March 8th 2026.

Key areas of focus supported by our networks over the last year have included working toward menopause friendly accreditation, improving workforce sexual safety, and increasing understanding of neurodivergence in the workplace. We have also continued our #ChooseRespect communication campaign to improve reporting of incidents of violence and aggression towards our staff whilst continuing to support those affected and progressing recommendations from a review to support the reduction in incidents. We have also seen further use of Adjustment Passports to support staff with long-term health conditions and have updated our attendance management guidance to improve the experience of staff with long term health conditions.

We embrace NHS equality frameworks and respond positively to the Workforce Disability Equality Standard (WDES); Workforce Race Equality Standard (WRES); Gender Pay Gap, Ethnicity Pay Gap and Equality Delivery System (EDS2) with outcomes being used to inform our plans. We have also undertaken our usual annual review of our Modern Slavery and Human Trafficking Statement.

EDI performance is monitored by the People and Culture Steering Group, which reports to the People and Culture Management Group and Hospital Management Group. Equality reports are considered for assurance 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 2025)

Table 1: Trust Wide Data

NHS Staff Survey 2025 – Trust Wide	Best Trust	Average	JPUH 2025	JPUH 2024
We are compassionate and inclusive	7.7	7.3	7.1	7.1
Equal opportunity career development and progression	65.6%	53.0%	51.4%	52.7%
Discrimination – patients/public	3.0%	8.6%	9.8%	9.1%
Discrimination – manager/staff	4.5%	8.7%	10.3%	10.7%

Table 2: Workforce Disability Equality Standard (WDES)

NHS Staff Survey 2025 – Trust Wide	LTC Average	JPUH 2025	JPUH 2024
Equal opportunities for career progression or promotion	47.8%	46.8%	48.1%
Bullying and Harassment – patients/public	29.1%	35.6%	30.2%
Bullying and Harassment - manager	14.1%	19.2%	13.8%
Bullying and Harassment - colleague	24.5%	31.6%	27.0%
Reporting Bullying and Harassment	53.2%	56.2%	50.2%
Felt pressure to come to work despite not feeling well enough	27.2%	29.5%	25.4%
Organisation values their work	32.1%	29.5%	34.1%
Provision of reasonable adjustments	73.7%	73.2%	76.1%

Table 3: Workforce Race Equality Standard (WRES)

NHS Staff Survey 2025 – Trust Wide	BME Average	JPUH 2025	JPUH 2024
Equal opportunities for career progression or promotion	49.1%	46.3%	47.8%
Bullying and Harassment – patients/public	29.0%	38.4%	33.5%
Bullying and Harassment – staff/manager	24.1%	33.7%	32.6%
Discrimination – manager or other colleague	14.7%	25.2%	24.4%

Gender Pay Gap

Organisations with 250 or more employees are mandated by the government to report annually on their gender pay gap. The requirements of the mandate within the Equality Act 2010 (Gender Pay Gap Information) Regulations 2017, are to publish information relating to pay for six specific measures as detailed in this report.

The report is based on the Government's methodology for calculating difference in pay between female and male employees, considering full pay relevant employees of James Paget University Hospital NHS Trust.

The most recent report Gender Pay Gap report is available on the Trust's website here:

<https://www.jpaget.nhs.uk/about-us/equality-diversity-and-inclusion/>

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 activities are free from ethical and labour standards abuses.

The Trust provides services from its main hospital site in Gorleston-on-Sea, Norfolk and a small number of other local sites.

Policies, procedures, governance and legal arrangements are robust, to ensure that proper checks and due diligence are applied in employment procedures maintaining 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. Mandatory training for all staff includes awareness and consideration of duties in relation to modern slavery and human trafficking, taking appropriate action in relation to any concerns and working with partner organisations where relevant. The Trust's safeguarding policies provide further guidance and clear reporting procedures, and the Trust has adopted the NHS Freedom to Speak Up Policy. These policies are reviewed every three years as a minimum.

Over the last year, the Trust has also continued to embed an external independent Guardian Service for improved staff assurance in raising any concerns; and held a training webinar on slavery and human trafficking led by Norfolk Constabulary, which was recorded and continues to be available for education and awareness. In addition, the Safeguarding Team is available to colleagues, providing specialist advice 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 have continued to take the following steps:

- Included specific clauses that reflect our obligations under the Modern Slavery Act 2015 in terms and conditions for supply, with use of the NHS Standard Contract templates whenever possible.
- Included pass/fail criteria for Procurement led tender processes and new vendor requests.
- Upskilled the Procurement and Supplies Team on the implications of the Act in order that they can support the wider organisation on its implementation.
- Communicated to all high risk suppliers providing an overview of the legislation, stating our intent and expectations.
- Included a specific right to audit against the obligations of the Modern Slavery Act 2015 for

those contracts deemed to be of high risk.

- Ensured suppliers engaged outside the normal procurement processes comply with the Modern Slavery Act 2015.
- Ensured staff and other workers employed directly by the Trust are paid at or above National Minimum Wage requirements and in line with NHS terms and conditions (where appropriate).
- Committed to referring to the appropriate authorities/agencies any concerns of modern slavery or human trafficking that we may identify.
- Ensured compliance with the Public Contract Regulations 2015.

There have been no reported incidents in the year April 2024 to March 2025.

This statement has been approved by our Hospital Management Group on 17 March 2026 for the year ended 31st March 2026.

Freedom to Speak Up

One of our 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.”

Freedom to Speak Up is about raising anything that gets in the way of providing good care or affects our working environment. This includes, but is not limited to, concerns about patient safety or staff safety. Staff are encouraged to speak up about anything that concerns them at work, whether this relates to behaviours, processes, culture, systems, or ways of working.

Speaking up is vital in helping us improve our services for patients and create a positive, supportive working environment for our staff. Our Board and senior leaders are committed to fostering an open, inclusive and supportive culture.

We have adopted the NHS Freedom to Speak Up Policy, which sets out how staff can raise concerns, the process that will be followed, and the support available. Our policy aligns with NHS England guidance, and we will not tolerate any form of detriment as a result of speaking up.

As of 2024 we have partnered with The Guardian Service Ltd to deliver independent, impartial and confidential Freedom to Speak Up service. The service includes a dedicated Guardian, and staff are able to contact a Guardian 24 hours a day, seven days a week to raise concerns. The Guardian Service is available to listen to any concern a member of staff may have about their work, whether they are seeking reassurance, or support, or wish to raise an issue formally.

There is a swift escalation process to Site Directors in the event of concerns relating to patient or staff safety.

Over the past year, more than one hundred concerns have been raised and resolved through the service.

The Guardian attends the People & Culture Management meeting on a monthly basis, with a detailed report. These reports set out key themes, updates to national guidance, and provide assurance that the Trust’s Freedom to Speak Up arrangements are effective and continuously improving and provide recommendations to the trust.

Speaking up can take courage, and we are therefore committed to nurturing a culture where people feel psychologically safe. Our Just and Learning Culture work, along with the Patient Safety Incident Response Framework, supports this commitment. We continue to conduct learning reviews for all formal employee relations cases and make changes as a result, to support continuous improvement.

The Guardian regularly visits wards and departments and attends events, network and team meetings to raise awareness of Freedom to Speak Up. Posters and flyers have been circulated to ensure staff know who to contact and how, and a screen saver has been introduced across Trust computers. The Guardian has also actively promoted Freedom to Speak Up e learning.

This year, we completed a Freedom to Speak Up assessment and planning tool, which has helped us identify further opportunities to embed a strong speaking up culture across the Trust. This has led to the development of additional e-learning and face-to-face training for staff and leaders.

The Guardian meets quarterly with the Executive Managing Director and monthly with the Director of People and Culture, as well as the Freedom to Speak Up Non-Executive Director. The Guardian and FTSU NED also conduct visits to areas where concerns have been raised, to ensure staff feel listened to and that issues were addressed in a timely and satisfactory way.

We would like to thank everyone who has spoken up over the past year. Every voice matters, and speaking up helps us to listen, learn and improve.

Data and policies

Staff Numbers contracted as at 31 March 2026

Workforce 31.03.26	Female WTE	Male WTE	Total WTE
Directors (excluding non-executives)	3.00	4.05	7.05
Senior Managers	23.96	25.55	49.51
Employees	2757.23	941.43	3698.66
Total	2784.19	971.03	3755.22

Average Staff Numbers – Whole Time Equivalents (WTEs)

Staff Group	Total WTE	Permanent WTE	Other WTE
Medical and Dental	475.33	188.26	287.07
Ambulance Staff	0.00	0.00	0.00
Administration and Estates	1146.40	1038.63	107.77
Healthcare assistants and other support staff	844.41	669.38	175.03
Nursing, midwifery, and health visiting staff	1138.38	1040.32	98.06
Nursing, midwifery, and health visiting learners	5.87	0.06	5.81
Scientific, therapeutic, and technical staff	328.79	306.34	22.45
Healthcare science staff	43.43	41.95	1.48
0.00	0.00	0.00	0.00
697.66	0.00	0.00	
Total Average numbers (WTE)	3982.62	3284.94	

Figures are subject to audit

Staff Costs Analysis

Staff costs

	Permanent	Other	2025/26 Total	2024/25 Total
	£000	£000	£000	£000
Salaries and wages	179,881	13,387	193,268	186,021
Social security costs	23,543	1,248	24,791	19,885
Apprenticeship levy	1,427	-	1,427	931
Employer's contributions to NHS pension scheme	34,985	1,632	36,617	35,041
Pension cost - other	37	-	37	35
Other post employment benefits	-	-	-	-
Other employment benefits	-	-	-	-
Termination benefits	-	-	-	-
Temporary staff	-	4,432	4,432	8,495
Total gross staff costs	239,873	20,699	260,572	250,408
Recoveries in respect of seconded staff	(16)	-	(16)	(64)
Total staff costs	239,857	20,699	260,556	250,344
Of which				
Costs capitalised as part of assets	3,114	-	3,114	2,701

Figures are subject to audit

Average number of employees (WTE basis)

Average number of employees (WTE basis)

	Permanent	Other	2025/26 Total	2024/25 Total
	Number	Number	Number	Number
Medical and dental	188	287	475	471
Ambulance staff	-	-	-	-
Administration and estates	1,039	109	1,147	1,168
Healthcare assistants and other support staff	669	175	844	882
Nursing, midwifery and health visiting staff	1,040	98	1,138	1,157
Nursing, midwifery and health visiting learners	0	6	6	9
Scientific, therapeutic and technical staff	306	22	329	331
Healthcare science staff	42	1	43	37
Social care staff	-	-	-	-
Other	-	-	-	-
Total average numbers	3,284	698	3,982	4,055
Of which:				
Number of employees (WTE) engaged on capital projects	46	-	46	38

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. This includes 24/7 access to wellbeing services and resources via our 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. In the last year, we have re-launched our Wellbeing Champion network and introduced a new Trauma Risk Management Service (TRiM) with four TRiM trained practitioners. TRiM is a trauma-focused peer support system which works in line with the PTSD management guidelines produced by NICE. TRiM training provides

practitioners with a background understanding of psychological trauma and its effects. In addition, the Trust has over forty nurses trained as Professional Nurse Advocates to support the resilience of our nursing workforce but they are also available to the wider workforce. Our annual staff appraisal discussions also include a focus on wellbeing as an integral element.

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

Sickness Absence	2025/26
Percentage of Long-Term Sick (over 28 days)	3.64%
Percentage of Short Term	2.11%
Average Working Days Lost (ESRBI Average Days (FTE) per FTE) – Full Time Equivalent	17.40%
Percentage of staff with no sick leave	16.87%

Top Sickness Reasons	Year 2025/26	
	% (of all Sickness)	% (of all fte available)
S10 Anxiety/stress/depression/other psychiatric illnesses	29.63%	1.70%
S25 Gastrointestinal problems	11.01%	0.63%
S12 Other musculoskeletal problems	10.03%	0.58%
S13 Cold, Cough, Flu – Influenza	9.41%	0.54%
S28 Injury / fracture	7.55%	0.43%

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, but are not limited to:

- **Recruitment, Equity and Diversity and Managing Attendance Policies** – for giving full and fair consideration to applications for employment; setting our expectations regarding anti-discriminatory and inclusive behaviour in the workplace; and supporting staff who require time absent from work due to ill health.
- **Just and Learning Workplace Policy** – this policy has been developed in partnership with our local StaffSide (trade union representative) 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 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 6.2% is below the average for NHS acute hospitals and we have good workforce stability with 92% of staff 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, which we review on an annual basis. We provide and promote a range of flexible working options to support people's work/life balance and partial or full retirement. In addition to offering 'stay' conversations and exit discussions, all leavers are sent an exit questionnaire to provide feedback on their reasons for leaving and experience of working for the Trust to inform learning and improvements.

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 Executive Managing Director 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.
- Executive Managing Director's Briefings – Monthly in person and online briefings 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.
- Top leaders Programme – Monthly event to engage leaders in conversation

about the issues that they and their teams are experiencing and how these can be addressed together.

- Staff Networks – Executive sponsored networks focused on issues relevant to protected characteristic groups.
- Your Voice – Listening and engagement sessions held regularly across all division.
- Executive Managing Director's Breakfast Sessions – These are held monthly with invites to staff whose birthday it is in the month. They provide an opportunity for an informal conversation over breakfast with the Executive Managing Director 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. 38.6% of staff completed the survey, which was slightly lower than last year's 40.5%. Responses for bank staff also dropped from 15.8% to 14.5%. However, staff have provided invaluable feedback as to how we can improve engagement, and so we are confident we can reverse this trend for the 2026 survey.

At a Trust level, we held our scores for the We Are Safe and Healthy, and We Are A Team, People Promise themes, but saw a slight decline for all other themes, as well as Staff Engagement and Morale.

2024 and 2025

Scores for each indicator together with that of the average NHS results are presented below.

Theme	2025		2024	
	JPUH	NHS average	JPUH	NHS average
We are compassionate and inclusive	7.11	7.28	7.07	7.21
We are recognised and rewarded	5.72	5.87	5.75	5.92
We each have a voice that counts	6.42	6.6	6.5	6.67
We are safe and healthy	5.83	6.07	5.8	6.09
We are always learning	5.31	5.57	5.47	5.64
We work flexibly	6.18	6.22	6.36	6.24
We are a team	6.53	6.75	6.53	6.74
Staff Engagement	6.59	6.74	6.68	6.84
Morale	5.63	5.84	5.71	5.93

2025

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 2024	Trust 2025	Change ▼
Diversity and equality	8.31	8.31	0.33
Negative experiences	7.70	7.70	0.18
Burnout	4.80	4.80	0.06
Line management	6.66	6.66	0.03
Compassionate leadership	6.83	6.83	0.03
Work pressure	4.83	4.83	0.03
Inclusion	6.63	6.63	0.01
We are recognised and rewarded	5.74	5.74	-0.01
Team working	6.40	6.40	-0.02
Stressors	6.16	6.16	-0.02
Negative or Low Change Areas	Trust 2024	Trust 2025	Change ▲
Thinking about leaving	5.88	5.88	-0.27
Advocacy	6.36	6.36	-0.23
Development	6.07	6.07	-0.20
Flexible working	6.22	6.22	-0.19
Appraisals	4.48	4.48	-0.19

Future priorities and targets

Whilst our Staff Survey results have shown improvement in a number of areas, our People Plan sets out our commitment to having an unrelenting focus on staff experience. We have an annually reviewed Staff Experience Plan with delivery being overseen by a Staff Experience Programme Board. The work over the last year has included Wellbeing Fundamentals (regular breaks, annual leave, wellbeing conversations), the relaunch of our wellbeing champions network and the start of a service to support staff who have experienced traumatic events at work. We have also built on existing work relating to a Just and Learning Culture, an Inclusive Workplace, Fair Recruitment and reducing violence and aggression towards staff.

We are committed to continuing to improve 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 three years. Our priorities for 2025/26 are to improve staff wellbeing through improved psychological and physical health support services, to drive down sickness absence; improving staff engagement by providing more ways for staff voices to be heard and their feedback acted upon; and increase the opportunities available to staff to learn and develop in their career. We will also continue our work to improve leadership and management across the Trust and reduce violence and aggression experienced by staff.

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 Executive Managing Director and the Director of People and Culture meet regularly with the StaffSide Chair and the StaffSide Secretary. We also hold regular 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

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.

Number of off-payroll workers engaged during the year ended 31 March 2026	2025/26
	Number of engagements
No of existing engagements as of 31 March 2026	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 fifty one staff exit packages during 2025/26.

Reporting of compensation schemes - exit packages 2025/26

	Number of compulsory redundancies Number	Number of other departures agreed Number	Total number of exit packages Number
Exit package cost band (including any special payment element)			
<£10,000	-	29	29
£10,000 - £25,000	-	12	12
£25,001 - 50,000	-	7	7
£50,001 - £100,000	-	3	3
£100,001 - £150,000	-	-	-
£150,001 - £200,000	-	-	-
>£200,000	-	-	-
Total number of exit packages by type	-	51	51
Total cost (£)	£0	£919,017	£919,017

Figures are subject to audit

Reporting of compensation schemes - exit packages 2024/25

Reporting of compensation schemes - exit packages 2024/25

	Number of compulsory redundancies Number	Number of other departures agreed Number	Total number of exit packages Number
Exit package cost band (including any special payment element)			
<£10,000	-	9	9
£10,000 - £25,000	-	1	1
£25,001 - 50,000	-	-	-
£50,001 - £100,000	-	-	-
£100,001 - £150,000	-	-	-
£150,001 - £200,000	-	-	-
>£200,000	-	-	-
Total number of exit packages by type	-	10	10
Total resource cost (£)	£0	£59,807	£59,807

Exit packages: non-compulsory departure payments

Exit packages: other (non-compulsory) departure payments

	2025/26		2024/25	
	Payments agreed Number	Total value of agreements £000	Payments agreed Number	Total value of agreements £000
Voluntary redundancies including early retirement contractual costs	9	441	-	-
Mutually agreed resignations (MARS) contractual costs	23	392	-	-
Early retirements in the efficiency of the service contractual costs	-	-	-	-
Contractual payments in lieu of notice	19	86	10	60
Exit payments following Employment Tribunals or court orders	-	-	-	-
Non-contractual payments requiring HMT / DHSC approval	-	-	-	-
Total	51	919	10	60
Of which:				
Non-contractual payments requiring HMT / DHSC approval made to individuals where the payment value was more than 12 months' of their annual salary	-	-	-	-

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 2025/26 which had a contract value greater than £50,000 in relation to advice provided to the Trust. These were provided by Hunter Healthcare (£245,188) and Reliable Business Solutions (£64,998), both of which were used for consulting on financial recovery.

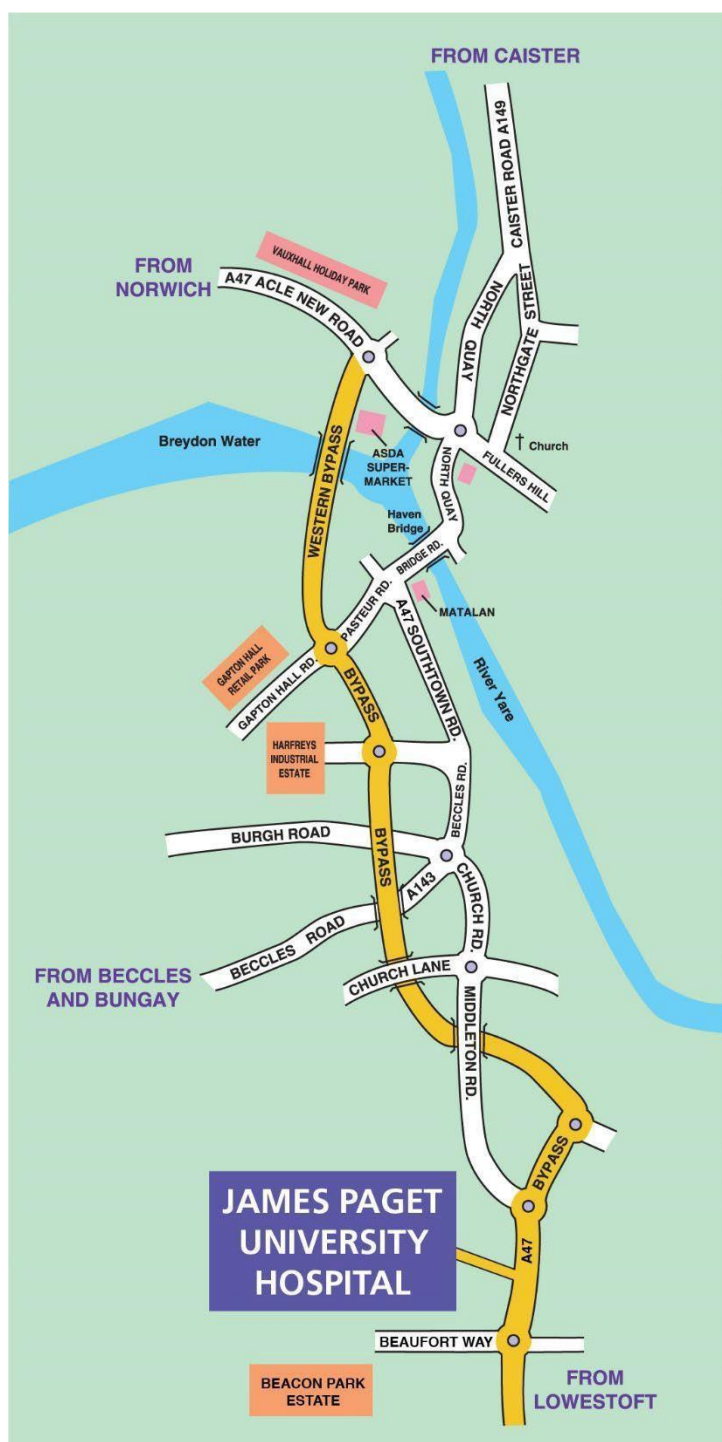
Total expenditure on management consultancy during the year was £1,716,079 (2024/25: £360,455).

Glossary and Key to Abbreviations

AHP	Allied Health Professional
Acute	Rapid onset, severe symptoms, and brief duration
Audit adjustment BAF	A continuous process of assessment, evaluation, and 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



James Paget
University
Hospitals NHS
Foundation Trust

Lowestoft Road Gorleston
Great Yarmouth Norfolk
NR31 6LA

01493 452452

Website: www.jpaget.nhs.uk

For queries on this report, the Board,
Governors, and membership
foundationtrust@jpaget.nhs.uk

Communications:

communications@jpaget.nhs.uk

Governors:

governors@jpaget.nhs.uk

Twitter: @JamesPagetNHS

Facebook:

@jamespagetuniversityhospital

Also available on LinkedIn and
Instagram

Patient Advice and Liaison Service

01493 453240

PALS@jpaget.nhs.uk

Proud
of the
Paget

NHS

**James Paget
University Hospitals**
NHS Foundation Trust

FINANCIAL STATEMENTS

FOR THE
YEAR ENDED
31 MARCH 2026



Foreword to the accounts

James Paget University Hospitals NHS Foundation Trust

These accounts, for the year ended 31 March 2026, have been prepared by James Paget University Hospitals NHS Foundation Trust in accordance with paragraphs 24 & 25 of Schedule 7 within the National Health Service Act 2006.



Signed

Professor Lesley Dwyer
Group Chief Executive
25 June 2026

Statement of Comprehensive Income

Statement of Comprehensive Income

		2025/26	2024/25
	Note	£000	£000
Operating income from patient care activities	3	359,338	338,236
Other operating income	4	20,258	24,351
Operating expenses	7,9	(386,071)	(377,563)
Operating surplus/(deficit) from continuing operations		(6,475)	(14,976)
Finance income	11	1,775	1,396
Finance expenses	12	(60)	(96)
PDC dividends payable		(2,488)	(2,505)
Net finance costs		(773)	(1,205)
Other gains / (losses)	13	(8)	(156)
Surplus / (deficit) for the year		(7,256)	(16,337)
Other comprehensive income			
Will not be reclassified to income and expenditure:			
Impairments	8	(106)	(720)
Revaluations	18	198	-
Total other comprehensive income / (expense) for the period		92	(720)
Total comprehensive income / (expense) for the period		(7,164)	(17,058)

Statement of Financial Position

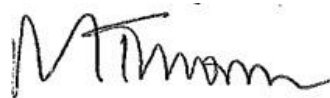
		31 March 2026 £000	31 March 2025 £000
	Note		
Non-current assets			
Intangible assets	15	20,186	14,711
Property, plant and equipment	16	149,322	131,276
Right of use assets	19	2,141	1,531
Receivables	22	468	568
Total non-current assets		172,117	148,086
Current assets			
Inventories	21	3,555	3,694
Receivables	22	16,405	13,137
Non-current assets for sale and assets in disposal groups	23	650	-
Cash and cash equivalents	24	44,315	39,426
Total current assets		64,925	56,257
Current liabilities			
Trade and other payables	25	(48,486)	(49,444)
Borrowings	27	(752)	(939)
Provisions	28	(342)	(360)
Other liabilities	26	(8,432)	(3,727)
Total current liabilities		(58,012)	(54,470)
Total assets less current liabilities		179,030	149,873
Non-current liabilities			
Borrowings	27	(1,011)	(657)
Provisions	28	(668)	(704)
Total non-current liabilities		(1,679)	(1,361)
Total assets employed		177,351	148,512
Financed by			
Public dividend capital		256,034	220,031
Revaluation reserve		2,219	2,127
Income and expenditure reserve		(80,902)	(73,646)
Total taxpayers' equity		177,351	148,512

The notes on pages 120 to 159 form part of these accounts.

The financial statements were approved by the Board on 25 June 2026 and signed on its behalf by:



Professor Lesley Dwyer
Group Chief Executive



Marcus Thorman
Group Chief Finance Officer

Statement of Changes in Taxpayers' Equity

	Public dividend capital	Revaluation reserve	Income and expenditure reserve	Total
	£000	£000	£000	£000
Taxpayers' equity at 1 April 2025 - brought forward	220,031	2,127	(73,646)	148,512
Surplus/(deficit) for the year	-	-	(7,256)	(7,256)
Impairments	-	(106)	-	(106)
Revaluations	-	198	-	198
Public dividend capital received	36,534	-	-	36,534
Public dividend capital repaid	(531)	-	-	(531)
Taxpayers' equity at 31 March 2026	256,034	2,219	(80,902)	177,351

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

	Public dividend capital	Revaluation reserve	Income and expenditure reserve	Total
	£000	£000	£000	£000
Taxpayers' equity at 1 April 2024 - brought forward	162,365	2,847	(57,309)	107,903
Surplus/(deficit) for the year	-	-	(16,337)	(16,337)
Impairments	-	(720)	-	(720)
Public dividend capital received	57,666	-	-	57,666
Taxpayers' equity at 31 March 2025	220,031	2,127	(73,646)	148,512

Information on reserves

Public dividend capital

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

Revaluation reserve

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

Income and expenditure reserve

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

Statement of Cash Flows

	Note	2025/26 £000	2024/25 £000
Cash flows from operating activities			
Operating surplus / (deficit)		(6,475)	(14,976)
Non-cash income and expense:			
Depreciation and amortisation	7.1	12,864	12,017
Net impairments	8	10,100	16,009
Income recognised in respect of capital donations	4	(1,728)	(89)
(Increase) / decrease in receivables and other assets		(3,830)	1,491
(Increase) / decrease in inventories		138	(225)
Increase / (decrease) in payables and other liabilities		5,869	3,935
Increase / (decrease) in provisions		(74)	(44)
Net cash flows from / (used in) operating activities		16,864	18,118
Cash flows from investing activities			
Interest received		1,758	1,404
Purchase of intangible assets		(3,976)	(9,698)
Purchase of PPE and investment property		(44,247)	(57,801)
Receipt of cash donations to purchase assets		1,369	87
Net cash flows from / (used in) investing activities		(45,096)	(66,008)
Cash flows from financing activities			
Public dividend capital received		36,534	57,666
Public dividend capital repaid		(531)	-
Capital element of lease rental payments		(1,033)	(1,832)
Interest paid on lease liability repayments		(40)	(73)
PDC dividend (paid) / refunded		(1,809)	(3,016)
Net cash flows from / (used in) financing activities		33,121	52,745
Increase / (decrease) in cash and cash equivalents		4,889	4,855
Cash and cash equivalents at 1 April - brought forward		39,426	34,571
Cash and cash equivalents at 31 March	24.1	44,315	39,426

Notes to the Accounts

Note 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 2025-26, issued by the Department of Health and Social Care. The accounting policies contained in the GAM follow International Financial Reporting Standards to the extent that they are meaningful and appropriate to the NHS, as determined by HM Treasury, which is advised by the Financial Reporting Advisory Board. Where the 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 2025-26. These Standards are still subject to HM Treasury FReM adoption.

- IFRS 14 Regulatory Deferral Accounts - Not UK-endorsed. Applies to first time adopters of IFRS after 1 January 2016. Therefore, not applicable to DHSC group bodies.
- IFRS 18 Presentation and Disclosure in Financial Statements - Application required for accounting periods beginning on or after 1 January 2027. Standard is not yet UK endorsed and not yet adopted by the FReM. Early adoption is not permitted.
- IFRS 19 Subsidiaries without Public Accountability: Disclosures - Application required for accounting periods beginning on or after 1 January 2027. Standard is not yet UK endorsed and not yet adopted by the FReM. 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:

- External Valuation where reliance has been placed on the valuation report as at 31 March 2026, as this represents the best available evidence of current value. Further details included in note 17.
- 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.
- An enhanced desktop valuation of land and building assets was carried out by Montagu Evans LLP, and was applied on 31 March 2026 based on an alternate site, modern equivalent asset basis.
- 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 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.

Notes to the Accounts

continued

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 Trust has reviewed the materiality of the charitable funds in accordance with IFRS 10 and the DHSC Group Accounting Manual.

With effect from 1 April 2025, although the Trust remains corporate trustee and retains control, the charitable funds are no longer material to the Trust's financial statements.

Therefore, the Trust has ceased to consolidate the NHS charitable funds in 2025/26.

This is a change in accounting assessment rather than a transfer of control.

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 is not coterminous.

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 Income, 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). The NHSPS sets out rules to establish the amount payable to Trusts for NHS-funded secondary healthcare.

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

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

The Trust also receives income from commissioners under 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 Aligned Payment Incentive (API) contracts and paid in line with actual activity performed.

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

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

Notes to the Accounts

continued

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.

Payment terms are standard reflecting cross government principles.

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 apprenticeship service account held by the Department for Education, the corresponding notional expense is also recognised at the point of recognition for the benefit.

1.4 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.

Notes to the Accounts

continued

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 carried out 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.

1.8.2 Subsequent expenditure

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

1.8.3

Valuation

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

Notes to the Accounts

continued

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 carried out by Montagu Evans LLP, and was applied on 31 March 2026.
- 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 Income.

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 tested 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.

Notes to the Accounts

continued

1.9 Intangible assets

1.9.1 Recognition

Intangible assets are non-monetary assets without physical substance controlled by the Trust. They are capable of being sold separately from the rest of the Trust's business or arise from contractual or other legal rights. Intangible assets are recognised only 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 where it meets recognition criteria.

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.

Notes to the Accounts

continued

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.

Where an implicit rate cannot be readily determined, the Trust's incremental borrowing rate is applied. This rate is determined by HM Treasury annually for each calendar year. A nominal rate of 4.72% applied to new leases commencing in 2025 and 5.32% to new leases commencing in 2026.

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.

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.

Notes to the Accounts

continued

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 2.95% (2024/25: 2.40%) 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	3.64%	4.03%
Medium-term	After 5 years up to 10 years	4.22%	4.07%
Long-term	After 10 years up to 40 years	5.32%	4.81%
Very long-term	Exceeding 40 years	5.07%	4.55%

HM Treasury provides discount rates for general provisions on a nominal rate basis. Expected future cash flows are therefore adjusted for the impact of inflation before discounting using nominal rates. The following inflation rates are set by HM Treasury, as at 31 March 2026:

	Inflation rate	Prior year rate
Year 1	3.64%	4.03%
Year 2	4.22%	4.07%
Into perpetuity	5.32%	4.81%

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 28.2 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 29).

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.

Notes to the Accounts

continued

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

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

1.18 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 Income 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 24.2 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 handled.

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

1.21 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.

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

The DHSC GAM does not require the following IFRS Standards to be applied in 2025/26:

IFRS 14 Regulatory Deferral Accounts - The standard is not UK-endorsed. Applies to first time adopters of IFRS after 1 January 2016. Therefore, not applicable to DHSC group bodies.

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

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

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

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

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

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

The impact of applying these changes in future periods has not yet been assessed. PPE and right of use assets currently subject to revaluation have a total book value of £79.0m as at 31 March 2026.

The revised valuation assumption may have a material or significant impact on PPE measurement in future periods

Notes to the Accounts

continued

Note 2 Operating Segments

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

The products and services provided to external customers are identified in notes 3.1 and 3.2 below under the headings “Income from activities 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.

Notes to the Accounts

continued

Note 3 Operating income from patient care activities

All income from patient care activities relates to contract income recognised in line with accounting policy 1.3

Note 3.1 Income from patient care activities (by nature)	2025/26	2024/25
	£000	£000
Acute services		
Income from commissioners under API contracts - variable element*	89,084	83,568
Income from commissioners under API contracts - fixed element*	225,369	219,862
High cost drugs income from commissioners	12,923	10,817
Other NHS clinical income	15,751	7,846
All services		
Private patient income	720	610
National pay award central funding***	-	658
Additional pension contribution central funding**	14,491	13,864
Other clinical income	1,000	1,011
Total income from activities	359,338	338,236

*Aligned payment and incentive contracts are the main form of contracting between NHS providers and their commissioners. More information can be found in the 2025/26 NHS Payment Scheme documentation.

<https://www.england.nhs.uk/pay-syst/nhs-payment-scheme/>

**Increases to the employer contribution rate for NHS pensions since 1 April 2019 have been funded by NHS England. NHS providers continue to pay at the former rate of 14.38% with the additional amount being paid over by NHS England on providers' behalf. The full cost of employer contributions (23.7%) and related NHS England funding (9.4%) have been recognised in these accounts.

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

Note 3.2 Income from patient care activities (by source)

Note 3.2 Income from patient care activities (by source)	2025/26	2024/25
	£000	£000
Income from patient care activities received from:		
NHS England	29,841	27,824
Integrated care boards	324,099	303,702
Other NHS providers	3,678	5,089
Local authorities	150	183
Non-NHS: private patients	720	610
Non-NHS: overseas patients (chargeable to patient)	282	199
Injury cost recovery scheme	511	600
Non NHS: other	57	29
Total income from activities	359,338	338,236
Of which:		
Related to continuing operations	359,338	338,237
Related to discontinued operations	-	-

Notes to the Accounts

continued

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

	2025/26	2024/25
	£000	£000
Income recognised this year	282	199
Cash payments received in-year	33	39
Amounts added to provision for impairment of receivables	109	129
Amounts written off in-year	479	6

Note 4 Other operating income

	2025/26			2024/25		
	Contract income	Non-contract income	Total	Contract income	Non-contract income	Total
	£000	£000	£000	£000	£000	£000
Research and development	1,075	-	1,075	1,060	-	1,060
Education and training	12,572	1,058	13,630	11,834	1,001	12,835
Non-patient care services to other bodies	2,402		2,402	2,622		2,622
Receipt of capital grants and donations and peppercorn leases		1,728	1,728		89	89
Charitable and other contributions to expenditure		151	151		147	147
Revenue from operating leases		332	332		316	316
Other income	940	-	940	7,282	-	7,282
Total other operating income	16,989	3,269	20,258	22,798	1,553	24,351
Of which:						
Related to continuing operations			20,258			24,351

Notes to the Accounts

continued

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

	2025/26	2024/25
	£000	£000
Revenue recognised in the reporting period that was included in within contract liabilities at the previous period end	1,694	1,791
Revenue recognised from performance obligations satisfied (or partially satisfied) in previous periods	149	31

Note 5.2 Transaction price allocated to remaining performance obligations

	31 March	31 March
	2026	2025
	£000	£000
Revenue from existing contracts allocated to remaining performance obligations is expected to be recognised:		
within one year	1,937	3,092
Total revenue allocated to remaining performance obligations	1,937	3,092

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

Notes to the Accounts

continued

Note 6 Operating leases - James Paget University Hospitals NHS Foundation Trust as lessor

This note discloses income generated in operating lease agreements where James Paget University Hospitals NHS Foundation Trust is the lessor.

The Trust acts as a lessor primarily in respect of property leases, including the letting of vacant or surplus estate, staff accommodation, and other non-clinical premises. Lease arrangements are generally classified as operating leases and rentals are recognised on a straight-line basis over the lease term.

The Trust retains ownership of the underlying assets and manages risks associated with residual values and asset condition through regular property inspections, planned maintenance programmes, lease terms that include appropriate repair and reinstatement obligations, and periodic review of market conditions. Credit risk is managed through standard tenant vetting processes and ongoing monitoring of lessee performance.

Note 6.1 Operating lease income

	2025/26 £000	2024/25 £000
Lease receipts recognised as income in year:		
Minimum lease receipts	332	316
Total in-year operating lease income	332	316

Note 6.2 Future lease receipts

	31 March 2026 £000	31 March 2025 £000
Future minimum lease receipts due in:		
- not later than one year	330	303
- later than one year and not later than two years	172	190
- later than two years and not later than three years	172	190
- later than three years and not later than four years	172	190
- later than four years and not later than five years	172	190
- later than five years	394	547
Total	1,412	1,610

Notes to the Accounts

continued

Note 7.1 Operating expenses

	2025/26	2024/25
	£000	£000
Purchase of healthcare from NHS and DHSC bodies	6,855	6,874
Purchase of healthcare from non-NHS and non-DHSC bodies	7,595	9,798
Staff and executive directors costs	256,992	247,643
Remuneration of non-executive directors	119	136
Supplies and services - clinical (excluding drugs costs)	28,715	27,619
Supplies and services - general	3,966	4,312
Drug costs (drugs inventory consumed and purchase of non-inventory drugs)	27,554	26,508
Inventories written down	216	158
Consultancy costs	1,716	360
Establishment	1,924	2,336
Premises	11,750	10,688
Transport (including patient travel)	181	259
Depreciation on property, plant and equipment	11,395	10,560
Amortisation on intangible assets	1,469	1,457
Net impairments	10,100	16,009
Movement in credit loss allowance: contract receivables / contract assets	1,078	190
Movement in credit loss allowance: all other receivables and investments	134	187
Change in provisions discount rate(s)	(43)	13
Fees payable to the external auditor audit services- statutory audit	260	180
Internal audit costs	143	138
Clinical negligence	9,691	8,911
Legal fees	132	209
Insurance (as a policy holder)	225	216
Education and training	2,724	2,468
Expenditure on short term leases	75	50
Expenditure on low value leases	34	25
Redundancy	450	-
Losses, ex gratia & special payments	15	18
Other services, eg external payroll	486	369
Other	120	(128)
Total	386,071	377,563
Of which:		
Related to continuing operations	386,071	377,563

Note 7.2 Other auditor remuneration

The limitation on auditor's liability for external audit work is £1,000k (2024/25: £1,000k).

Notes to the Accounts

continued

Note 8 Impairment of assets

	2025/26	2024/25
	£000	£000
Net impairments charged to operating surplus / deficit resulting from:		
Changes in market price	10,100	16,009
Total net impairments charged to operating surplus / deficit	10,100	16,009
Impairments charged to the revaluation reserve	106	720
Total net impairments	10,206	16,729

During the year, the Trust recognised impairment losses in relation to land and buildings arising from the annual revaluation exercise. The impairments reflect changes in market conditions, including movements in land and property values and updated assumptions used by the external valuer, resulting in a reduction in the carrying value of certain assets.

Impairments have been recognised where the revalued amount of an asset was below its carrying value. Amounts have been charged to the Statement of Comprehensive Income where no revaluation surplus existed for the asset, with the balance charged against the Revaluation Reserve where appropriate. The assets impaired relate to operational land and buildings and the recoverable amounts were measured at existing use value, in line with the RICS Red Book and Department of Health and Social Care guidance.

Note 9 Employee benefits

	2025/26	2024/25
	Total	Total
	£000	£000
Salaries and wages	193,268	186,021
Social security costs	24,791	19,885
Apprenticeship levy	1,427	931
Employer's contributions to NHS pensions	36,617	35,042
Pension cost - other	37	34
Temporary staff (including agency)	4,432	8,495
Total gross staff costs	260,572	250,407
Recoveries in respect of seconded staff	(16)	(64)
Total staff costs	260,556	250,343
Of which		
Costs capitalised as part of assets	3,114	2,701

Note 9.1 Retirements due to ill-health

During 2025/26 there were 5 early retirements from the trust agreed on the grounds of ill-health (4 in the year ended 31 March 2025). The estimated additional pension liabilities of these ill-health retirements is £213k (£68k in 2024/25).

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

Notes to the Accounts

continued

Note 10 Pension costs

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

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

a) Accounting valuation

A valuation of scheme liability is carried out annually by the scheme actuary (currently the Government Actuary's Department) as at the end of the reporting period. This utilises an actuarial assessment for the previous accounting period in conjunction with updated membership and financial data for the current reporting period, and is accepted as providing suitably robust figures for financial reporting purposes. The valuation of the scheme liability as at 31 March 2026, is based on valuation data as at 31 March 2024, updated to 31 March 2026 with summary global member and accounting data. In undertaking this actuarial assessment, the methodology prescribed in IAS 19, relevant FReM interpretations, and the discount rate prescribed by HM Treasury have also been used.

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

b) Full actuarial (funding) valuation

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

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

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

Notes to the Accounts

continued

Note 11 Finance income

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

	2025/26	2024/25
	£000	£000
Interest on bank accounts	1,775	1,396
Total finance income	1,775	1,396

Note 12.1 Finance expenditure

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

	2025/26	2024/25
	£000	£000
Interest expense:		
Interest on lease obligations	40	73
Total interest expense	40	73
Unwinding of discount on provisions	20	23
Total finance costs	60	96

Note 12.2 The late payment of commercial debts (interest) Act 1998

	2025/26	2024/25
	£000	£000
Total liability accruing in year under this legislation as a result of late payments	-	-
Amounts included within interest payable arising from claims made under this legislation	-	-
Compensation paid to cover debt recovery costs under this legislation	-	-

Note 13 Other gains / (losses)

	2025/26	2024/25
	£000	£000
Gains on disposal of assets	-	-
Losses on disposal of assets	(8)	(156)
Total other gains / (losses)	(8)	(156)

Note 14 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 3.1 is £1,578,000 (2024/25 £1,599,000), and included within operating expenses in note 7 is £4,095,000 (2024/25 £3,906,000).

Notes to the Accounts

continued

Note 15.1 Intangible assets - 2025/26

	Software licences £000	Websites £000	Intangible assets under construction £000	Total £000
Cost at 1 April 2025 - brought forward *	10,492	61	9,823	20,376
Additions	1,205	-	5,121	6,326
Reclassifications	423	-	204	627
Disposals / derecognition	(158)	-	-	(158)
Cost at 31 March 2026	11,962	61	15,148	27,171
Amortisation at 1 April 2025 - brought forward	5,605	60	-	5,665
Provided during the year	1,468	1	-	1,469
Disposals / derecognition	(149)	-	-	(149)
Amortisation at 31 March 2026	6,924	61	-	6,985
Net book value at 31 March 2026	5,038	-	15,148	20,186
Net book value at 1 April 2025	4,887	1	9,823	14,711

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

Note 15.2 Intangible assets - 2024/25

	Software licences £000	Websites £000	Intangible assets under construction £000	Total £000
Valuation / gross cost at 1 April 2024 - as previously stated	11,485	61	1,339	12,885
Additions	738	-	7,750	8,488
Reclassifications	677	-	734	1,411
Disposals / derecognition	(2,409)	-	-	(2,409)
Valuation / gross cost at 31 March 2025	10,492	61	9,823	20,376
Amortisation at 1 April 2024 - as previously stated	6,508	53	-	6,561
Provided during the year	1,449	7	-	1,456
Reclassifications	57	-	-	57
Disposals / derecognition	(2,409)	-	-	(2,409)
Amortisation at 31 March 2025	5,605	60	-	5,665
Net book value at 31 March 2025	4,887	1	9,823	14,711
Net book value at 1 April 2024	4,977	8	1,339	6,324

Notes to the Accounts

continued

Note 16.1 Property, plant and equipment - 2025/26

	Land £000	Buildings excluding dwellings £000	Dwellings £000	Assets under construction £000	Plant & machinery £000	Transport equipment £000	Information technology £000	Furniture & fittings £000	Total £000
Valuation/gross cost at 1 April 2025 - brought forward	1,956	65,496	1,590	39,705	31,601	409	11,096	2,130	153,983
Additions	-	-	-	35,359	3,916	14	487	-	39,776
Impairments	(288)	(14,310)	(692)	-	-	-	-	-	(15,290)
Revaluations	-	78	-	-	-	-	-	-	78
Reclassifications	-	26,186	-	(30,243)	866	-	1,730	832	(629)
Transfers to / from assets held for sale	(197)	-	(461)	-	-	-	-	-	(658)
Disposals / derecognition	-	-	-	-	(1,163)	(28)	(312)	(14)	(1,517)
Valuation/gross cost at 31 March 2026	1,471	77,450	437	44,821	35,220	395	13,001	2,948	175,743
Accumulated depreciation at 1 April 2025 - brought forward	-	0	-	-	15,468	305	5,999	935	22,707
Provided during the year	-	5,377	55	-	3,173	29	1,626	184	10,444
Impairments	-	(5,037)	(47)	-	-	-	-	-	(5,084)
Revaluations	-	(119)	-	-	-	-	-	-	(119)
Reclassifications	-	-	-	-	(2)	-	-	-	(2)
Transfers to / from assets held for sale	-	-	(8)	-	-	-	-	-	(8)
Disposals / derecognition	-	-	-	-	(1,163)	(28)	(312)	(14)	(1,517)
Accumulated depreciation at 31 March 2026	-	221	-	-	17,476	306	7,313	1,105	26,421
Net book value at 31 March 2026	1,471	77,229	437	44,821	17,744	89	5,688	1,843	149,322
Net book value at 1 April 2025	1,956	65,496	1,590	39,705	16,133	104	5,097	1,195	131,276

Notes to the Accounts

continued

Note 16.2 Property, plant and equipment - 2024/25

	Land £000	Buildings excluding dwellings £000	Dwellings £000	Assets under construction £000	Plant & machinery £000	Transport equipment £000	Information technology £000	Furniture & fittings £000	Total £000
Valuation / gross cost at 1 April 2024 - as previously stated	2,743	40,063	1,590	48,530	26,038	417	13,505	1,977	134,863
Additions	-	-	-	45,539	3,270	-	639	-	49,448
Impairments	(787)	(20,908)	(34)	-	-	-	-	-	(21,729)
Reversals of impairments	-	131	-	-	-	-	-	-	131
Reclassifications	-	46,210	34	(54,364)	4,685	-	1,713	462	(1,260)
Transfers to / from assets held for sale	-	-	-	-	-	-	-	-	-
Disposals / derecognition	-	-	-	-	(2,392)	(8)	(4,761)	(309)	(7,470)
Valuation/gross cost at 31 March 2025	1,956	65,496	1,590	39,705	31,601	409	11,096	2,130	153,983
Accumulated depreciation at 1 April 2024 - as previously stated	-	-	-	-	15,356	298	9,042	1,123	25,819
Provided during the year	-	4,815	54	-	2,468	15	1,503	120	8,975
Impairments	-	(4,815)	-	-	-	-	-	-	(4,815)
Reversals of impairments	-	-	(54)	-	-	-	-	-	(54)
Reclassifications	-	-	-	-	-	-	96	-	96
Disposals / derecognition	-	-	-	-	(2,356)	(8)	(4,642)	(308)	(7,314)
Accumulated depreciation at 31 March 2025	-	0	-	-	15,468	305	5,999	935	22,707
Net book value at 31 March 2025	1,956	65,496	1,590	39,705	16,133	104	5,097	1,195	131,276
Net book value at 1 April 2024	2,743	40,063	1,590	48,530	10,682	119	4,463	854	109,044

Notes to the Accounts

continued

Note 16.3 Property, plant and equipment financing - 31 March 2026

	Land	Buildings excluding dwellings	Dwellings	Assets under construction	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000	£000
Owned - purchased	1,471	74,942	437	44,821	16,263	89	5,669	1,796	145,488
Owned - donated/granted	-	2,287	-	-	1,481	-	19	47	3,834
Total net book value at 31 March 2026	1,471	77,229	437	44,821	17,744	89	5,688	1,843	149,322

Note 16.4 Property, plant and equipment financing - 31 March 2025

	Land	Buildings excluding dwellings	Dwellings	Assets under construction	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000	£000
Owned - purchased	1,956	62,897	1,590	39,705	15,687	104	5,060	1,135	128,134
Owned - donated/granted	-	2,599	-	-	446	-	37	60	3,142
Total net book value at 31 March 2025	1,956	65,496	1,590	39,705	16,133	104	5,097	1,195	131,276

Notes to the Accounts

continued

Note 17 Donations of property, plant and equipment

During the year, the Trust received donations of property, plant and equipment with a total value of £1,368,000 (2024/25 £88,000). The donated assets comprised a surgical robotic system with a fair value of £1,360,000 and operating theatre lighting equipment with a fair value of £8,000.

The donated assets have been recognised at fair value on receipt and capitalised within property, plant and equipment in accordance with the Group Accounting Manual. The assets are used in the delivery of clinical services.

No donations were received in the form of cash to acquire non-current assets during the year, and therefore no differences arose between cash provided and the fair value of assets acquired.

Note 18 Revaluations of property, plant and equipment

Land, building and dwelling assets were subject to an enhanced desktop valuation carried out by the Trust's externally appointed independent valuers on an alternate site basis as at 31st March 2026.

Of £10,206k net impairments, £10,101k (2024/25 - £16,729k) has been recognised in operating expenses and £106k debit and £198k credit (2024/25 - £720k debit) has been recognised directly in equity during the period.

Assets in existing use:

For specialised properties (i.e. those for which no active market exists), depreciated replacement cost has been used and is considered to be a satisfactory approximation of current value in existing use.

Within this methodology, consistent with previous years, a Modern Equivalent Asset (MEA) approach was undertaken referenced to National Indices acceptable to the RICS. Consideration was given to improvements carried out during the year and where appropriate asset lives were adjusted accordingly based on the remaining useful life (UEL) advised by the Valuer. This had minimal effect on remaining lives. Modern Equivalent Asset (MEA) concept is applied: the "replacement cost" being based on the cost of a modern replacement asset that has the same productive capacity as the property being valued.

Within this methodology, consistent with previous years, a Modern Equivalent Asset (MEA) approach was undertaken referenced to National Indices acceptable to the RICS. Consideration was given to improvements carried out during the year and where appropriate asset lives were adjusted accordingly based on the remaining useful life (UEL) advised by the Valuer. This had minimal effect on remaining lives. Modern Equivalent Asset (MEA) concept is applied: the "replacement cost" being based on the cost of a modern replacement asset that has the same productive capacity as the property being valued.

The valuer has utilised assumptions with the valuation report to determine the conclusion, but responsibility over challenging the assumptions used is management's responsibility. The following assumptions have been utilised in the report:

- Building Cost Information Service (BCIS) Rates – the valuation reflects construction cost increases this year in view of evidence coming through from industry data produced by the RICS BCIS.
- Useful Economic Lives (UEL) - The assessment of remaining life is subjective and is assessed having regard to the age, nature and use of each individual building as well as forming a view on its obsolescence based on economic, functional and physical influences.

Based on the valuation report if there was a 5% positive or negative movement in the valuation of buildings this would have resulted in a movement of £3.4m in the value of assets. This movement would have been reflected in either the revaluation reserve or income and expenditure as a revaluation adjustment as appropriate, however, it would have had no impact of the depreciation charge in year or the underlying reported position.

Note 19 Leases - James Paget University Hospitals NHS Foundation Trust as a lessee

This note details information about leases for which the Trust is a lessee.

The Trust enters into lease arrangements primarily as a lessee to support the delivery of healthcare services. These leases mainly relate to land and buildings, including clinical and non-clinical premises and accommodation, and to a lesser extent items of plant and equipment. Lease terms vary depending on the nature of the underlying asset and the operational requirements of the Trust.

Notes to the Accounts

continued

Note 19.1 Right of use assets - 2025/26

	Property (land and buildings)	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Intangible assets	Total	Of which: leased from DHSC group bodies
	£000	£000	£000	£000	£000	£000	£000	£000
Valuation / gross cost at 1 April 2025 - brought forward	565	5,852	155	2,569	-	-	9,141	-
Additions	1,561	-	-	-	-	-	1,561	360
Reclassifications	(25)	26	25	(26)	-	-	-	-
Disposals / derecognition	-	(3,106)	-	(597)	-	-	(3,703)	-
Valuation/gross cost at 31 March 2026	2,101	2,772	180	1,946	-	-	6,999	360
Accumulated depreciation at 1 April 2025 - brought forward	297	4,972	69	2,272	-	-	7,610	-
Provided during the year	297	475	39	140	-	-	951	3
Reclassifications	(26)	27	(1)	-	-	-	-	-
Disposals / derecognition	-	(3,106)	-	(597)	-	-	(3,703)	-
Accumulated depreciation at 31 March 2026	568	2,368	107	1,815	-	-	4,858	3
Net book value at 31 March 2026	1,533	404	73	131	-	-	2,141	357
Net book value at 1 April 2025	268	880	86	297	-	-	1,531	-
Net book value of right of use assets leased from other NHS providers								357
Net book value of right of use assets leased from other DHSC group bodies								-

Notes to the Accounts

continued

Note 19.2 Right of use assets - 2024/25

	Property (land and buildings)	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Intangible assets	Total	Of which: leased from DHSC group bodies
	£000	£000	£000	£000	£000	£000	£000	£000
Valuation / gross cost at 1 April 2024 - brought forward	297	5,879	136	4,107	-	520	10,939	-
Additions	242	-	40	-	-	-	282	-
Reclassifications	26	(27)	1	(96)	-	(57)	(153)	-
Disposals / derecognition	-	-	(22)	(1,442)	-	(463)	(1,927)	-
Valuation/gross cost at 31 March 2025	565	5,852	155	2,569	-	-	9,141	-
Accumulated depreciation at 1 April 2024 - brought forward	199	4,132	50	3,203	-	520	8,104	-
Provided during the year	98	840	40	607	-	-	1,585	-
Reclassifications	-	-	-	(96)	-	(57)	(153)	-
Disposals / derecognition	-	-	(21)	(1,442)	-	(463)	(1,926)	-
Accumulated depreciation at 31 March 2025	297	4,972	69	2,272	-	-	7,610	-
Net book value at 31 March 2025	268	880	86	297	-	-	1,531	-
Net book value at 1 April 2024	98	1,747	86	904	-	-	2,835	-
Net book value of right of use assets leased from other NHS providers								-
Net book value of right of use assets leased from other DHSC group bodies								-

Notes to the Accounts

continued

Note 19.3 Reconciliation of the carrying value of lease liabilities

Lease liabilities are included within borrowings in the statement of financial position. A breakdown of borrowings is disclosed in note 27.1.

	2025/26	2024/25
	£000	£000
Carrying value at 1 April	1,596	3,146
Lease additions	1,201	282
Interest charge arising in year	40	73
Lease payments (cash outflows)	(1,073)	(1,905)
Carrying value at 31 March	1,764	1,596

Lease payments for short term leases, leases of low value underlying assets and variable lease payments not dependent on an index or rate are recognised in operating expenditure.

These payments are disclosed in Note 7.1. Cash outflows in respect of leases recognised on-SoFP are disclosed in the reconciliation above.

Note 19.4 Maturity analysis of future lease payments

	Total	Of which leased from DHSC group bodies:	Total	Of which leased from DHSC group bodies:
	31 March 2026	31 March 2026	31 March 2025	31 March 2025
	£000	£000	£000	£000
Undiscounted future lease payments payable in:				
- not later than one year;	831	-	1,001	-
- later than one year and not later than five years;	1,099	-	694	-
Total gross future lease payments	1,930	-	1,695	-
Finance charges allocated to future periods	(166)	-	(99)	-
Net lease liabilities at 31 March 2026	1,764	-	1,596	-
Of which:				
Leased from other NHS providers	-	-	-	-
Leased from other DHSC group bodies	-	-	-	-

Note 20 Disclosure of interests in other entities

The Trust has reviewed the materiality of the charitable funds in accordance with IFRS 10 and the DHSC Group Accounting Manual.

With effect from 1 April 2025, although the Trust remains corporate trustee and retains control, the charitable funds are no longer material to the Trust's financial statements.

Therefore, the Trust has ceased to consolidate the NHS charitable funds in 2025/26. This is a change in accounting assessment rather than a transfer of control.

Notes to the Accounts

continued

Note 21 Inventories

	31 March 2026 £000	31 March 2025 £000
Drugs	1,527	1,650
Consumables	2,000	2,030
Energy	28	14
Total inventories	3,555	3,694
of which:		

Inventories recognised in expenses for the year were £43,404k (2024/25: £42,695k). Write-down of inventories recognised as expenses for the year were £216k (2024/25: £158k).

Note 22.1 Receivables

	31 March 2026 £000	31 March 2025 £000
Current		
Contract receivables	12,144	7,267
Allowance for impaired contract receivables / assets	(1,064)	(473)
Allowance for other impaired receivables	(158)	(152)
Prepayments (non-PFI)	3,415	3,065
Interest receivable	179	162
Operating lease receivables	-	3
PDC dividend receivable	375	1,054
VAT receivable	407	1,143
Other receivables	1,107	1,068
Total current receivables	16,405	13,137
Non-current		
Contract receivables	451	488
Allowance for other impaired receivables	(111)	(119)
Prepayments (non-PFI)	128	199
Total non-current receivables	468	568
Of which receivable from NHS and DHSC group bodies:		
Current	8,512	5,142
Non-current	-	-

Notes to the Accounts

continued

Note 22.2 Allowances for credit losses

	2025/26		2024/25	
	Contract receivables and contract assets	All other receivables	Contract receivables and contract assets	All other receivables
	£000	£000	£000	£000
Allowances as at 1 April - brought forward	473	271	290	236
New allowances arising	1,385	269	275	231
Reversals of allowances	(307)	(135)	(85)	(44)
Utilisation of allowances (write offs)	(487)	(136)	(7)	(152)
Allowances as at 31 Mar 2026	1,064	269	473	271

Note 23 Non-current assets held for sale and assets in disposal groups

	2025/26 £000	2024/25 £000
NBV of non-current assets for sale and assets in disposal groups at 1 April	-	-
Transfers by absorption	-	-
year	650	-
Assets sold in year	-	-
Impairment of assets held for sale	-	-
Reversal of impairment of assets held for sale	-	-
for reasons other than sale	-	-
NBV of non-current assets for sale and assets in disposal groups at 31 March	650	-

During the year, the Trust classified four off-site residential properties located at Howes Road, Bradwell as held for sale.

The properties were classified as held for sale following a review of the Trust's estate, which identified the assets as surplus to operational requirements and no longer required for the delivery of healthcare services. The Trust intends to dispose of the properties through sale on the open market, with disposal expected to be completed within 12 months of the date of classification.

There were no reversals of assets held for sale during the year.

Notes to the Accounts

continued

Note 24.1 Cash and cash equivalents movements

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

	2025/26 £000	2024/25 £000
At 1 April	39,426	34,571
Net change in year	4,889	4,855
At 31 March	44,315	39,426
Broken down into:		
Cash at commercial banks and in hand	84	85
Cash with the Government Banking Service	44,231	39,341
Total cash and cash equivalents as in SoFP	44,315	39,426
Total cash and cash equivalents as in SoCF	44,315	39,426

Note 24.2 Third party assets held by the trust

James Paget University Hospitals NHS Foundation Trust held cash and cash equivalents which relate to monies held by the Trust on behalf of patients or other parties and in which the trust has no beneficial interest. This has been excluded from the cash and cash equivalents figure reported in the accounts.

	31 March 2026 £000	31 March 2025 £000
Bank balances	3	3
Monies on deposit	-	-
Total third party assets	3	3

Note 25.1 Trade and other payables

	31 March 2026 £000	31 March 2025 £000
Current		
Trade payables	8,763	9,931
Capital payables	15,193	17,313
Accruals	10,220	9,118
Social security costs	2,744	2,275
Other taxes payable	2,568	2,518
Pension contributions payable	3,050	2,848
Other payables	5,948	5,441
Total current trade and other payables	48,486	49,444
Of which payables from NHS and DHSC group bodies:		
Current	5,667	7,986
Non-current	-	-

Note 25.2 Early retirements in NHS payables above

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

	31 March 2026 £000	31 March 2026 Number	31 March 2025 £000	31 March 2025 Number
- to buy out the liability for early retirements over 5 years	213		68	
- number of cases involved		5		4

Notes to the Accounts

continued

Note 26 Other liabilities

	31 March 2026 £000	31 March 2025 £000
Current		
Deferred income: contract liabilities	8,432	3,727
Total other current liabilities	8,432	3,727

Note 27.1 Borrowings

	31 March 2026 £000	31 March 2025 £000
Current		
Lease liabilities	752	939
Total current borrowings	752	939
Non-current		
Lease liabilities	1,011	657
Total non-current borrowings	1,011	657

Note 27.2 Reconciliation of liabilities arising from financing activities

	Lease Liabilities £000	Total £000
Carrying value at 1 April 2025	1,596	1,596
Cash movements:		
Financing cash flows - payments and receipts of principal	(1,033)	(1,033)
Financing cash flows - payments of interest	(40)	(40)
Non-cash movements:		
Additions	1,201	1,201
Application of effective interest rate	40	40
Carrying value at 31 March 2026	1,764	1,764

	Lease Liabilities £000	Total £000
Carrying value at 1 April 2024	3,146	3,146
Cash movements:		
Financing cash flows - payments and receipts of principal	(1,832)	(1,832)
Financing cash flows - payments of interest	(73)	(73)
Non-cash movements:		
Additions	282	282
Application of effective interest rate	73	73
Carrying value at 31 March 2025	1,596	1,596

Notes to the Accounts

continued

Note 28 Provisions for liabilities and charges analysis

	Pensions: early departure costs £000	Pensions: injury benefits £000	Legal claims £000	Other £000	Total £000
At 1 April 2025	517	274	79	194	1,064
Change in the discount rate	(22)	(21)	-	-	(43)
Arising during the year	62	17	54	-	133
Utilised during the year	(73)	(18)	(15)	(4)	(110)
Reversed unused	-	-	(54)	-	(54)
Unwinding of discount	12	8	-	-	20
At 31 March 2026	496	260	64	190	1,010
Expected timing of cash flows:					
- not later than one year;	71	17	64	190	342
- later than one year and not later than five years;	278	70	-	-	348
- later than five years.	147	173	-	-	320
Total	496	260	64	190	1,010

Note 28.1 Clinical negligence liabilities

At 31 March 2026, £112,111k was included in provisions of NHS Resolution in respect of clinical negligence liabilities of James Paget University Hospitals NHS Foundation Trust (31 March 2025: £100,964k).

Notes to the Accounts

continued

Note 29 Contingent assets and liabilities

	31 March 2026 £000	31 March 2025 £000
Value of contingent liabilities		
NHS Resolution legal claims	11	26
Gross value of contingent liabilities	11	26
Amounts recoverable against liabilities	-	-
Net value of contingent liabilities	11	26
Net value of contingent assets	-	-

The Trust is a member of the Clinical Negligence Scheme for Trusts (CNST), operated by NHS Resolution. Under the terms of the scheme, NHS Resolution accepts financial responsibility for clinical negligence liabilities incurred by the Trust, although the Trust remains legally liable for clinical negligence claims.

Claims against the Trust are recognised as provisions or contingent liabilities by NHS Resolution and are included within the CNST provision reported in the consolidated Department of Health and Social Care accounts.

In addition, the Trust discloses remote contingent liabilities in respect of clinical negligence claims covered by CNST for Parliamentary accountability purposes, in accordance with the Group Accounting Manual. As the likelihood of an outflow of resources in respect of these claims is considered remote, no amounts have been recognised in the financial statements.

The Trust has no other material contingent liabilities or contingent assets at the reporting date.

Note 30 Contractual capital commitments

	31 March 2026 £000	31 March 2025 £000
Property, plant and equipment	811	31,520
Intangible assets	1,506	2,482
Total	2,317	34,002

Note 31 Other financial commitments

The trust is committed to making payments under non-cancellable contracts (which are not leases, PFI contracts or other service concession arrangement), analysed by the period during which the payment is made:

	31 March 2026 £000	31 March 2025 £000
not later than 1 year	801	427
after 1 year and not later than 5 years	-	320
paid thereafter	-	-
Total	801	747

Notes to the Accounts

continued

Note 32 Financial instruments

Note 32.1 Financial risk management

Financial risk management

Financial reporting standard IFRS 7 requires disclosure of the role that financial instruments have had during the period in creating or changing the risks a body faces in undertaking its activities. Because of the continuing service provider relationship that the Trust has with Integrated Care Boards and the way those Integrated Care Boards are financed, the Trust is not exposed to the degree of financial risk faced by business entities. Also financial instruments play a much more limited role in creating or changing risk than would be typical of listed companies, to which the financial reporting standards mainly apply. The Trust has limited powers to borrow or invest surplus funds and financial assets and liabilities are generated by day-to-day operational activities rather than being held to change the risks facing the Trust in undertaking its activities.

The Trust's treasury management operations are carried out by the finance department, within parameters defined formally within the Trust's standing financial instructions and policies agreed by the board of directors. Trust treasury activity is subject to review by the Trust's internal auditors

Currency risk

The Trust is principally a domestic organisation with the great majority of transactions, assets and liabilities being in the UK and sterling based. The Trust has no overseas operations. The Trust therefore has low exposure to currency rate fluctuations.

Interest rate risk

The Trust has borrowings in the form of finance leases. The interest rate is generally fixed, resulting in a low level of associated risk.

Credit risk

The majority of the Trust's income comes from contracts with other public sector bodies, therefore the Trust has low exposure to credit risk. The maximum exposures as at 31 March 2026 are in receivables from customers, as disclosed in the Trade and Other Receivables note.

The Trust's Treasury Management Policy has clear criteria, is updated regularly and there is a very low level of risk associated with cash and any deposits with financial institutions.

Liquidity risk

The Trust's operating costs are incurred under contracts with Integrated Care Boards, which are financed from resources voted annually by Parliament. The Trust is not, therefore, exposed to significant liquidity risks.

Notes to the Accounts

continued

Note 32.2 Carrying values of financial assets

Carrying values of financial assets as at 31 March 2026

Trade and other receivables excluding non financial assets
Cash and cash equivalents
Total at 31 March 2026

Held at amortised cost £000	Total book value £000
12,547	12,547
44,316	44,316
56,863	56,863

Carrying values of financial assets as at 31 March 2025

Trade and other receivables excluding non financial assets
Cash and cash equivalents
Total at 31 March 2025

Held at amortised cost £000	Total book value £000
8,046	8,046
39,426	39,426
47,472	47,472

Note 32.3 Carrying values of financial liabilities

Carrying values of financial liabilities as at 31 March 2026

Obligations under leases
Trade and other payables excluding non financial liabilities
Provisions under contract
Total at 31 March 2026

Held at amortised cost £000	Total book value £000
1,764	1,764
34,285	34,285
757	757
36,806	36,806

Carrying values of financial liabilities as at 31 March 2025

Obligations under leases
Trade and other payables excluding non financial liabilities
Provisions under contract
Total at 31 March 2025

Held at amortised cost £000	Total book value £000
1,596	1,596
35,252	35,252
791	791
37,639	37,639

Note 32.4 Maturity of financial liabilities

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

	31 March 2026 £000	31 March 2025 £000
In one year or less	35,204	36,340
In more than one year but not more than five years	1,448	971
In more than five years	320	427
Total	36,972	37,738

Notes to the Accounts

continued

Note 33 Losses and special payments

	2025/26		2024/25	
	Total number of cases Number	Total value of cases £000	Total number of cases Number	Total value of cases £000
Losses				
Cash losses	23	3	-	-
Fruitless payments and constructive losses	-	-	-	-
Bad debts and claims abandoned	161	485	23	7
Stores losses and damage to property	7	9	4	64
Total losses	191	497	27	71
Special payments				
Compensation under court order or legally binding arbitration award	-	-	-	-
Extra-contractual payments	-	-	-	-
Ex-gratia payments	27	13	21	17
Special severance payments	-	-	-	-
Extra-statutory and extra-regulatory payments	-	-	-	-
Total special payments	27	13	21	17
Total losses and special payments	218	510	48	88
Compensation payments received				

Notes to the Accounts

continued

Note 34 Related parties

The James Paget University Hospitals NHS Foundation Trust is a body corporate established by order of the Secretary of State for Health.

During the year none of the Board Members or members of the key management staff or parties related to them has undertaken any material transactions with the Foundation Trust.

The Department of Health and Social Care is regarded as a related party. It is the parent department for DHSC group bodies. Accordingly we are required to provide a note of the main entities within the public sector which the Trust has had dealings with. They are included in the table below. A de minimus of £2m income or expenditure has been used.

	Total Income 2025/26 £000	Total Expenditure 2025/26 £000	Total Income 2024/25 £000	Total Expenditure 2024/25 £000
Related Party Transactions				
Value of transactions with board members	-	-	-	-
Value of transactions with key staff members	-	-	-	-
Norfolk and Norwich University Hospitals NHS Foundation Trust	5,617	13,570	6,436	12,363
The Queen Elizabeth Hospital King's Lynn NHS Foundation Trust	150	74	427	44
NHS Norfolk and Waveney ICB	321,671	130	301,878	470
NHS England	28,268	13	25,906	26
NHS Resolution	-	9,811	-	9,031
HM Revenue & Customs	-	26,219	11	20,816
NHS Pension Scheme	-	36,617	-	35,041
Other non WGA Related Parties				
James Paget Hospitals Charitable Fund	1,519	-	235	-
NHS Confederation (Services) Co Ltd - note 1	-	2	-	-
Macmillan Cancer Support - note 1	-	-	-	-
	Total Receivables 2025/26 £000	Total Payables 2025/26 £000	Total Receivables 2024/25 £000	Total Payables 2024/25 £000
Related Party Balances				
Value of balances (other than salary) with related parties in relation to doubtful debt	-	-	-	-
Norfolk and Norwich University Hospitals NHS Foundation Trust	1,378	3,562	1,362	7,252
The Queen Elizabeth Hospital King's Lynn NHS Foundation Trust	130	136	256	17
NHS Norfolk and Waveney ICB	5,798	1,642	2,039	2,593
NHS England	394	1,472	290	519
NHS Resolution	-	-	-	-
HM Revenue & Customs	407	5,312	1,143	4,793
NHS Pension Scheme	-	3,050	-	2,848
Other non WGA Related Parties				
James Paget Hospitals Charitable Fund	469	-	197	-
NHS Confederation (Services) Co Ltd - note 1	-	1	-	-
Macmillan Cancer Support - note 1	1	-	1	-

Note 1 - Entity deemed related party within Departmental Group

Remuneration of Key Management Personnel

The following table analyses the remuneration of key management personnel (deemed to be the Board of Directors) in accordance with IAS 24.

	Year Ended 31 March 2026 £000	Year Ended 31 March 2025 £000
Short term employee benefits (pay)	1,326	945
Post-employment benefits (employers pension contribution)	163	124

The highest paid Director in 2025/26 received remuneration of £236k, excluding pension related benefits and exit packages, for their services as Chief Executive Officer to May 2025 and Group Delivery Officer from May 2026. In 2024/25 the highest paid Director received remuneration of £200k, not including pension related benefits and exit packages, for their services as Chief Medical Officer including an element relating to their non managerial role.

